

## Case Study

### Habilitation Therapy in Dementia Care

by Paul Raia, Ph.D.  
Alzheimer's Association  
MA/NH Chapter

#### Educational Objectives

1. To describe the goal of Habilitation Therapy and how it differs from other methods of dementia care, including rehabilitation.
2. To identify areas or domains in which we have opportunities to bring about and sustain positive emotions.
3. To discuss four communication strategies to use with mid- to later-stage Alzheimer's patients.

#### Background

Until recently, the life of the person with Alzheimer's disease was defined as revolving entirely around inevitable loss, for Alzheimer's disease has been seen as a disease for which there is no cure and no treatment. In consequence, we have devoted all of our resources to biomedical research in order to find the "magic pill."

Although a cure is nowhere in sight, the paradigm holds enormous power among professionals and the public at large. A contrasting view sees Alzheimer's disease and related disorders as disabilities, albeit caused by progressive and fatal neurological illness. In this view, individuals respond to their disease according to how supportive their environments are. Here, the emphasis is on active treatment of the symptoms of the dementia through a careful focus on those capacities that remain, particularly the person's psychological capacity. Developing a better understanding of the psychology of dementia, i.e., how a person thinks, feels, communicates, compensates, and responds to change, to emotion, to love, may bring some of the biggest breakthroughs in treatment. This new paradigm, which my colleague Joanne Koenig-Coste and I introduced in 1996 as *habilitation* (Raia & Koenig-Coste, 1996), is more a disposition or a way of thinking than a complete therapeutic model.

The aim of "habilitation therapy" is not to restore people with a dementia such as Alzheimer's disease to what they once were (i.e., rehabili-

tation), but to maximize their functional independence and morale. This approach also allows minimizing or eliminating many difficult symptoms of the dementia, in spite of the person's progressive physical, cognitive, and emotional illnesses. The primary learning task becomes how to value what is still there and not dwell on functions the person has lost. To borrow from the philosopher Erich Fromm (1976), family and professional caregivers need to emphasize "being" rather than "having." This model is no cure. But it is a systematic behavioral method of treating symptoms that can benefit both the person with Alzheimer's disease and the caregiver.

#### Habilitation Theory in Practice

The goal of habilitation therapy is deceptively simple: to bring about a positive emotion and to maintain that emotional state over the course of the day. Clinically, however, it presents a challenge. If cognitive capacities involving memory, logic, reason, decision making, judgment, language, attention, perception, and motor control all are being gradually lost to the disease, what remains?

#### Inside This Issue:

VCoA Editorial, 6  
VDA Editorial, 8  
VCoA Focus: Paige Ulvi, 10

Aging with Disabilities, 11  
The Waist Land, 12  
Adult Day Services & Stress, 13

Small Miracles, 14  
Virginia Gold, 15  
Calendar of Events, 18

What cognitive capacity can we use as a channel into the brain? The answer: the capacities to feel and exhibit emotions, to perceive emotions in others, and to respond to emotion persist far into the disease process. Habilitation therapy can be defined as a proactive behavioral/milieu therapy activated within five “domains:” critical areas in which positive emotions can be created and maintained. Stated another way, a domain is an opportunity to bring about a positive emotion or, at least, to not cause a negative one.

### **The Physical Domain**

Even a once-familiar environment can become frightening and confusing to someone with Alzheimer's disease. Within the physical domain, the habilitation therapy model attempts to reduce the potential for fear and disorientation by “directing” cognition, often without the person’s awareness. In this way, the manipulated environment becomes a prosthetic for the brain, enabling the person to function with limited frustration.

A well-designed prosthetic environment, like all the other domains in this model, has as a goal to bring about a positive emotion and to maintain that emotion.

#### Case Study

A 73-year old woman with Alzheimer's disease, living at home with her husband, was having difficulty dressing herself in the morning. He would take her to her enormous walk-in closet and say it was time to get dressed. When he would return 20 minutes later, she was

still standing in the closet in her nightgown. Alzheimer's patients have problems making decisions, so the environment had to be altered to reduce the number of choices. I instructed the husband to remove all but two or three outfits from the closet and suggested that he say something like: “We have two very pretty outfits here, a blue one and a red one. I like the blue one because it matches your eyes. Which one would you like to wear today?” Once we limited the number of choices, she was able to get dressed on her own. With her environment structured so that she can use her remaining skills, chances are that she will hold on to these skills longer. It also serves to bring about a positive emotion because she feels more independent.

Perhaps the single most important adaptation to an environment is enhanced lighting. By increasing artificial light from approximately 30-foot-candle power (typical lighting in a home) to 60- to 70-foot-candle power and controlling the glare and shadows from outside ambient light, we can improve independence, reduce late afternoon and early evening agitation, promote better sleep patterns, and stabilize mood.

### **The Social Domain**

Structured activities are the engine that drives the social domain. Understandably, people with Alzheimer's disease who spend significant amounts of time doing nothing experience more psychiatric symptoms, such as depression, anxiety, paranoia, delusions, and hallucinations, than people who are occupied by a meaningful activity.

By developing a failure-free activities plan, we can avoid cognitive skill areas that have been lost. This plan may require that the person’s cognitive strengths and weaknesses be assessed through a battery of neuropsychological tests. A cautionary note: For some patients, these tests can cause frustration and bring about negative emotions. In these instances, our knowledge of the patient and observation of his or her skill level are better indicators of how to design failure-free activities.

In the social domain, time is filled with opportunities for reminiscence (e.g., cooking classes, word games, and holiday reflections), for fun (dancing, sing-a-longs), and for creativity (herb gardening, jigsaw puzzles, and art projects). However, these activities are not “time fillers” but carefully and individually selected cognitive enhancers that maintain healthy neural connections and promote branching or arborization of neurons. Branching of neuronal axons allows an electrical impulse in the brain to bypass damaged areas of the brain and make connections with healthy cells. So, failure-free activities help individuals hold on to their capacities longer and maintain positive emotions. Another benefit of activities, especially musical activities, is that they very quickly change emotions. To address his wife’s “sundowning” behavior (late-day confusion), one caregiver began ballroom dancing with her late every afternoon. She enjoys it and does not experience sundowning, plus they are able to relive some previously inaccessible personal emotions of their youth. Thus, activities can be used prophylactically to avoid anticipated

swings in mood or increased confusion. An activity cannot be introduced once the person is already agitated.

### Case Study

An all-dementia program at one facility focuses on education as a formal activity. The staff created week-long educational modules on various adult topics. For one week, residents attend an hour and a half long morning discussion on a set topic, say Italy, where they would study the history, culture, food, art, geography and political system. In the afternoon, they would meet again for an hour and a half and do something related to what they discussed that morning. They might listen to an opera, make a food, go to an art museum, etc. The intention is not on the retention of information, but rather, on the joy of being in a learning environment with peers. The staff developed more than 30 different week-long modules.

### **The Communication Domain**

Nowhere in the habilitation model is the process of eliciting positive emotions more critical than in the communication domain. In our highly verbal world, expressive and receptive language deficits are catastrophic losses for someone with Alzheimer's disease. In the communication domain, habilitation therapy calls for increased use of body language, encouraging the use of gestures, demonstrations, signs, and pictures. Here are summaries of four strategies, with a fuller discussion available in Raia (1999).

The first strategy of habilitative

communication is that one can never change behavior with words, but only by changing what one does, the approach to the patient, or the environment. Because the patient has no short-term memory and limited capacity to learn, we cannot tell the patient to do something or not to do something and expect him or her to remember it the next time.

The second strategy is never to use the word no. If the patient wakes up at 4:00 a.m. and wants to take a walk outside in a rainstorm, one should say, "Sure, let's do it." If one says no, muscles tense up, tone of voice changes, and the patient sees the caregiver as limiting his or her independence. Even if the patient is given the most logical, eloquent argument why he or she should not go outside, there is nothing in his or her brain that can appreciate the reasoning. Rather than logic, one should use distraction. Two techniques, "refocusing" and "redirecting," help distract the patient long enough so that his or her faulty memory will work to the caregiver's advantage. For example, one might say, "Sure, let's go walk in the rainstorm, but before we go, I need to have a cup of tea and a sandwich. My favorite kind of sandwich is turkey. What's yours?" The caregiver is refocusing the person's attention. He or she then might go on to say, "Help me make the sandwich." Such dialogue redirects behavior.

