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age in action

Activities in geriatrics and gerontology education and research

Virginia Center on Aging
and
Virginia Department for Aging and Rehabilitative Services

Case Study

Arthritis and Physical Activity in Mid- and Later-Life

by Nicholas Turkas, M.S.

Educational Objectives

1. Describe some of the more common types of arthritic conditions.
2. Discuss co-morbidities or co-existing conditions often occurring with arthritis.
3. Describe the Arthritis Foundation as a relevant resource when dealing with arthritic conditions.

Background

Arthritis is the most prevalent chronic condition among older Americans, with most having one or more of its many forms. The pain and stiffness of some types of arthritis may often discourage those with an arthritic condition from physical activity, even from social interactions. The consequences of these "pulling back" behaviors may not only actually worsen the arthritic condition, but also may create isolation and a lowered quality of life. The Arthritis Foundation addresses these realities through outreach, education, and opportunities. The Foundation's website is a source of relevant information and is cited throughout this paper as a source.

What is Arthritis?

Arthritis comprises more than 100 different rheumatic diseases and conditions, the most common of which is osteoarthritis. Other frequently occurring forms of arthritis include rheumatoid arthritis, lupus, fibromyalgia, and gout. Common symptoms include pain, aching, stiffness, and swelling in or around the joints. Some forms of arthritis, such as rheumatoid arthritis and lupus, can affect multiple organs and cause widespread symptoms. Although arthritis is more common among adults aged 65 years or older, people of all ages (including children) can be affected. Nearly two-thirds of people with arthritis are younger than age 65. Arthritis is more common among women (24.3%) than men (18.7%) in every age group, and it affects members of all racial and ethnic groups. Arthritis also is more common among adults who are obese than among those who are normal weight or underweight (Cheng et al., 2010).

In Virginia, 54% of seniors ages 65 years and older report living with arthritis. The most common form of arthritis, osteoarthritis (OA), is characterized by the breakdown of cartilage, the part of a joint that cushions the ends of the bones and allows easy movement. As cartilage deteriorates, bones begin to rub against one another. This can cause stiffness and pain that make it difficult to use that joint. OA can also damage ligaments, menisci, and muscles. Over time, OA may cause a need for joint replacements (Dunkin, 2001).

There are two types of OA: primary and secondary. Primary osteoarthritis is generally associated with aging and the "wear and tear" of everyday life. With increasing age, a person becomes more likely to have some degree of primary osteoarthritis. However, not everyone gets it, not even the very old. This is because OA is a disease, and not part of the normal aging process. Secondary osteoarthritis, in contrast, tends to develop relatively

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early in life, typically 10 or more years after a specific cause, such as an injury or obesity.

Osteoarthritis occurs most often in knees, hips, and hands. But other joints, including the shoulders, can be affected. OA rarely affects other joints except as a result of injury or unusual physical stress (see www.arthritis.org/what-is-osteoarthritis.php).

Rheumatoid arthritis, or RA, is a form of inflammatory arthritis and an autoimmune disease. For reasons no one fully understands, in rheumatoid arthritis, the immune system, designed to protect our health by attacking foreign cells, such as viruses and bacteria, instead attacks the body's own tissues, specifically the synovium, a thin membrane that lines the joints. As a result of the attack, fluid builds up in the joints, causing pain in the joints and inflammation that is systemic, meaning it can occur throughout the body.

Rheumatoid arthritis is a chronic disease, one that cannot be cured. Most people with RA experience intermittent bouts of intense disease activity, called flares. In some people, the disease is continuously active and worsens over time. Others enjoy long periods of remission, having no disease activity or symptoms at all. Evidence shows that early diagnosis and aggressive treatment to put the disease into remission are the best means of avoiding joint destruction, organ damage, and disability.

Other common forms of arthritis include lupus, an autoimmune disease that causes joint pain, skin rashes, and may cause kidney and neurological problems; fibromyalgia, intensive muscle pain, and fatigue; and gout, joint pain in the big toe, often a result of poor diet.

Why Is Arthritis a Public Health Problem?

An estimated 50 million U.S. adults (about one in five) report doctor-diagnosed arthritis (Cheng et al., 2010). An even greater number may have arthritic conditions not formally diagnosed. As the U.S. population ages, these numbers are expected to increase sharply, with the number of adults with doctor-diagnosed arthritis projected to rise to 67 million by 2030, and more than one-third of these adults having limited activity as a result. Importantly, arthritis occurs with other significant co-morbidities; half of the people diagnosed with arthritis live with diabetes or heart disease. More than 42% of the U S adults with arthritis, or 21.1 million adults, have activity limitations attributable to their arthritis. In addition, the CDC currently states that some form of arthritis or other rheumatic condition affects one in every 250 children (see www.cdc.gov/arthritis/data_statistics/arthritis_related_stats.htm).

Arthritis is a substantial barrier to the people living with this disease. For years, it was believed that exercise was dangerous and could "wear out" joints. Thinking has changed. Now, most people know that exercise is an important part of a way to manage arthritis pain. However, people with arthritis report other barriers, such as lack of motivation and time, competing responsibilities, and difficulty finding an enjoyable activity. Unfortunately, a lack of training and understanding among some health care professionals and exercise instructors may compound these factors (see www.arthritis.org).