The third strategy, perhaps the hardest to learn and apply, is that one never brings a midstage patient back to our sense of reality; rather, the caregiver must go to where the patient is. Reality orientation as a

therapeutic technique works just fine for cognitively intact elders, but it is not at all useful for mid-stage confused patients with Alzheimer's disease.

A fourth communication strategy emphasizes our roles in reducing fear for the patients and acknowledging underlying emotions. As they decline and lose capacities, part of what is also lost is the ability to articulate their fears and cope with them. Essentially, what is lost is the person's ability to self-soothe if fears become overwhelming. The focus of our communications is to make the person feel loved and safe.

Habilitation therapy underscores listening techniques related to emotions, directing us to listen not so much to the often misused words and muddled sentences, but to the driving emotion behind them. For example, if the person is experiencing symptoms of suspiciousness and accuses the caregiver of taking her pocketbook, the caregiver can say something like, "I know how you feel. When I lose my pocketbook [or wallet] I feel panicky. Let me help you find it." You have acknowledged the validity of the patient's emotion and once this offer of assistance is communicated, the outcome is likely to be a change in the person's emotional state.

### Case Study

Evelyn, a 91-year-old widow with dementia, becomes increasingly confused in the late afternoon and early evening, a condition referred to as "sundowning." During this period, Evelyn might approach a

caregiver and say that she just saw her mother. Using “reality orientation,” the caregiver tells Evelyn that her mother is dead and that she did not really see her. This propels Evelyn into mourning because it is the first time she has heard that her mother has died. The tragedy here is that within a matter of seconds Evelyn forgets that she was told her mother is dead, but she is left with the emotion of profound sadness with no context for it, and no ability to control the emotion. Within habilitation therapy, rather than tell the patient that her mother is dead, we would say, “Tell me about your mother. I hear that she is a wonderful person.” Or, if this happens frequently and predictably, the caregiver could have a picture of the patient and her mother taken many years earlier and use the picture to create a story, which may or may not be true, to bring about a positive emotion.

### **The Functional Domain**

All too frequently in Alzheimer's care we note an inability to perform routine tasks sooner than would be expected from the trajectory of the disease. Dysfunction caused by the person's emotional reaction to the disease (e.g., depression) or to physical or care factors in the environment is said to be an “excess disability.”

Excess disabilities with environmental causes can be avoided by creating supports that encourage independence in the person's activities of daily living: eating, walking, toileting, dressing, grooming, and bathing. As in the activity domain, previous routines become the cornerstones here, as caregivers strug-

gle to keep one step ahead of dependence. To preserve the person's sense of worth we need to ask, if she fails at more complicated chores, can she instead help by shredding lettuce or setting the table?

Caregivers also can change the task to fit the person and prioritize which activities for daily living (or parts of an activity) are important and which are not. Bathing, for example, may be the most difficult activity asked of the person. One should begin by spending at least five minutes just talking and building rapport. This is what I call the “spend five and save 20” rule. Proposing an activity as a question (“Would you like to take a bath?”) too often leads to a resounding “no.” Assist the person with verbal cues, using a technique called “chunking,” which involves a series of short, simple, calmly stated commands, such as “come with me,” “unbutton your shirt,” “take out your arm.” Schedule bathing when the person is in the best frame of mind, most alert, and cooperative. If necessary, provide hands-on assistance, mindful not to let water pour over the person's face and eyes, which can be frightening. Wash the hair and the face at a different time. Showering for a patient with Alzheimer's disease is best done from the feet up, stopping at the neck, rather than working from the head down.

### Case Study

Tom, a 53-year-old patient with Alzheimer's disease, had great difficulty with his morning shower, being combative and behaving poorly afterward. Under habilita-

tion therapy it is imperative to intervene and prevent the development of the negative emotion. The first step is triage. If showering is so difficult for him, how many times a week are we willing to risk starting off the day with a negative emotion? Talking with this man's family revealed that there were four things that calmed him: backrubs, blue sports cars, women in short skirts, and the music of the Beach Boys. We developed an intervention that employed these calming agents. To begin with, only one nursing assistant was involved with assisting with this man's shower rather than three aides involved previously. The aide would come into the man's room and just chat with him for a few minutes, the “spend five to save 20 rule.” She then gave the man a backrub to create a relaxed mood. Once he was relaxed, she simply said, “Come with me,” and led him down the hall to the shower. On the walls between the “young” patient's room and the shower we had taped pictures of blue sports cars and tasteful pictures of women in short skirts to distract him and avoid any anticipatory anxiety. In the shower room, the music of the Beach Boys was playing; the room was warm and well illuminated. While singing with the young man, the aide undressed him, giving him a bathrobe to avoid modesty problems. Using a handheld shower nozzle, the aide started washing at the man's feet and quickly moved up the body, stopping at the neck. The actual washing took less than three minutes.

### **The Behavioral Domain**

To manage problematic (i.e., reac-

tive) behaviors successfully, the habilitation therapy model requires that caregivers adopt a dementia-centered perspective. This accepts that we cannot change the person's behavior directly, but only indirectly by changing either our approach technique or the person's physical environment.

Difficult behaviors in people with Alzheimer's disease are most often defensive in nature, such as compensation for the confoundedness or fear of an increasingly unfamiliar world. Behavior, in this sense, is a form of communication directed to us. Sometimes these events are obvious because they are external, we can see them, and sometimes triggers are more difficult to see because they are internal, caused by delusions, hallucinations, paranoia, or misunderstood events and motives. Internal triggers can be more physical in nature, for example, pain, hunger, dehydration, constipation, infections, fever, sleep deprivation, etc. Caregivers must assess several possible causes for each challenging behavior.

### Case Study

Will, who has Alzheimer's disease and lives in a nursing home, would on occasion calmly get up from his chair, walk across the room, and hit another resident. By keeping a log, we began to see that he would only hit someone if he was in the activities room, but not every time he was in that room. Later, we saw that he would only hit people on sunny days, but not on every sunny day on which he was in the activities room. Then, we saw that he only hit people on sunny days if he was sitting on one side of the room.

With the log we were able eventually to determine that he would hit people if he sat in the activities room and the sun was shining in his eyes. The intervention was simply to make sure that the blinds were closed on sunny days if this particular man was in the activities room. Thus, with patience and careful analysis of the situation we were able to avoid the use of a psychoactive medication. Of course, it may be dangerous to allow repeated episodes of assaults to occur in order to gather data to determine the cause of the triggering behavior.

### **Conclusion**

Through its multiple and interconnected domains, habilitation seeks to create a proactive therapeutic milieu for understanding the needs of people with Alzheimer's disease. It differs from rehabilitation, which seeks to restore external function, by its emphasis on the internal: emotion. Habilitation is as much a positive attitude about Alzheimer's disease and related disorders as it is a therapeutic method.

### **Study Questions**

1. How would you use Habilitation Therapy techniques to address restless behavior in a midstage Alzheimer's patient in the late afternoon?
2. Using your kitchen at home as an example to work from, how could you modify it to be more of a prosthetic supportive environment for someone with Alzheimer's disease?
3. How would you assist someone with Alzheimer's disease in brushing her teeth? Give the actual directions you would use and the way you would introduce the task

using Habilitation Therapy methods.

4. Why does Habilitation Therapy focus so much on emotions?

### **References**

Fromm, E. (1976). *To have or to be*. New York: Harper and Row.

James, W. (1890). *The principles of psychology* (Vol. 1). New York: Holt.

Maslow, A.H. (1968). *Toward a psychology of being* (2nd ed.). New York: Van Nostrand.

Raia, P. & Koenig-Coste, J. (1996). Habilitation therapy. *Alzheimer's Association of Eastern Massachusetts Newsletter*, 14 (2), 1-2, 4-6.

Raia, P. (1999). Habilitation therapy: A new starscape. In L. Volicer (Ed.), *Enhancing the quality of life in advanced dementia*. New York: Brunner/Mazel Publishers.

### **About the Author**



Paul Raia, Ph.D., has worked in the fields of gerontology and psychology for more than 30 years, the last 25 at the Alzheimer's Association

Massachusetts/New Hampshire chapter. As Vice President of Clinical Services, Dr. Raia initiated the first support group for individuals with early stage Alzheimer's disease in the country. His interests include the design of Special Care Units for those with dementia, and behavioral management methods. His e-mail is [Paul.Raia@alz.org](mailto:Paul.Raia@alz.org).

## Editorials

### From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

#### *Baby Boomers and Stereotypes*

*(A version of this editorial appeared in the Fredericksburg (VA) Free Lance-Star, August 21, 2011. Reprinted by permission)*

There's been a flurry of attention on Baby Boomers, especially since the leading edge of Boomers turned 65 recently, and a number of questions. Will they change established practices in health, government, marriage, business? How do we reach them and, often, how do we market to them? The questions contain one basic flaw. They assume uniformity or at least great similarity among Boomers.

Think of it: the Post-War Baby Boom ran roughly from 1946 to 1964, although some quibble that it ended when it peaked in 1957. The Boom produced as many as 76-78 million people. Yet some want to bundle so many people into convenient packages and easily understood clichés. What none of us would accept at an earlier age, stereotyping, seems not only all right for Boomers but even something to seek.

It is true that certain events and experiences can have almost an imprinting effect, such as the Viet Nam War, Woodstock, or the administrations of certain presidents. But even these are altered by the point in development when one experiences them or the sub-group

that acts as a reference point. Consider how differently the Viet Nam War might influence someone who was 10 years old in 1970 versus 20 years old. Yet both are today's Baby Boomers.

One of the most significant breakthroughs in our understanding of human aging is the realization that people tend to grow less like their age mates as they grow older. On most any measure, from heart functioning to abstract reasoning to acquired vocabulary, research shows that there tends to be more variability the older the sample, more range of scores within older groups of adults than within younger counterparts, making generalizations very difficult.

While these findings are not absolute, they are fundamentally true, enough for me to have concluded years ago that the thrust of human development over the life course is individuation. With age we become more and more like ourselves. This would mean millions and millions of individual Baby Boomers, each with his or her own characteristics and life trajectory. Stereotyping would, therefore, be wrong but it is happening. Be suspicious when someone says, "Baby Boomers want..." or "Baby Boomers won't..."

A helpful analogy is a style of painting called pointillism, where the artist composes using small dots of paint on the canvas. From a distance, the viewer sees the intended image, an apparent whole. But looking up close, one sees thousands of individual dots of color, some big, some small, spread out all over the canvas. This is the pic-

ture of the Baby Boom and of aging today. From a distance, it looks like uniformity but in reality the big picture is made up of incredible numbers of separate colors, textures, sizes, depths, and so on.

Lots of people make the mistake of focusing only on the big picture and ignoring the separate dots. This includes government policy makers, educators, health care providers, and people in business. As for business, if ever there was a case for distinguishing between selling (pushing a product) and marketing (finding out what the consumer wants), the great variety within the Baby Boom is it.

True, in a number of ways there are commonalities among us as we age, like graying or loss of hair, the need for correctives lenses, and gravitational pull on our body shapes. But these are relatively minor. On most important dimensions, growing older increases the variety within an age group, with each older person reflecting the individual patch work of his or her personal life history. So, if we were to follow a birth group of Baby Boomers through the life course, we would see that the life course would affect each one a bit differently, as each experiences and catalogues events through individual prisms already shaped by life's experiences.

This reality, increasing variability with age, is an unpopular message, especially for people looking for an easy stereotype. But this fact has not stopped many from making pronouncements and generalizations about Boomers. Of course, interested parties can still compute averages but, with ranges getting larger,

## Editorials

averages become more meaningless. In fact, with such a huge number of Boomers, successful outreach or marketing must narrow its focus and hone in on just a tiny segment or sub-set of the many dots.

Many gerontological and geriatric professionals (those who study and care for older adults) are aware of what we call the *geriatric* or *aging imperative*; namely, the thrust of human development after the reproductive cycle seems to be individuation, becoming more and more like oneself. While earlier in life we were shaped by norms that influenced what clothes we wore, when and who we married, and so on, perhaps in a primal drive to ensure the continuation of the species, after mid-life Mother Nature seems to have little drive to conformity. Of course, the greater the numbers of people there are in a group, the greater the likelihood of finding some who share certain characteristics; but this does not negate the geriatric imperative. *One to the millionth power is still one.*

Individuation may help to explain why the number of physicians and nurses in geriatrics in the United States has been steadily declining at the very time when logic would dictate that the numbers should be increasing. (Note: if Baby Boomers are successful, they *will* grow older!) Geriatric health care providers have the most diverse and heterogeneous patient base, and the influx of Boomers over time will only make it greater. Five older adults visiting the health care provider with similar symptoms or complaints will nonetheless have five different support systems, levels of understanding what's being

said, financial resources, likelihoods of following the provider's advice, belief systems, etc., all of which influence the outcome of treatment. Because of individuation, the geriatric provider, perhaps more than others, needs to pay careful and continuous attention to the trajectories of older patients, and to gather full updates of their progress, and to discover how this one differs from that one. But all this takes time and time is often the least available commodity among health care providers drifting toward shorter and shorter "encounter times" with their patients; furthermore, insurance tends to discourage taking this necessary extra time because, after the initial intake and patient history, such extensive interactions tend not to be reimbursed by third party payers.

In Virginia, we have a new Virginia Geriatric Education Center (VGEC), which is a consortium of health care providers at Virginia Commonwealth University, Eastern Virginia Medical School, and the University of Virginia, which is dedicated to developing interprofessional care for older adults, care that draws upon the talents of providers in medicine, pharmacy, nursing, social work, and physical therapy and that involves the patient in the process. The VGEC is training current health care providers and the students who are the next generation of providers to respond meaningfully to increasing numbers of older individuals.

Among the take away messages for Baby Boomers is that you are an individual first. In many, perhaps most, ways, the fact that you are a

member of a large Baby Boom is not very relevant. From mid-life on we have opportunities to make the most of our uniqueness rather than to be swayed by the herd.

## Disabilities-Friendly Emergency Information Website

---

In an effort to keep the community informed during disasters, the Texas Public Health District has developed a website that features 18 emergency preparedness topics in formats that are friendly to deaf, blind, and limited sight populations. It is available to the public at no cost in both video and downloadable document formats.

The website ([www.accessibleemergencyinfo.com](http://www.accessibleemergencyinfo.com)) is not branded so that groups/agencies across the nation can use it to promote the inclusion of persons with disabilities in emergency preparedness and health-related topics. The site features videos with ASL interpreters. The videos have an audible voice over and text appears alongside the interpreter. The site also features the Emergency Preparedness Guide formatted in Braille, large print, and regular font for download.

To support future improvements of the site, they have included a discussion page and two surveys for those viewing the information to assess preparedness levels before and after viewing the material. The intent was to create a website to assist at-risk populations and serve other organizations as a tool to become prepared for all hazards.

## Editorials

### From the **Interim Commissioner, Virginia Department for the Aging**

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

#### *Lessons from Irene and Resources for the Future*

As I put fingers to keyboard for this editorial, almost all Virginians have regained electrical power after what, for many, was a long ordeal caused by Hurricane Irene. From what I can gather, many of our preparedness measures worked, yet we may still be learning lessons for future emergencies. And I should add that in the environment we now live in, there will be future emergencies.

I was impressed with the use of the Internet in getting out weather forecasts, preparedness reminders, and other useful information. All of the Area Agencies on Aging were busy getting alerts out before the storm.

An issue that we will be working on in the future will be how to get basic supplies to those who cannot leave their homes. In one part of the state, ice and water were dropped off at central locations; but to take advantage of this supply, one had to go to the drop off sites. I want publically to thank Anheuser Busch for working with Bay Aging to get water and other supplies to those who could not venture out to get them. With this public-private partnership, many were allowed to continue with medications and realize a higher level of comfort in a

trying time.

Since September is acclaimed as *National Preparedness Month*, it is timely to remind all of what can be done to survive future emergencies. I have brazenly copied from the Virginia Department of Emergency Management's website some good recommendations for planning that we should all heed; and for those with or caring for others with mobility limitations, we need to redouble our efforts to be sure that all Virginians are prepared for whatever emergencies come next.

#### **For Older Virginians**

If you or someone in your family is older, be sure to include special items in your supply kit that are in addition to the basic supplies. If you take medicine regularly or use a medical treatment on a daily basis, be sure you have what you need to make it on your own for at least a week, maybe longer.

- When assembling your emergency kit, be sure it's not too heavy or bulky for you to carry. You might need to store items in more than one container or a suitcase with wheels.
- Ask your doctor about how to store properly your prescription medications, such as heart and high blood pressure medicine, insulin, and other prescription drugs.
- Include items to fill denture needs.
- Include extra eye glasses.
- Remember to pack hearing aid batteries, wheelchair batteries, and oxygen.
- Make a list of all prescription medicines that includes the purpose and dosage of each, and any allergy

information. Talk to your pharmacist or doctor about what else you need to prepare.