Co-Existing Conditions

Nearly half (47%) of adults with arthritis have at least one other chronic condition (Murphy et al., 2009). Murphy et al. identified four common co-existing conditions among adults with arthritis in 2007. Some 11.2 million people, or nearly one in four adults with arthritis (24%), also had heart disease, the most common co-morbidity. Next most common are chronic respiratory conditions, 19% (9.0 million), and diabetes, 16% (7.3 million). Stroke is the fourth most common condition and affected 3.2 million people with arthritis.

Researchers cannot say definitively why people with arthritis have so many co-morbidities. Studies by Murphy et al. (2009) and Cheng et al. (2010) suggest that arthritis and other chronic conditions share some of the same non-modifiable risk factors, e.g., age, and modifiable risk factors, e.g., obesity, that predict these conditions. For instance, an estimated 33.8% of women and 25.2% of men who are obese report doctor-diagnosed arthritis. Furthermore, arthritis itself may directly cause physical inactivity, thereby precipitating weight gain, obesity, and other chronic conditions. Notably, the CDC recommends that all people with arthritis, with or without co-morbidities, participate in regular physical activity (see www.cdc.gov/arthritis/data_statistics/comorbidities.htm)

Arthritis Foundation Programs

The Arthritis Foundation is a resource organization of staff and volunteers networked throughout the United States to offer information, activities, and inspiration for people with arthritic conditions. Recognizing the therapeutic benefits of activity, the Arthritis Foundation offers a variety of group exercise programs in community settings. These programs are different from typical exercise programs. While, in general, there is no shortage of group exercise classes, including aerobics, Jazzercise, Zumba, Cardio-Kick Boxing, and Yoga, many of these classes include bouncing and pounding movements and are led by instructors who are unfamiliar with arthritis. In contrast, the Arthritis Foundation Exercise Program features low-impact physical activity proven to reduce pain and decrease stiffness. Developed by the Arthritis Foundation, the Exercise Program uses movements created by physical therapists that address pain and fatigue while increasing strength. The routines include gentle range-of-motion exercises that are suitable for every fitness level. Led by a certified instructor, the classes may be taken either standing or sitting. The simple routines are easy to replicate at home. Classes meet for one hour, two to three times per week for eight weeks and are designed to be relaxing and enjoyable. Participants may use hand and ankle weights to increase resistance. Resistance bands, scarves, and balls may be used for variety. The program is evidence-based, and studies show that individuals attending the classes report having less pain, more confidence in their ability to continue activities, increased social activity, and fewer doctor and emergency room visits (Callahan et al., 2004; Wang et al., 2007).

The Arthritis Foundation also offers an adapted form of Tai Chi. Once synonymous with martial arts, Tai Chi normally requires years of patient study to "master." The Arthritis Foundation Tai Chi Program, developed by Dr. Paul Lam, uses gentle Sun-style Tai Chi routines that are safe, easy to learn, and suitable for every fitness level.

The fluid, circular movements of Tai Chi look like a blend of dance and karate. The "soft" martial art of Tai Chi has been practiced in China for more than 600 years. The Arthritis Foundation's Tai Chi program is led by certified instructors. Its one-hour classes meet two times a week for eight weeks and are designed to be relaxing and enjoyable. The program can be done while sitting or standing. Each session includes warm-up and cool-down exercises, six basic core movements, and six advanced extension movements. The benefits of the program include reduced stress, and increased balance and flexibility.

In addition, the Arthritis Foundation offers an evidence-based walking program, Walk with Ease, and the Arthritis Foundation Aquatics Program. All leaders are certified by the Arthritis Foundation. All facilities that offer classes sign a collaborative letter of agreement. The agreements and certifications are valid for three years.

Case Study #1

Gladys is a 70-year-old widow living in a small city. She lives alone, but regularly interacts with her extended family who call or visit. Her story is typical of many Arthritis Foundation Exercise Program participants. She was overweight and did not regularly exercise. Her osteoarthritis in her knees and shoulder had progressed to the point that the pain and stiffness were limiting her activities of daily living. At the urging of her primary care physician, she joined the Arthritis Foundation Exercise Program at a local community center. She found the class to be welcoming, filled with others living with arthritis who understood her pain. Over time, Gladys began to regain her strength and function. The program provides stretching, strengthening, and range-of-motion exercise. Her persistence has paid off, for now, five years later, Gladys teaches the class, having been trained by the Arthritis Foundation, which regularly offers training opportunities throughout her area. She especially enjoys the opportunity that she has as an instructor to welcome new people to the class and share success stories.

Case Study #2

Donna, age 58, has lived for many years with three types of arthritis: osteoarthritis, rheumatoid arthritis, and fibromyalgia. She has used a cane to aid her mobility and walked with a slow, almost painful looking, gait. Pain, stiffness, and, especially, fatigue have proven to be major obstacles for her with regard to fitness programs. She would join and participate in various exercise

classes in the past with minimal success. She became discouraged and had almost resigned herself to a life of inactivity. A friend told her about the Arthritis Foundation's Tai Chi classes. Donna signed up for the class, not sure what to expect. But now she calls Tai Chi her "miracle drug." It emphasizes slow, focused movements that are quite different from traditional western-style exercise classes. Donna found that the movements built up strength in her shoulders, core, and legs. She no longer uses a cane and has begun teaching classes regularly, including an outreach program at a prison.