- Make sure you have contact numbers for your pharmacy and medical supply providers if you require oxygen, dialysis supplies, diabetes supplies, etc.
- Include a list of doctors, relatives, or friends who should be notified if you are hurt.
- Include copies of important documents in your emergency supply kit.
- Have copies of your medical insurance and Medicare cards readily available.
- Keep a list of the style and serial number of medical devices or other life-sustaining equipment. Include operating information and instructions.
- Make sure that a friend or family member has copies of these documents.
- If you have a communication disability, make sure your emergency information contains instructions for the best way to communicate with you.

[www.vaemergency.gov/readyvirginia/getakit/older](http://www.vaemergency.gov/readyvirginia/getakit/older)

The following links provide additional emergency preparedness information and opportunities to get involved in National Preparedness Month!

[www.vaemergency.com](http://www.vaemergency.com)

[www.ReadyVirginia.gov](http://www.ReadyVirginia.gov)

[www.citizencorps.gov/index.shtml](http://www.citizencorps.gov/index.shtml)

<http://community.fema.gov/connect.ti/READYNPM>

I would welcome any stories of

issues that arose where we can identify measures that can improve our response capacity for all Virginians, but particularly for those of us who are *Vintage Virginians*. Since Hurricane Katrina, the Commonwealth has been working to increase awareness and identify strategies to assist us all in minimizing the damage that might come from natural or manmade disasters. If you wish to share your stories or ideas, just contact me at:  
[Jim.rothrock@drs.virginia.gov](mailto:Jim.rothrock@drs.virginia.gov).

### Fall Alerts

In the next issue of *Age in Action*, I am confident that I will be able to share information on measures that our General Assembly will be considering when it convenes in January of 2012. And, with this in mind, I would advise you to educate our legislators about matters of importance to you and to work to elect those who will represent you the best. The statewide elections occur this fall. Take advantage of your right to vote. Make sure your voice is heard.

Another heads up that I offer is the Governor's Housing Conference to be held in November in Hampton. This is always a great event and Governor McDonnell and Bob Sledd, his special advisor on housing, have worked with many stakeholders on issues that would be of interest to our readers. Information on this conference can be found at the following website:  
[www.vagovernorshousingconference.com](http://www.vagovernorshousingconference.com)

Also in November we will have the final report from the Older Dominion Partnership. This report will

offer guidelines for working together to fashion programs, supports, and opportunities to sustain the independence of Vintage Virginians and Boomers.

And finally, as noted previously, Virginia now offers resources to assist communities in planning to become more livable. To access this site go to:[www.vadrs.org/vblc](http://www.vadrs.org/vblc).

With these resources, it is much easier for us in the Commonwealth to age in place and enjoy a greater sense of community.

---

The Virginia Department for the Aging has three Boards. Upcoming meetings, which are open to the public, are as follows:

**The Commonwealth Alzheimer's Disease and Related Disorders Commission**  
December 13, 2011, at VDA  
10:00 a.m. - 2:00 p.m.

**The Commonwealth Council on Aging**  
January 25, 2012, after VCoA's Legislative Breakfast

**The Virginia Public Guardian & Conservator Board**  
December 1, 2011, at VDA  
10:00 a.m. - 2:00 p.m.

For information on these meetings, contact Cecily Slasor at (800) 552-3402 or [Cecily.slasor@vda.virginia.gov](mailto:Cecily.slasor@vda.virginia.gov).

## VCU Department of Gerontology Alumni Spotlight

---

Congratulations to Bonnie Nemeth, Lisa Riehl Zimmerman, and Katie Young on their recent accomplishments!

Bonnie is employed with Senior Connections and is working toward her certificate as a Long Term Care Ombudsman. The mission of the Ombudsman Program is to act as an advocate for persons receiving long-term care, whether the care is provided by a nursing home, assisted living facility, home health care agency or adult day care.

Lisa was recently appointed as Alzheimer's Case Manager at Suncoast Center, Inc. in St. Petersburg, Florida. This mission of Suncoast Center is "strengthening, protecting and restoring lives for a healthy community."

Katie attended the Generations United conference in Washington, DC in July. Her "Time Out" Respite Program received GU's Program of Distinction Award.

Our best wishes to Bonnie, Lisa, and Katie on their new initiatives and awards. Please, alumni, let us know about your special events, promotions, and accomplishments in aging services!

## Focus on the Virginia Center on Aging

Paige Ulvi



Paige Ulvi joined VCoA in April 2010 on a part-time basis as Administrative and Program Assistant while attending VCU.

Upon graduation, she was offered the full-time position of Research Assistant, which she happily accepted. She has a number of assignments but works most closely with VCoA's Research Coordinator Jessica Hellerstein on the Virginia Geriatric Education Center (VGEC) and Geriatric Training and Education (GTE) initiatives. She relates that she has always had a strong interest in research and, since joining VCoA, has gained enthusiasm in learning more about the fields of geriatrics and gerontology; she says that she has a fervent desire to pursue opportunity in all areas of her life.

Paige grew up in Northern Virginia with her parents and younger sister. After graduating high school in 2005, she enrolled in Northern Virginia Community College, graduating with an A.S. degree and with honors as a member of the prestigious Phi Theta Kappa International Honor Society. While in school, she worked for her father's company, Triumph Enterprises, Inc., a defense contracting firm, as a Proposal Development Assistant. During her time there, she discovered her passion for business, which, in turn, prompted her enrollment at

VCU in the School of Business, where she earned her B.S. in Entrepreneurship and Small Business Management.

She has volunteered with Virginia Blood Services during blood drives and became a foster parent for the SPCA, resulting in the adoption of Cassiopia, the third feline addition to her family. Paige enjoys bicycling and has had a passion for reading since she picked up her first book. She also takes pleasure in paintball, hiking, water sports, and video games. Her artistic talents and writing skills produced her first publication at the age of 11 and numerous awards in art shows over the years, for various works from etching to painting. Having spent a large portion of her early college career in the art field, she has an extensive portfolio.

Paige derives the most happiness from spending time with her family in Northern Virginia, who share her interest in many of the same activities. For instance, she and her mother practice their artistic talents through jewelry making, and she is actively involved with her father's many company events year round. She is very close to her sister, whom she considers her best friend. Her mother owned a retail store focused on the needs of girls in athletics. Not surprisingly, Paige participated in gymnastics, Irish dancing, volleyball, and basketball.

Growing up with entrepreneurial parents led her to aim her sights in the same direction. She fell in love with entrepreneurship in her first entrepreneurial class and went on the lead the winning team for her concept in the class. In her senior

year, she led her team, with another successful concept, into the Association for Corporate Growth Business Plan Competition in 2011. As a student of VCU's School of Business, Paige also excelled in statistics, a considerable asset in acquiring her present position with VCoA. She quickly learned to incorporate diverse areas of the business world into her learning and actions. She gained skills in strategic management, economics, and marketing, and was recognized as a public speaker in her communications classes.

Paige has not traveled as much as she would like, but intends to visit many new places and cultures around the world, Egypt being on the top of her list. She's harbored a fascination for Egypt and archeology since childhood. Her fascination with Egyptian history can be seen in much of her artwork.

Paige is an outdoors person, whether simply reading a book on the grass in Monroe Park or actively playing in competitive sports. But she says that she loves nothing more than learning; next spring she intends to begin coursework toward a Master degree with a double major in Business Administration and Information Systems. VCoA is happy to have her with us.

Ed Ansello's Tibbitts Award Lecture, "Marginal Gerontology and the Curriculum Palette," is now available for educational purposes at VCoA's website: [www.vcu.edu/vcoa](http://www.vcu.edu/vcoa).

## The Area Planning and Services Committee (APSC) on Aging with Lifelong Disabilities, in Greater Richmond

Adults with lifelong disabilities are living longer and fuller lives, until recently catching both the disabilities and aging services networks relatively off guard. Developmental disabilities services have logically been oriented to early intervention, with the intent of improving the person's prospects early in the life course; and so, skills and personnel have tended to be pediatrically-oriented. At the same time, the aging network has been oriented toward a mass quantity operation, that is, serving as great a number of older adults as possible with limited amounts of funding; and so, it has been mainstream-oriented and disabilities among older clientele have posed challenges in services.

The APSC is a tested entity, deriving from more than a decade of federally-funded field-testing in several states of models of intersystem cooperation. In current terminology, one might call the APSC an evidence-based practice. Field research showed that effective intersystem coalitions emphasized three priorities: strategies for Collaboration, Outreach, and Capacity Building. On the local level, the APSC is the means to carry out these strategies. The APSC in greater Richmond is a lively coalition of some two dozen organizational and individual members from Chesterfield, Hanover, Henrico, and Richmond, representing intellectual disabilities, parks and recreation,

residential services, blindness and visual impairment, communities of faith, higher education, family caregivers, and more. It works to address both the opportunities and challenges that present themselves as more adults with lifelong disabilities grow into later life. In effect, the APSC acts as a creative form of *de facto* public policy, trying to respond in the present to issues that formal regulations have not yet incorporated. For instance, how can aging-related services that are offered only to adults ages 60 and above respond to persons with lifelong disabilities who may manifest "aging" behaviors prematurely?

The APSC, in operation since 2003, has set as its purposes: Identifying existing services and service needs; Improving communication and collaboration among service providers; Providing cross-training on both aging and developmental disabilities; Offering educational forums for the community; Raising public awareness about aging with lifelong disabilities; and Planning for emerging issues related to aging with a lifelong disability.

The APSC meets monthly, the fourth Monday. Its members have been designated by their organizations as their representatives, in order to help assure both continuity and legitimacy, for many coalitions fail when fueled simply by individual motivation. The APSC maintains separate subcommittees for staff training and for an annual public conference. Staff training workshops are usually in November and the annual conference is in June. Workshops have focused on lifelong disabilities and: having a health heart, dementia, exercise,

arthritis, remaining at home, etc. Conferences have addressed spirituality and loss, community supports for consumers and caregivers, self-advocacy, inclusion, livable communities, etc. In addition, the APSC has produced a DVD about healthy eating, a protocol for periodically assessing the health of consumers, and has co-sponsored with other groups events such as conferences to broaden public and professional awareness. For more information about the APSC, please contact Lisa Poe at [poel@rrsi.org](mailto:poel@rrsi.org) or Ed Ansello at [eansello@vcu.edu](mailto:eansello@vcu.edu).

### Holiday Gift Basket Project for Seniors

This annual project is a partnership of Senior Connections, The Capital Area Agency on Aging and the City of Richmond Office On Aging and Special Needs. This initiative promotes healthy aging and helps seniors remain independent in their homes and communities. It brings holiday cheer to isolated seniors and those in need of support.



We are requesting donations of: nonperishable food items, gift cards from grocery stores and pharmacies, household supplies, and emergency/disaster preparedness items.

December 9, 2011 is the deadline for deliveries. For information please contact (804) 646-6885 or [Toni.Beechaum@richmondgov.com](mailto:Toni.Beechaum@richmondgov.com).

## The Waist Land: U.S. Obesity Epidemic Continues, Especially in the South

An article this summer by Steven Reinberg in *HealthDay* summarizing findings of a study on obesity conducted by the Trust for America's Health and a news release by the National Heart, Blood and Lung Institute (NHBLI) of the National Institutes of Health on August 31st combined to show some of the what and the why of the alarming increase in obesity in this country. Obesity is linked to a number of conditions that jeopardize health in later life, including diabetes, cardiovascular problems, and joint difficulties. As with some other conditions, behaviors earlier in life help predict the quality of later life.

The Trust study, entitled *F as in Fat: How Obesity Threatens America's Future*, found that obesity rates climbed over the past year in 16 states, that no state reported a decline in the proportion of excessively overweight residents, and that more than 30 percent of the people in 12 states are obese, compared to only one state just four years ago.

Twenty years ago, "there wasn't a single state that had an obesity rate above 15 percent, and now every state is above that," said Jeff Levi, executive director of Trust for America's Health. "We have seen a dramatic shift over a generation," he added. "This isn't just about how much people weigh, but it has to do with serious health problems like diabetes and hypertension. These are the things that are driving health

care costs."

With the exception of Michigan, the 10 most obese states are in the South. The Northeast and West reported the lowest obesity rates. In addition, in eight states, more than 10 percent of adults suffer from Type 2 diabetes, according to the report.

Mississippi, where 34.4 percent of the people are obese, has the highest obesity rate. Other states with obesity rates above 30 percent include: Alabama, Arkansas, Kentucky, Louisiana, Michigan, Missouri, Oklahoma, South Carolina, Tennessee, Texas and West Virginia. Thirty-eight other states have obesity rates above 25 percent. (See Table below.)

Other findings include: The number of adults who do not exercise rose across 14 states. Obesity prevalence varies with education and income. The least educated and the poorest had the highest rates of obesity; college graduates had the lowest.

The NHBLI release reports that from 1980 to 2008 obesity rates doubled for adults and tripled for children. The NHBLI offers some insight into a contributing cause of obesity: serving sizes. Portions have ballooned, as have their consumers, in the last 20 years. Comparing portion sizes 20 years ago and today, the NHBLI reports the following typical changes:

- Bagels: 3-inch, 140 calories vs. 6-inch, 350 calories
- Fast Food Cheeseburgers: 333 calories vs. 590 calories
- Soda: 6.5 ounces, 85 calories vs. 20 ounces, 250 calories

- French fries: 2.4 ounces, 210 calories vs. 6.9 ounces, 610 calories
- Two slices of pizza: 500 calories vs. 850 calories
- Movie popcorn: 5 cups, 270 calories vs. tub, 630 calories

And, they add, portion sizes in restaurants are larger, as are coffee sizes at outlets; a plate of spaghetti with meatballs has typically grown from one cup of pasta to two, while the 16-20 ounce cup of coffee (often enhanced with syrups and whipped cream) has replaced the 12 ounce cup. Not surprisingly, more than one-third of children and adolescents are obese or overweight, with the highest prevalence in the South. "This generation of kids could have shorter life spans, because people are getting diabetes and hypertension much earlier," the Trust's Levi said. He added that the solution is simple: eat less, exercise more. "We have reconstructed our lives so that we don't build in physical activity. We have neighborhoods and communities that are food deserts, where the only food you can find is unhealthy fast food," he noted.

Obesity expert Dr. David L. Katz, director of the Prevention Research Center at Yale University School of Medicine in New Haven, Conn., called the Trust's report "a reminder that obesity ranks among the most urgent public health problems of our time. While efforts to reverse obesity trends are proliferating, the tide has not yet turned, and more needs to be done." The report makes it clear that interventions need to be tailored to diverse settings, with Katz stating, "I support the view that the root cause of epidemic obesity is everything about

modern living, and that it will take the aggregation of a lot of effective programming to change our course."

"We now know the pieces that need to be put into place [to reduce obesity]," he added. "Some of them are about what we as individuals do, but a lot of it is also about what we as a community come together to do," Levi stated.

The list below, from the Report *Fas in Fat: How Obesity Threatens America's Future*, shows the percentage of obese adults in all 50 states and D.C.:

State	%	State	%
MS	34.4	ME	26.5
AL	32.3	WA	26.4
WV	32.2	FL	26.1
TN	31.9	AK	25.9
LA	31.6	VA	25.9
KY	31.5	ID	25.7
OK	31.4	NH	25.6
SC	30.9	NM	25.6
AR	30.6	AZ	25.4
MI	30.5	OR	25.4
MO	30.3	WY	25.4
TX	30.1	MN	25.3
OH	29.6	NV	25.0
NC	29.4	CA	24.8
IN	29.1	NY	24.7
KS	29.0	RI	24.3
GA	28.7	NJ	24.1
SD	28.7	MT	23.8
PA	28.5	VT	23.5
IA	28.1	UT	23.4
DE	28.0	HI	23.1
ND	28.0	MA	22.3
IL	27.7	CT	21.8
NE	27.6	DC	21.7
WI	27.4	CO	19.8
MD	27.1		

## Adult Day Care Services Significantly Reduce the Stress Levels of Family Caregivers of Older Adults with Dementia

In the first known study to demonstrate clearly that Adult Day Services (ADS) are effective in helping reduce stress on family caregivers, Penn State researchers have determined stress is reduced by an average of 66% in caregivers who use adult day care services.