Suggested Activities to Manage Arthritis Pain

Educate Yourself

Learning about your particular type of arthritis and ways to improve your health can help you make the right decisions for your health.

See Your Doctor

Although there is no cure for most types of arthritis, early diagnosis and appropriate management are important, especially for inflammatory types of arthritis. For example, early use of disease-modifying drugs can affect the course of rheumatoid arthritis. If you have symptoms of arthritis, see your doctor and begin appropriate management of your condition.

Watch Your Weight

The prevalence of arthritis increases with increasing weight. Research suggests that maintaining a healthy weight reduces the risk of developing arthritis and may decrease disease progression. A loss of just 11 pounds can decrease the occurrence of new knee osteoarthritis and a modest weight loss can help reduce pain and disability (Messier et al., 2005).

Protect Your Joints

Joint injury can lead to osteoarthritis. People who experience sports or occupational injuries or have jobs with repetitive motions like repeated knee bending tend to have more osteoarthritis. Avoid joint injury to reduce your risk of developing osteoarthritis.

Be Active

Research has shown that physical activity decreases pain, improves function, and delays disability (U.S. Department of Health and Human Services, 2008). Make sure that you get at least 30 minutes of moderate physical activity at least five days a week. You can parcel your activity into 10-minute intervals.

Arthritis Foundation fitness programs are designed to help you live better with arthritis. These programs help to reduce pain, increase strength and flexibility, and help you feel better. You may take part in a fitness program alone or in a group setting. Group classes are led by Arthritis Foundation certified instructors and can be modified to meet your needs.

Walk

The Arthritis Foundation Walk with Ease Program is an exercise program that can reduce pain and improve overall health. If you can be on your feet for 10 minutes without increased pain, you can have success with Walk with Ease.

Exercise

The Arthritis Foundation Exercise Program is a low-impact physical activity program proven to reduce pain and decrease stiffness. The routines include gentle range-of-motion exercises that are suitable for every fitness level.

Aquatics

The Arthritis Foundation Aquatic Program is a warm water exercise program that capitalizes on water's buoyancy and comfort to reduce pain and improve overall health. Suitable for every fitness level, the classes are held in a friendly and supportive environment that encourages social interaction among participants.

Tai Chi

Tai Chi (at left) is an ancient practice shown to reduce pain and improve mental and physical well-being. The Arthritis Foundation Tai Chi Program, developed by Dr. Paul Lam, uses gentle Sun-style Tai Chi routines that are safe, easy to learn, and suitable for every fitness level.

Study Questions

1. What are the most common forms of arthritis?
2. Why are co-morbidities seen so often with arthritis?
3. What are some of the barriers to exercise for people with arthritis?
4. What community programs does the Arthritis Foundation provide?

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Related Resources

www.arthritis.org
www.cdc.gov/arthritis
www.letsmovetogether.org

About the Author

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Medicaid Spending by Categories

The Kaiser Commission on Medicaid and the Uninsured of the Henry J. Kaiser Foundation issued this October a report on Medicaid spending in the United States. Medicaid is an income-eligible program of assistance for Families, Elderly Adults, and Individuals with Disabilities. Each of these three categories of participants accounts differently in terms of enrollments and program expenses. For instance, the overwhelming majority (75%) of the people covered by Medicaid are Families, some 63 million people in 2009. This compares to just 25% or 16 million enrollees in total who are Elderly Adults or Individuals with Disabilities. The situation is reversed when it comes to expenses. Most Medicaid spending in the United States, two of every three dollars, is for care provided to elders and people with disabilities. In 2009, the latest date for complete information, Medicaid spent $346 billion on services. Of this amount, there was $118 billion for services to Families (34% of all expenditures for services) and $228 billion (66%) on services to elders and people with disabilities. The reasons reflect the greater complexity of needs within the Elderly Adults and Individuals with Disabilities categories. They have higher "per person" costs. The Kaiser report notes that 2009 per person annual Medicaid expenses were: Families (Adults:$2,926; Children: $2,313); Elderly: $13,186: Individuals with Disabilities: $15,453.

From the **Director, Virginia Center on Aging**

Edward F. Ansello, Ph.D.

All the World's A Stage

Being an older person can be like being a book inside a big library. Each book is different and the library contains huge numbers contending for attention.

I thought of this analogy as I read through a report on global aging from the United Nations Population Fund (UNFPA) called *Ageing in the Twenty-First Century: A Celebration and A Challenge.* Each country has its library and each library's holdings are expanding enormously.

This report on global aging, which I'll call *Ageing* for short, is quite readable, even at 192 pages. It employs graphics and interviews with elders across the world to weave a narrative about growing older that has striking similarities, along with some differences, by region. Its intent, carried out over three years, was to determine progress since the Second World Assembly in Ageing in 2002 (Madrid) in three priority areas: development, health and well-being, and enabling and supportive environments. Over 20 United Nations entities and international aging-related organizations collaborated to measure how well the planet is doing in creating societies for all ages. Besides reviewing national data, they held group discussions with older men and women in 36 countries around the world to obtain first-hand accounts and to compare these with official national policies, plans, or legislation.

Overall, the take-away is positive. Population aging is called "a triumph of development" and "one of humanity's greatest achievements." In 1950 there were about 205 million people globally who were ages 60 and above; today it's almost 810 million. Today, around the world, two people reach age 60 every second, producing a total of about 58 million 60th birthdays a year. In 2010-2015, life expectancy at birth is 78 years in developed nations, 68 years in developing nations.

Population aging is occurring worldwide because of success in attacking causes of infant mortality, improved public hygiene, and falling fertility rates; health care in later life itself has had only marginal impact in the numbers.

Aging is transforming nations. Like many transformations, some parties embrace, some parties ignore, and some parties undermine the experience. Aging, undoubtedly, presents nations with both the opportunities to realize the potentials of its citizens for and in an extended life course and the challenges of altered socioeconomic systems. Some nations are probing the benefits of longer life, a so-called "longevity dividend."

An important finding in *Ageing* is "the incredible productivity and contributions of those aged 60 and over, as caregivers, voters, volunteers, entrepreneurs and more. The report shows that, with the right measures in place to secure health care, regular income, social networks and legal protection, there is a longevity dividend to be reaped worldwide by current and future generations." (p. 14)

Put another way, societies should appreciate the differences associated with being older but also deem to later life the value and protections given to other ages.

The present reality is a mixed bag. Successful aging is aided and abetted or frustrated and denied by national policies. Lessons for policymakers and community leaders are here, if they take time to heed them. The same applies to ourselves and our communities. Too often, unfortunately, aging is either ignored or coated with the tar of being a problem.

It is sobering to see how seldom "aging" and "older adults" broadly considered rise to the level of national consciousness, even in times of national elections. It is distressing that so few leaders and policy makers seem to be considering how profoundly the citizenry's longer life is transforming virtually every aspect of life, not just so-called benefits programs.

Gender and aging are intertwined, affecting policy and practice throughout the world. As *Ageing* states, "The so-called 'feminization' of ageing, particularly the relatively large proportion of the 'oldest old' who are women, has important implications for policy." (p. 27) Anti-female policies in restrictive nations have obvious consequences for the well being of older women. They grow older having been denied access to education, with limited employment and travel

options. They may have had and continue to have less access to health care services or home/land ownership. In other, less restrictive nations, less blatant national policies may still have telling consequences for women, such as lifetimes of lower earnings resulting in greater poverty and lesser access to health care in later life.

In developing countries, *Ageing* reports, some three fifths of the older women are illiterate, compared to one third of the older men. This illiteracy seriously reduces older women's ability to obtain information or take part in economic, health, political, and social activities. One study which is cited notes that low literacy in Latin and Caribbean nations "was associated with low levels of participation in cancer screening." Clearly, efforts to educate young girls will have numerous benefits throughout their life courses and their lives will improve the lives of their daughters and granddaughters.

Ageing shares some eye-opening data about longevity. Some national practices seem to enmesh work and value; sometimes they seem to say that if you work you are valuable; other times they seem to say that if you are of a certain age you are entitled not to work; still others allow age discrimination. The mixture of age and work, to my mind, can be a misplaced or, at least, an inadequate focus. As a national policy, should there be more to life than work? What should be national policies when populations reach super-longevity and working doesn't make sense? Centenarians, those who are 100 years old or more, are the fastest growing sub-group among the older age groups, which themselves are the fastest growing populations in both developing and developed nations. There are already some 316,000 centenarians in the world.

Ageing raises questions about the impact of societies on aging and vice versa. It notes barriers, some that differ by nation or region, that change the way older people live, and, of course, this changes the meaning of old age. Not surprisingly, those countries that have more barriers to older persons to education, employment, health care, decision making, politics, social life, etc, are likely to see population aging and older people as burdens.

Ageing offers 10 “priority actions to maximize the opportunity of ageing populations.” Each is relevant in our communities, states, provinces, and nations, but, for space, I’ll list just three:

1. "Recognize the inevitability of population ageing and the need to adequately prepare all stakeholders (governments, civil society, private sector, communities, and families)...(by) strengthening national and local capacities, and developing the political, economic and social reforms needed to adapt societies to an ageing world." In other words, call everyone's attention to the elephant in the room.

2. "Invest in young people today by promoting healthy habits, and ensuring education and employment opportunities, access to health services, and social security coverage for all workers as the best investment to improve the lives of future generations of older persons." The report mentions lifelong learning and retraining opportunities as related investments.

3. "Mainstream ageing into all gender policies and gender into ageing policies, taking into account the specific requirements of older women and men."

Ageing is both a report and a sermon. It seeks to promote "a new rights-based culture of ageing and a change of mindset and societal attitudes towards ageing and older persons." This goal is courageously ambitious, maybe even unreachable. Like so many great goals, breaking things down to achievable objectives or action steps can make the process less daunting. Read this report and determine what you and your community might do to create policies and practices that encourage the opportunities of longer life and the steps needed to realize them.

To learn more and to take action, see www.helpage.org/resources.

Medicare Open Enrollment

This year’s open enrollment period for Medicare Part D prescription drug coverage is **October 15th - December 7th.** Medicare can be confusing, and Senior Services of Southeastern Virginia can help. Please call (757) 461-9481 or visit www.ssseva.org for more information.