Steven Zarit, Ph.D., professor and head, department of Human Development and Family Studies, Penn State, a noted researcher, headed up the team effort. The team paired daily self-reports of subjective distress and health symptoms from care-related and non-care stressors with biomarkers obtained from caregiver's saliva samples that were provided at scheduled times during each day. Assays were obtained for three key biomarkers with implications for health: cortisol, alpha-amylase, and dehydroepiandrosterone-sulfate (DHEA-S). Cortisol is a hormone produced by stress.

The team evaluated the cortisol levels of 150 caregivers who began the use of adult day services. The researchers reported their results online in the *Journals of Gerontology Series B: Psychological and Social Sciences* 10.1093/geronb/gbr030 June 2011. Among the findings:

- Family caregivers experienced 66% less care-related stress on days that their relative used ADS com-

pared to days they did not use ADS.

- Caregivers reported that their relative appeared more alert and easier to manage after spending the day at an ADS program and that their relative benefited from the stimulation and social interactions.

- ADS use improved sleep and behavior in participants, which related to positive changes in well-being among their family caregivers.

"One way of alleviating that stress is through the use of an adult day care center, which allows them a predictable break from caregiving responsibilities...The changes we have seen are as large as you'd get with medication, but with no side effects," Zarit added.

### Invitation to Switch to E-Mail Delivery of Age in Action

*Age in Action* will be transitioning over time to an electronic version only. While we currently publish the same issue in identical print and PDF versions, we plan to move to an exclusively electronic format.

If you now receive *Age in Action* as a hard copy by postal mail, please consider switching to email distribution. Just send an email listing your present postal address and best e-mail address for future deliveries, to Ed Ansello at [eansello@vcu.edu](mailto:eansello@vcu.edu).

## Small Miracles

by Saul Friedman



*(Saul Friedman, Pulitzer Prize winner, whose columns reached many people, including readers of Age in Action, over his decades of passionate journalism, died this past December 24th. He was an unabashed advocate for people, especially the disadvantaged. His commentaries seldom pulled punches and he aroused readers on every side of the political spectrum. With his permission, we published abridgements of his columns in each issue of Age in Action during 2011. The following column, his last for TimeGoesBy.net, appeared in December 2010.)*

In this, the season of miracles, let me confess I have never believed in the big ones: the virgin birth, death and resurrection of the carpenter from Galilee or the lamp with oil for one day that somehow burned for eight days. I might as well have believed in Santa Claus. But this did not mean I had no faith in the mysterious or the unexplainable. That would have meant having no room in one's intellect for, say, beauty, love or music so lovely, like a Chopin etude, that it makes one cry.

In short, if you'll indulge me for leaving, for a moment, my usual senior subjects, I truly believe in the smaller, more life-touching miracles. I am walking proof of such

miracles.

A few years ago, when I was recovering from a stroke that partially paralyzed my right side, I worried that it might have affected my ability to hear and be moved by good music. Someone brought me a Sony Walkman (remember those?) and I cried with joy in my wheelchair when I discovered I could hear and even sing melodies. My sound of music was not impaired. And I wheeled myself crazily down the hospital halls, singing (badly) a favorite opera aria.

Later, as I worked with a physical therapist, I watched in wonder as she coaxed from my stiff right hand some movement in my little finger. It was a small miracle, happening somewhere inside my brain, that marked my journey of recovery. And I did recover.

One dictionary says a miracle is an amazing, wonder-filled occurrence that cannot be explained by the laws of nature. Maybe, but I do not believe that the same unmoved mover that paralyzed my hand also moved my little finger. My faith in that patient and caring therapist brought us that miracle.

The esophageal cancer, discovered by accident because of the stroke, was the next big crisis, from years of smoking, competitive journalism, maddening editors and chewing Tums.

And the miracle worker was a young Chinese surgeon who specialized in dealing with older patients because, in his culture, old age is to be venerated as a kind of miracle. He once operated on and

cured a 90-year-old woman of lung cancer because, he told me, reaching that age with lung cancer was, by itself, miraculous.

Most people don't survive cancer of the esophagus because it's discovered too late. The anti-acid remedies sold to millions of unsuspecting indigestion and acid reflux sufferers, relieve the discomfort but mask the dangers of cancer. I was a victim and survivor of such dangers.

(We) owe our cancers and/or the cures not to divine intervention, but to the miracles of illness and health. They are life affirming.

Life, illness, happiness, good fortune and bad, even good and bad presidents (I have covered) are all part of what the 11th Century Persian poet Omar Khayyam had in mind when he wrote, "Be happy for this moment. This moment is your life." And,

*"That inverted bowl they call the sky, Where under crawling, cooped we live and die. Lift not your hands to it for help, For it impotently moves as you or I."*

The esophageal cancer was cured and I celebrated those five cancer-free years. But alas, earlier this year, again by accident, a new cancer was discovered in the lining of my stomach. It has a fancy name, linitus plastica, and it's unique in that there is no mass, only a few cells that don't show up on a CT scan. And it is very slow-growing, if it grows at all, and it is without pain or symptoms. So I live with it, as I've mentioned, under the care of the Hospice of the Chesapeake.

And when an interviewer for a local paper asked how I live with such uncertainty, I told him, that there is no life without uncertainty.

But as Camus told us, we live and struggle and work and play and love, even in the face the inevitability of our own end. I am still lucky. I have my work, which seems to touch and help some people. Each morning and afternoon, when the weather is moderate, I sit on my deck on the shores of Chesapeake Bay, where I sailed for many years and still have a (power) boat. And smoke one of my indulgences, a fine and expensive cigar. The bay is ever changing and the prevailing winds from the south can be fierce, but she's even more beautiful in a dark and clattering summer storm which I can watch as it passes over my house and heads east.

My daughters visit me often, although one is in California, and when the grandchildren are over to help me pick crabs, they understand about living with uncertainty without letting on. So we treasure those times, and we shrug off the future. And they believe me when tell them how lucky we are.

Now that the cold has closed in, my wife drives me to the nearby cigar lounge where Mike, the proprietor, picks me out a couple of good ones from his humididor. I can watch a game on the giant HDTV or simply chat with other patrons, who defer to me because of my age and experiences as a reporter. Most of them have been in the military or they're spooks, more conservative than I am. One guy came in to smoke and clean his target weapons, a pistol and an elaborate 30.08 rifle with a

scope. He is building a special hide-away in the woods outside Washington for the day "they" come to take away his freedoms. He was described by Mike as a RWNJ, a "right-wing nut job."

Another smoker, between covert assignments for the Drug Enforcement Agency, is trying to develop a retirement community in Nicaragua. The VA psychiatrist, watching a guest cigar roller at work, tells us about treating too many returnees from Iraq and Afghanistan for the shocks inevitable in war. Mike's wife, Connie, a nurse at Walter Reed recalls the hollow sadness in the eyes of loved ones when they come to visit their legless or armless kinfolk. Most of these testosterone-heavy cigar enthusiasts, isolationists in the best sense, don't see why the hell we're still in Afghanistan.

The point of all this, in a season made for reflection, is to tell the story of how it feels to become and stay old for one very lucky older American (so that) most of us, despite and because of illness, embrace life more fully than ever.

I still order fresh cigars, as if trying to guarantee me the time to smoke them. If things go well, my wife and I will go on a cruise to the Mediterranean next month so Evelyn can see the Nile and the pyramids that I saw as a reporter.

## Virginia Gold: A Quality Improvement Initiative

---

by Gerald A. Craver, Ph.D.  
and Amy K. Burkett, B.S.W.  
Virginia Department of Medical  
Assistance Services

### Background

Nursing facilities are an important source of long-term care for seniors and individuals with disabilities. Because many residents require assistance with activities of daily living, appropriate care is dependent on the availability of qualified certified nursing assistants (CNAs) (Burgio et al., 2004). Unfortunately, annual CNA turnover often exceeds 100 percent (Mukamel et al., 2009). While the turnover is expensive (about \$2,200 per CNA) and has far-reaching consequences for both facilities and staff, its most serious consequences are borne by residents in the form of poor health outcomes because it disrupts continuity of care and contributes to psychological distress (Castle & Engberg, 2005).

The CNA workforce is comprised primarily of low-income and single-parent women. The workforce's racial and ethnic diversity may contribute to working conditions where the potential for miscommunication and conflict is high (Stone & Dawson, 2008). Because CNAs are frontline caregivers, considerable research has been done to identify factors associated with CNA turnover. Examples include lack of training and promotion opportunities, low pay, stressful working conditions, and limited

benefits (Squillace et al., 2009; Dill et al., 2010). The demand for CNAs is projected to increase along with an aging population, and a pressing need exists to develop interventions that address these issues. Failure to identify solutions could have serious consequences as increasing numbers of Americans turn to nursing facilities for long-term care.