From the Commissioner, Virginia Department for Aging and Rehabilitative Services

Jim Rothrock

Lessons Learned from a Movie and the HCBS Conference

In *Jaws*, one of the most successful and behavior altering movies of all time, swimming became very unpopular for awhile. We encounter one of the screen's most memorable villains, the Great White Shark. For about an hour, we don't actually see the shark, but are introduced to it by shadowy images, the results of some of its snacks, and that ominous music—da da da dah, da da da dah, da da da dah ……

And then there is that memorable scene where Roy Scheider, the police chief, and Robert Shaw, the crusty sea captain,actually meet the beast as it breaches. (For me, this was one of the biggest scares of my life!) Scheider's character then says a line that relates to one of the biggest issues we all face today……..***We're gonna need a bigger boat.***

When we look at age wave demographics (in Virginia, the number of Vintage Virginians grows from about 900,000 today to more that 1.8million by 2030, according to a recent study by the Older Dominion Partnership), we may feel like it's time for us to buy a *bigger boat*, as well.

I just had the good fortune to attend the annual Home and Community Based Services Conference in Arlington. More than 1,100 people connected with the aging and disability network gathered to hear about the need for a bigger boat and emerging challenges and opportunities.

A significant amount of time was spent on learning about the newest agency in our federal HHS Secretariat, the Administration on Community Living, which brings together key aging and disability agencies to build livable communities. One of the more impressive speakers was Henry Claypool, Senior Policy Advisor within the new ACL. He has been a champion within the disability network and now is working with ACL to move us all towards increased community living options.

Claypool noted the historical evolution of federal policies that affect individuals within the aging and disability network. The genesis was The Rehab Act of 1973 which brought about non- discriminatory practices for all entities receiving federal funds. Although this was thought to relate only to individuals with disabilities, buildings became more accessible, parking options increased, and, all in all, a more accessible nation began to take form. This obviously benefitted everyone in this growing network of aging and disabled persons. The next big chapter was the Americans with Disabilities Act (ADA) which, again, was originally perceived as a disability- specific bill. The newly required public and private access, communication requirements, increased awareness of a more open and usable society have again aided all. Recently, we saw the Olmstead Decision which stated that those in institutions, aged and/or disabled, have the legal right to live in the community. And now, the ACL brings together aging and disability agencies in a creative and collaborative model to examine any and all measures to build community living options. These measures offer a well thought out and comprehensive platform allowing us, if we choose, to create a community that supports our people, not defined by age or diagnosis, but by common elements found in what they need to stay in their homes: affordable and accessible housing, responsive transportation, supports needed to aid in activities of daily living,and freedom from barriers to independence.

Kathleen Sebelius, the Secretary of HHS, also underscored her appreciation of the differences between those who are aged and those who have disabling conditions, but cited the common themes that support their ability to have "quality lives, in their own homes, in their own communities."

Sebelius further noted both the changes in our health care system that will focus not so much on the medical model but in the future will offer coaching to covered participants on how to sustain themselves in their homes, and the value of our Aging and Disability Resource Centers, which are becoming the entry point to guide folks to the services and supports they need.

Another highlight of the conference was Kathy Greenlee, the Assistant Secretary and leader of the newly created Administration on Community Living. It was so good to hear

from someone at the top that many of the parts of our system are seen as critical to national reform in health and Medicaid. Our efforts to create a No Wrong Door system using our ADRCs was noted as a critical need. Our state has also been a leader in Options Counseling, which is driven by person-centered practices and directs the person needing long term services and supports to relevant programs and resources, not just to those already in our programming. Opening our thinking to building programming not on what we have in our menu of services but on the needs of those we serve is a cornerstone for the future.

Ms. Greenlee then challenged us all to build better relationships with our Medicaid partners, the Managed Care Organizations, and to sustain our network of Community Based Organizations (in Virginia we have our AAAs, our CILs, and our network of Brain Injury programs at the core), for, over time, we will surely see this expanded to local housing authorities, transportation providers, and an array of partners who will be critical additions to our network.

My take away from this meeting was that our nation is preparing to get a bigger boat and it's incumbent on us all to see how we can bring our efforts and resources to this charge.

Note: I should acknowledge that I stole this bigger boat angle from Joseph Lugo, a colleague at ACL. I promised him that I'd footnote him the first three times I used it. This is my third, so from now on, I'll claim it.

SeniorNavigator, disAbilityNavigator, and Solutions Centers

VirginiaNavigator.org maintains a family of websites that offer free, accessible, and accurate information for older adults, individuals with disabilities, family caregivers, and most everyone interested in resources to improve quality of life. VirginiaNavigator, SeniorNavigator, and disAbilityNavigator readily link to each other. SeniorNavigator.org's home page, for instance, is currently focusing on hunger in Virginia among older adults, following AARP's recent Hunger Summit; but the website always offers information on such standing topics as Aging Well, Caregiving, Health, Housing and Long-Term Care, and Transportation. The disAbilityNavigator.org website offers articles and links on Living a Healthy Life, Making a Home, Connecting with Others, Planning My Future, Knowing My Rights, and more. A visit to SeniorNavigator's Solution Centers opens opportunities to explore the Take Back Your Life center designed to help victims of domestic violence in later life; it offers information organized into three tracks that might help someone who may be a victim, someone who knows of domestic violence toward another, or someone who might work in some capacity to offer help but needs to know more about the issues; the latter may include someone in a social services agency or community of faith. A visit to the Aging Well: Healthy Choices Solutions Center opens the door to readable and useable information on nutrition, physical activity, and how to quit smoking. The Virginia Health Navigator Solutions Center contains understandable information on health care and health care reform. If one needs information on adult day care services, medical specialists, or community agencies, a visit to SeniorNavigator.com will guide the visitor through the VirginiaNavigator Personalized Resource Locator. Where relevant, resource information can be displayed according to the site visitor's zip code. This is a family of resources worth knowing.

VCU Department of Gerontology Offers New Certificate Program

The Virginia Commonwealth University Department of Gerontology will be offering a new Certificate program for healthcare professionals, aging services providers, and caregivers interested in professional identity and hands-on skills development in aging services. This program will include topics related to Person Centered Care and Culture Change, Nutritional Needs for Older Adults, Agitated and/or Aggressive Behavior Management, Optimal Aging, and much more. The requirements for the completion of the Certificate will be offered through a variety of online and in-class formats. For more information on this program, contact agingstudies@vcu.edu.

COMMONWEALTH OF VIRGINIA

Alzheimer's and Related Diseases Research Award Fund

2010 – 2011 FINAL PROJECT REPORT SUMMARIES

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 2010-2011 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).

VCU Severn B. Churn, Ph.D. "Neuronal Mechanisms of Trauma-induced Alzheimer's Disease"
Several studies have shown an association between traumatic brain injury (TBI) and the development of AD. Recently, similar mechanisms have been associated with TBI-induced memory loss and the development of AD. This investigation focused on the TBI-induced pathological activation of a neuronally-enriched enzyme, calcineurin. Activation of calcineurin has been shown to result in the loss of dendritic spines, the major communication route between neurons. Through several, carefully controlled studies, the investigator was able to demonstrate a prolonged, pathological activation of calcineurin that resulted in delayed loss of dendritic spines. In cortical, but not hippocampal, structures the spine loss could be prevented by the application of calcineurin antagonists acutely after TBI. These studies are the first to identify a cellular mechanism through which TBI could accelerate the progression of AD. *(Dr. Churn may be contacted at 804/828-0290.)*

GMU Vasiliki N. Ikonomidou, Ph.D. and Pamela Greenwood, Ph.D. "Detection of ApoE-related White Matter Degeneration Using Tissue Specific Magnetic Resonance Imaging (MRI): Sensitivity and Implications for Cognitive Function"
This study examined whether Tissue Specific Imaging (TSI), a new MRI technique sensitive to the detection of white matter degeneration, and associated T1 quantitative techniques are capable of detecting Alzheimer's Disease associated changes in middle aged adults, thus potentially serving as a early-detection biomarker for AD. It was anticipated that carriers of the ApoE-e4 genetic risk factor for AD would show a larger degree of white matter degeneration as detected by TSI. While using TSI for differentiating between carriers and non-carriers proved not feasible in the selected cohort, the data acquired are currently serving as the basis for further investigations identifying differences between carriers and non-carriers, and the association of such differences with both cognitive performance and brain anatomical changes. The dataset served as a basis for the development of an automated technique for the detection of Virchow-Robin spaces, a marker of potential vascular pathology that is known to have increased incidence in AD. Furthermore, the investigators are currently exploring the use of texture analysis techniques to develop a more robust methodology for white matter characterization. (*Dr. Ikonomidou may be contacted at 703/993-9354; Dr. Greenwood may be contacted at 703/993-4268.*)

VCU Kate Lapane, Ph.D. "Assessment of Factors Which Influence Physician Decision-making Regarding Medication Use in Patients with Dementia at the End of Life"
Few studies have examined the importance of rationalization of medications in patients with advanced dementia nearing the end-of-life, and little is known about the impact of non-clinical factors on prescribing decisions. The investigators evaluated the extent to which nursing home placement, family involvement, and advanced directives influence prescribing decision-making in patients with end-stage dementia. A multidisciplinary team developed four vignettes of patients with end-stage dementia with specific questions relating to discontinuation or initiation of specific medications. Using a modified Dillman approach, the investigator invited a sample of primary care physicians with an active Virginia medical license to participate via email. Of the 269 responders, 191 were eligible for the study. They received vignettes that varied with respect to three randomly assigned factors: 1) Place of residence of the patient (community-dwelling, nursing home); 2) Presence/absence of an advance

directive; and 3) Family desires active measures, family desires supportive measures, no family involvement. Chi-square analyses were performed and a balance of potential confounds was achieved through randomization. Continuation of therapies not likely conferring benefits (e.g., statins) was commonplace, regardless of randomly assigned factors. Physicians were less likely to initiate antibiotic therapy for patients with advanced directives (e.g., treating pneumonia with fever: 38% with advanced directives vs. 53% without ($p < .05$). Medication initiation was not influenced by family involvement or nursing home residence. Prescribing decisions for patients with end-stage dementia may be influenced by non-clinical factors. Guidance on strategies todiscontinue medications may be warranted. *(Dr. Lapane may be contacted at 804/628-2506.)*