### **The Virginia Gold Program**

In 2007, the Virginia General Assembly directed the Department of Medical Assistance Services (DMAS) to develop a two year quality improvement program for nursing facilities. The program, which became operational on September 1, 2009, was known as the Virginia Gold Quality Improvement Program. Virginia Gold was designed to improve nursing facility quality of care by providing facilities with grant funding to develop more supportive work environments and best practices for CNAs. The program expired on August 31, 2011.

To implement Virginia Gold, DMAS solicited applications from licensed, Medicare/Medicaid-certified nursing facilities in April 2009. Twenty-eight facilities submitted applications indicating how the funding would improve the work environment and quality of care. From this number, five facilities were selected to participate. Each was awarded up to \$50,000 in annual funding to develop improvement projects specific to the needs of their staff and residents. (Additional information on Virginia Gold is available online at:

[http://dmasva.dmas.virginia.gov/Content\\_pgs/ltc-vagold.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/ltc-vagold.aspx).)

### **Preliminary Impact of the Virginia Gold Program**

An evaluation was performed at the end of Virginia Gold's first year to assess its performance across all five facilities. Ten focus groups with CNAs and residents were conducted to collect data. The interviews revealed that prior to Virginia Gold, the facility work environments were characterized by poor communication and lack of teamwork among CNAs and other staff that interfered with their ability to care for residents. However, certain processes developed as a result of Virginia Gold that improved the work environments, such as peer mentoring and the dissemination of consistent information, enhanced communication, and worker empowerment. These processes offered CNAs advancement opportunities, job quality, and credibility, while demonstrating that the facilities viewed them as valuable employees. Overall, the evaluation found that Virginia Gold was performing as intended because these processes are characteristics of supportive work environments.

### **Virginia Gold Nursing Facility Quality Improvement Projects**

Each of the five pilot facilities improved their work environments by implementing various projects that included new staff orientation and mentoring, recognition and awards, and training activities. Examples of these activities follow.

#### Autumn Care of Portsmouth, Virginia

Autumn Care improved its work environment by enhancing CNA screening and hiring practices and developing new staff orientation and peer mentoring activities. It also implemented a medical benefit program through a local community health center that provided CNAs with basic health care services at reduced costs, and an employee assistance program that provided CNAs with counseling services and information in a variety of areas including domestic violence, substance abuse, child care, and financial planning. In addition, Autumn Care improved relations between CNAs and nurses by conducting training on team building, supervisory skills, and stress management.

#### Birmingham Green/Northern Virginia Health Center Commission of Manassas, Virginia

Because 32 languages are spoken by staff and residents at Birmingham Green, this facility improved its work environment by conducting training and other activities emphasizing cultural sensitivity and awareness. The facility also conducted training activities for CNAs to improve their professional skills, and nursing supervisors to improve their management and interpersonal skills. In addition, Birmingham Green implemented a wellness program for CNAs to improve their health, attendance, and productivity by promoting healthy behaviors.

#### Dogwood Village of Orange County, Virginia

Dogwood Village developed a more

supportive work environment by implementing new staff orientation and peer mentoring. These activities were well received because they helped newly hired CNAs adjust to working in a demanding health care field and by providing experienced CNAs with advancement opportunities. The facility also implemented a computerized screening tool as part of its CNA hiring process, and included CNAs in the interviewing process. In addition, Dogwood Village implemented the “Design on a Dime Challenge” project, which helped empower CNAs by allowing them to offer suggestions for redesigning various areas of the facility. The CNAs are currently redesigning facility shower rooms to provide residents with a more therapeutic and relaxing experience.

#### Francis Marion Manor of Marion, Virginia

To improve its work environment, Francis Marion Manor developed an orientation manual and promoted several experienced CNAs as peer mentors to help newly hired CNAs adjust to working at the facility through orientation and training activities. The facility also utilized walkie-talkies to allow CNAs to communicate with each other in lieu of the intercom system, which can be disruptive to residents. This initiative improved the time it takes for CNAs to respond to resident assistance calls. In addition, the administrator became a “Crucial Conversations” instructor, allowing her to train staff on communications and conflict resolution skills, with the intent that this should be sustainable well into the future.

#### Trinity Mission Health and Rehabilitation Center of Charlottesville, Virginia

As part of its participation in Virginia Gold, Trinity Mission improved communications and teamwork through new staff orientation, peer mentoring, and several training activities. It also implemented a career ladder that provided CNAs with advancement opportunities and pay increases, and included CNAs in resident care planning meetings. In addition, Trinity Mission implemented a CNA recognition program that included appreciation awards and events, and it implemented consistent assignment to improve quality of care by allowing CNAs to become familiar with the needs of specific residents, while allowing residents to gain comfort through familiarity with the same CNAs.

#### **Conclusion**

CNAs perform an important role in nursing facilities because they provide the majority of paid direct care to residents. Unfortunately, many facilities experience difficulty retaining CNAs due to the stressful nature of the work. The experience of Virginia Gold suggests that facility work environments can be improved through relatively simple enhancements, such as peer mentoring, professional-level training, recognition, and consistent assignment. This is particularly important because the five facilities were provided with approximately \$250,000 during the first year to develop more supportive work environments. However, each facility completed the first year under budget, spending only \$136,469 to imple-

ment their projects. Financing quality improvement projects in nursing facilities may therefore represent a good investment.

#### **References**

- Burgio, L.D., Fisher, S.E., Fairchild, J.K., Scilley, K., & Hardin, J.M. (2004). Quality of care in the nursing home: effects of staff assignment and work shift. *The Gerontologist, 44*(3), 368–377.
- Castle, N.G. & Engberg, J. (2005). Staff turnover and quality of care in nursing homes. *Medical Care, 43*(6), 616–626.
- Dill, J.S., Morgan, J.C., & Konrad, T.R. (2010). Strengthening the care of long-term care workforce: the influence of the WIN A STEP UP workforce intervention on the turnover of direct care workers. *Journal of Applied Gerontology, 29*(2), 196–214.
- Mukamel, D.B., Spector, W.D., Limcangco, R., Wang, Y., Feng, Z., & Mor, V. (2009). The costs of turnover in nursing homes. *Medical Care, 42*(10), 1039–1045.
- Squillace, M.R., Remsburg, R.E., Harris-Kojetin, L.D., Bercovitz, A., Rosenoff, E., & Han, B. (2009). The national nursing assistant survey: improving the evidence base for policy initiatives to strengthen the certified nursing assistant workforce. *The Gerontologist, 49*(2), 185–197.
- Stone, R.I. & Dawson, S.L. (2008). The origins of better jobs better care. *The Gerontologist, 48* (Special Issue 1), 5–13.

## Calendar of Events

### October 12, 2011

*Empty Plate Campaign.* "\$50 Fills A Plate 12 Times For A Needy Senior." These funds help Senior Connections fill empty plates with essential services such as food, in-home care, emergency services and transportation. 11:30 a.m. - 1:00 p.m. Science Museum of Virginia, Richmond. For information, contact Mary Creasy at (804) 343-3023 or [mcreasy@youraaa.org](mailto:mcreasy@youraaa.org).

### October 15, 2011

*Practical Caregiving: What to Do When It's Time.* Presented by the Prince William Area Agency on Aging. 8:30 a.m. - 4:30 p.m. Manassas Park Community Center. For information, call (703) 792-6374.

### October 29, 2011

*Modern Aging: Transforming Obstacles into Opportunities.* Co-hosted by the VCU Department of Gerontology, Lift Caregiving, and VCU Geriatric Medicine. The event will showcase Central Virginia's aging services providers. Glen Allen Cultural Arts Center. For information, contact Jay White at (804) 828-1565 or [whitejt2@vcu.edu](mailto:whitejt2@vcu.edu).

### November 3, 2011

*Conference on Dementia.* Presented by the Alzheimer's Association Greater Richmond Chapter. 9:00 a.m. - 4:30 p.m. Ramada Plaza Richmond West. To register, call (804) 967-2580 or visit [www.alz.org/grva](http://www.alz.org/grva).

### November 3, 2011

*Best Practices for Tobacco Control and Prevention.* Annual conference hosted by the Virginia Department of Health Tobacco Use Control and Healthy Communities Projects and the American Cancer Society. 8:30 a.m. - 4:30 p.m. Westin Hotel, Richmond. For information, visit [www.cleartheairva.org](http://www.cleartheairva.org).

### November 4, 2011

*The Big Boom: Planning for a New Generation of Seniors.* 2011 Senior Resource Group Conference on Senior Programming, Therapeutic Recreation, and Aging. Deep Run Recreation Center, Henrico County. For information, call the Virginia Recreation & Park Society at (804) 730-9447 or visit [www.vrps.com](http://www.vrps.com).

### November 5, 2011

*Help Is Here: From Your Loved One's Perspective.* The 11th Annual Caregivers Symposium. Sponsored by Partners in Aging. For information, visit [www.partnersinaging.org](http://www.partnersinaging.org) or call (540) 371-3375.

### November 13-15, 2011

*Virginia Association of Free Clinics' 18th Annual Conference.* Stonewall Jackson Hotel and Conference Center. Staunton. For information, visit [www.cvent.com/d/bdq611](http://www.cvent.com/d/bdq611).

### November 16, 2011

*Long Term Care Insurance Seminar.* Presented by Long-Term Care Consultants, Inc. Free. 5:30 p.m. - 6:30 p.m. 9100 Arboretum Parkway, 2nd Floor Conference Room, Richmond. For information, call (804) 272-5827 or contact [Linda@ltccinc.com](mailto:Linda@ltccinc.com).

### November 18 - 22, 2011

*Lifestyle Leads to Lifespan.* The Gerontological Society of America's 64th Annual Scientific Meeting. Boston, MA. For information, visit [www.geron.org](http://www.geron.org).

### November 29, 2011

*10th Annual Alzheimer's Education Conference: Best Practices in Dementia Care.* Presented by the Alzheimer's Association Central and Western Virginia Chapter. Featuring Dr. Sam Gandy, an international expert in the metabolism of amyloid. Hotel Roanoke & Conference Center, Roanoke. For information, call (434) 973-6122 or visit [www.alz.org/cwva](http://www.alz.org/cwva).

### December 1, 2011

*Hoarding Seminar.* Presented by The Harrisonburg-Rockingham Elder Alliance. Rockingham County Fire and Rescue Conference Center, Harrisonburg. For information, call (540) 433-1830 or e-mail [asee@brls.org](mailto:asee@brls.org).

### December 7-9, 2011

*Models and Money: Finding Solutions with Limited Resources.* 2011 Virginia Rural Health Association's Annual Conference. Stonewall Jackson Hotel and Conference Center, Staunton. For information, visit [www.vrha.org](http://www.vrha.org).

### January 25, 2012

*Virginia Center on Aging's 26th 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

Volume 26 Number 4  
Fall 2011

**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](mailto:kivey220@yahoo.com).

**Winter 2012 Issue Deadline:  
December 15, 2011**



## Virginia Center on Aging

at Virginia Commonwealth University, Richmond, Virginia  
[www.vcu.edu/vcoa](http://www.vcu.edu/vcoa)

### Staff:

#### Director

Edward F. Ansello, PhD

#### Elderhostel Coordinators

Catherine Dodson, MS - Richmond

Jim Gray, MS - Natural Bridge

Barbara Wright - Staunton

#### Associate Director for Research

Constance L. Coogle, PhD

#### Elderhostel/Road Scholar Program Administrator

Jeffrey Ruggles, MFA

#### Research Specialist

Paula Knapp Kupstas, PhD

#### Lifelong Learning Institute

Monica Hughes

#### Law Enforcement Liaison

Barbara Walker

#### Program Assistant

Julia C. Link, MEd

#### Program Manager

Bert Waters, MS

#### Project Coordinator

Lisa Furr, MA

#### Research Associate

Sung Hong, PhD

#### Research Coordinator

Jessica Hellerstein

#### Administrative Assistant

Paige Ulvi

#### Editor, *Age in Action*

Kimberly S. Ivey, MS

### Advisory Committee:

Paul F. Aravich, PhD

Frank Baskind, PhD

James Bennett, MD, PhD

Cecil Drain, PhD

William F. Egelhoff, Director Emeritus

Jonathan Evans, MD

Patricia Giesen

Hon. Franklin P. Hall

James Hinterlong, PhD

Robert D. Holsworth, PhD

Paul G. Izzo, JD, *Chairman*

Richard W. Lindsay, MD

Christopher M. McCarthy, Esq

Hon. Jennifer L. McClellan

Kenneth J. Newell, MS

Hon. John O'Bannon

Mary C. Payne

Sheldon Retchin, MD, MPH

Sandra C. Rollins, MSSW

David Sadowski

Robert L. Schneider, PhD

Ralph E. Small, PharmD

Beverly Soble

Alexander Tartaglia, DMin

Marcia A. Tetterton, MS

Gordon Walker

Thelma Bland Watson, PhD

Victor Yanchick, PhD

## Virginia Department for the Aging

[www.vda.virginia.gov](http://www.vda.virginia.gov)

### Staff:

**Interim Commissioner:** Jim Rothrock

Tim Catherman, MHA, Director, Administrative Services

Pat Cummins, MEd, Program Coordinator

Leonard Eshmont, PMP, Director, Information Technology

Nick Gemelos, No Wrong Door IT Coordinator

Solomon Girmay, MBA, External Financial Auditor

April Holmes, MS Ed, Prevention Program for Older Adults

Joseph Hoyle, MD MPH, Policy Analyst

Janet James, JD, Public Guardianship & Legal Services

Georgie Lewis, Customer Service Specialist

Nancy Lo, MSW, GrandDriver Coordinator

Debra Loving, Information Systems Specialist

Christy Miller, PMP, CSTE, IT Business Analyst

Kathy Miller, RN, MS, MSHA, Director of Programs

Marica Monroe, CPA, Financial Manager

Ellen Nau, MA, Program Coordinator

Peggy Nieder, Program Coordinator

Ann Petersen, Graduate Student Intern

Charlotte Peterson, Accountant Senior

Elizabeth Pierce, MSW, VICAP State Director

Katie Roeper, Assistant Commissioner

Cecily Slasor, Customer Service Specialist

Elaine Smith, MS, RD, Program Coordinator

Pam Smith, VICAP Customer Service Specialist

Jane Snead, VCO, Contract Coordinator

Crystal Stotesberry, VCA, Accountant

Jackie Taggart, Administrative Staff Assistant

Kathleen Vaughan, MA, No Wrong Door Coordinator

### Commonwealth Council on Aging:

#### Members

Juanita Armstrong Bailey

Beth Barber, Vice Chair

Robert B. Blancato

Gene Ecton Davis

Jeffrey C. Delafuente, MS, FCCP, Secretary

David M. Farnum

Karen L. Fortier

Pete Giesen

Richard W. Lindsay, MD

Susan McCammon

Brenda Kelly Nelum

Nancy A. New

Valerie Scott Price

Roberto Quinones, Chair

Stephen G. Reardon, Esq.

Joan Boyd Short

E. Harris Spindle, Jr.

Vernon Wildy

#### Ex Officio Members

The Hon. William A. Hazel, Jr., MD, *Secretary of Health and Human Resources*

Paul Lavigne, *VAAAA*

Gail S. Nardi, *VDSS*

Jim Rothrock, *VDA*

Terry Smith, *DMAS*



Virginia Commonwealth University  
*Age in Action*  
Virginia Center on Aging  
P.O. Box 980229  
Richmond, VA 23298-0229

Nonprofit Organization  
U.S. POSTAGE PAID  
Permit No. 869  
RICHMOND, VIRGINIA

*Return Service Requested*



## Virginia Association for Home Care and Hospice 28th Annual Conference and Trade Show

**November 8-9, 2011**

**The Boar's Head Inn  
Charlottesville, VA**

### **Join us this year for:**

- The Largest Trade Show in Virginia for Home Care and Hospice Professionals
  - Industry-specific educational programs
  - Great networking opportunities
- Charlottesville's beautiful, relaxing setting

### **Keynote Speaker:**

Dr. Richard W. Lindsay

*"Is the Affordable Care Act the Answer?"*



For more information or to register,  
call (804) 285-8636 or visit [www.vahc.org](http://www.vahc.org).

Virginia Commonwealth University is an equal opportunity/affirmative action institution and does not discriminate on the basis of race, gender, age, religion, ethnic origin, or disability. If special accommodations are needed, please contact Dr. Edward F. Ansello, VCoA, at (804) 828-1525.