Alzheimer's Association Southeastern Virginia — **Patricia Lacey, MBA, Sonya Barsness, MSG, and Scott Sautter, Ph.D. "The Impact of Early Alzheimer's Support and Education Programs on Both Diagnosed Participants and Their Care Partners"**

This study investigated the social and psychological impact of EASE (Early Alzheimer's Support and Education), a program intended to empower diagnosed individuals and their partners to become active participants in their care. The study employed a quasi-experimental (switching replications) research design with validated measures and a wait-listed comparison group. It was hypothesized that, in comparison with those assigned to the delayed intervention group (n = 17), EASE participants (n = 20) would show improvements in personal self-efficacy, mental and physical health status, and the quality of life for those diagnosed with Alzheimer's disease. No statistically significant group differences were documented between the intervention and wait list groups, but 2 X 2 factorial and repeated measure ANOVAs showed main effects for time of testing on all three outcome measures, and improvements in the intervention group were generally sustained three months after the program. Comparing scores for care partners and those diagnosed revealed statistically significant interaction effects for several of the health status and quality of life indicators. Scores provided by those with the diagnosis decreased (worsened) from the time of pre-testing, while the scores for the care partners increased (improved). However, both care-partners and those with the diagnosis indicated that the overall quality of life for the diagnosed person improved,. Given the benefits of the EASE program documented in this study (e.g., lessened depression, improved quality of life, and perceived ability to handle unforeseen situations), it is surprising that the primary hypothesis was not supported. It appears that there was a positive anticipatory effect for the wait-list group in knowing that they would participate. Perhaps simply making the decision to participate in EASE improved their outlook and knowledge of future participation influenced both self-efficacy and quality of life. Although early stage programs have garnered some evidence-based support, additional research is needed to document new models of support and education, and determine the long-term effects of these as the disease progresses. *(Ms. Lacey may be contacted at 757/459-2405; Ms. Barsness may be contacted at 757/773-7841; Dr. Sautter may be contact at 757/498-9585.)*

EVMS — **Serina A. Neumann, Ph.D. and colleagues "Donepezil's Effect on Cardiac Function in Patients with Alzheimer's Disease Through an In Vivo, Non Invasive Measure of Peripheral Neuro-cholinergic Function: Relation to Therapeutic Efficacy"**

AD is known to affect the nervous system in ways that influence heart function, which may place AD patients at increased risk for cardiovascular-related death. One of the very probable mechanisms of the subtle cardiac autonomic dysfunction in AD is degenerative damage of central nervous structures related to the autonomic nervous system and the influence of these neurodegenerative changes on higher cerebral functions. Involvement of peripheral nervous structures may also play a role. The characterization of changes in cardiac autonomic function in AD patients, however, has been scarcely evaluated. Furthermore, the effectiveness of treatment for AD with standard FDA-approved drugs like donepezil (Aricept®) may be related to the protection of heart function. This investigation measured both cardiac autonomic function (measured by heart rate variability) and mental thinking abilities in four elderly men while taking donepezil for suspected mild AD. The investigators found irregular heart function in two of the four patients; one during the initial evaluation and the other at three months. This study helped to characterize cardiac autonomic function and potential relations to neuropsychological function in AD patients in the early phase of treatment with donepezil, and adds to the understanding of donepezil's effect on cardiac autonomic function in these patients.

Thank you, Marilyn Maxwell

Mountain Empire Older Citizens (MEOC), the area agency on aging serving Lee, Scott, and Wise Counties and the City of Norton, will mark the end of an era on October 31st. With many wishes for a wonderful retirement, but with much sadness at her departure, MEOC staff will bid farewell to Marilyn Pace Maxwell, MEOC's founding and only director for 38 years.

Marilyn became the region's Gerontology Planner in January 1974 and developed the area's first Older Americans Act (OAA) services. Under her leadership and guided by her passion, MEOC has grown from an agency providing two OAA-funded services in 1974 to a multi-funded, multi-faceted agency providing over 30 programs for older persons and their family caregivers, currently employing 305 local people, and serving more than 10,000 persons annually. In addition to services for older adults, MEOC provides services for at-risk and abused children, support services and advocacy for cancer patients and their families, and public transit services for the region. Under Marilyn's leadership and vision, MEOC is now home to one of the nation's first rural Programs of All-inclusive Care for the Elderly (PACE).

A passionate advocate for the people of southwest Virginia, Marilyn has developed a comprehensive infrastructure of nationally recognized and award winning services, along the way winning many accolades herself, including University of North Carolina School of Social Work Distinguished Alumni Award in 2000, Wise County Citizen of the Year in 2002, and the 2012 National Association of Area Agencies on Aging Excellence in Leadership Award, awarded annually to only one area agency on aging person in the nation. Marilyn was a Virginia appointee to the past three White House Conferences on Aging and was a longtime appointee to the Governor's Commission on Alzheimer's Disease and Related Disorders.

Marilyn is at heart a community organizer. MEOC serves a rural planning district located in the mountains of Central Appalachia, a health disparities region characterized by a very poor, very frail older population with a high rate of disabilities, high rate of unemployment, and the highest percentage of uninsured persons in the state. Ever aware of the pressing needs of the area's low income elderly population, Marilyn organized an Emergency Fuel Fund for the Elderly funded entirely by local dollars and widely and wildly supported by all sectors of the community. This past year, under her leadership, the community raised $232,000 from local churches, schools, businesses, and concerned individuals for the Emergency Fuel Fund, enabling the program to assist in 1,604 crisis situations of older persons trapped in heat-related emergencies with no hope for assistance elsewhere. This is community partnership and community organizing at its best. Every penny raised goes directly to assist an older person, thereby increasing MEOC's already strong credibility as an organization always focused on mission, service, and advocacy.

Marilyn's trademark is unselfishness. She is mission-oriented. Marilyn does what she does, not because she covets recognition or credit for the things she accomplishes, but because she is answering a calling. MEOC's history, under her direction, has been one of cooperation and collaboration with other service providers to bring services to the poorest and frailest. This attitude has always extended to the MEOC staff, as well. Marilyn is an encourager, providing guidance and support, but allowing staff the freedom to work without micromanagement while acknowledging and rewarding excellence and commitment.

In addition to her many accomplishments in the field of aging, Marilyn is a community hero. For years Marilyn coached a local high school's JV basketball team and was assistant varsity coach, mentoring and providing a role model for many of our area's young women. Only health concerns coupled with her ever-growing responsibilities at MEOC grew persuaded her to retire after the 1996 season and to give up one of the great loves of her life. During her tenure as an assistant professor of Social Work at the University of Virginia's College at Wise, Marilyn coached the UVA-Wise softball team to a state championship.

Marilyn is very active in the local faith community and is one of the organizers of the very successful

Norton Community Thanksgiving, a partnership among Norton churches and MEOC which serves more than 600 Thanksgiving dinners each year.

Marilyn has earned the admiration, respect, and love of those around her (clients, staff, the community) by perseverance and accomplishment in the face of personal adversity. She is a three-time cancer survivor. She will be sorely missed by those with whom she has worked and for whom she has worked, those in southwest Virginia whose lives have been made better because of her focus on mission and her commitment to service.

Happy retirement, Marilyn. May all your retirement dreams come true. You deserve a rest . . . and a round of applause!

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Tribute written by Judy W. Miller, Director of Care Coordination at Mountain Empire Older Citizens, Inc.

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

We currently publish *Age in Action* in identical print and PDF versions. *Age in Action* will be transitioning over time to an electronic version only. If you now receive hard copies by postal mail, please consider switching to e-mail distribution. Send an e-mail listing your present postal address and best e-mail address for future deliveries, to Ed Ansello at eansello@vcu.edu.

Belly Fat

Researchers at the Mayo Clinic reported this summer findings that show that where fat is located on our bodies may be even more important than how much. People who are of normal weight but have fat concentrated in their bellies have a higher death risk, even than those who are obese. Those studied who had a normal body mass index but central obesity, i.e., high waist-to-hip ratio, had the highest cardiovascular death risk and the highest death risk from all causes. Waist-to hip ratio is exactly that, the comparison of waist size to hip size; e.g., a 36 inch waist with 40 inch hips means a ratio of 90%. Ratios above 85% for women or 90% for men were found to be dangerous to health.

"We knew from previous research that central obesity is bad, but what is new in this research is that the distribution of the fat is very important even in people with a normal weight," says senior author Francisco Lopez-Jimenez, M.D., a cardiologist at Mayo Clinic in Rochester. "This group has the highest death rate, even higher than those who are considered obese based on body mass index. From a public health perspective, this is a significant finding."

The study, funded in part by the National Institutes of Health, included 12,785 people age 18 and older from the Third National Health and Nutrition Examination Survey, a representative sample of the U.S. population. The survey recorded body measurements such as height, weight, waist circumference, and hip circumference, as well as socioeconomic status, comorbidities, and physiological and laboratory measurements. Baseline data were matched to the National Death Index to assess deaths at follow-up.

Those studied were divided by body mass index (BMI) into three categories (normal BMI: 18.5–24.9; overweight BMI: 25.0–29.9; and obese BMI: 30+) and two categories of waist-to-hip ratio (normal: less than 0.85 in women and less than 0.90 in men; and high: above 0.85 in women and above 0.90 in men). Analyses were adjusted for age, sex, race, smoking, hypertension, diabetes, dyslipidemia, and baseline body mass index. People with chronic obstructive pulmonary disease and cancer were excluded. The mean age was 44; 47.4% were men. The median follow-up period was 14.3 years. There were 2,562 deaths, of which 1,138 were cardiovascular related. The risk of cardiovascular death was 2.75 times higher, and the risk of death from all causes was 2.08 times higher, in people of normal weight with central obesity, compared with those with a normal body mass index and waist-to-hip ratio.

Many people know their body mass index these days; it's also important for them to know that a normal one doesn't mean their heart disease risk is low, adds Dr. Lopez-Jimenez. Where their fat is distributed on their body can mean a lot, and that can be determined easily by getting a waist-to-hip measurement, even if their body weight is within normal limits, he says.

Diagnosed with a Visual Impairment: Now What?

by Audrey A. Dannenberg

Do you have a relative, friend, patient, or client with a visual impairment? The diagnosis might be macular degeneration, diabetic retinopathy, glaucoma, optic nerve atrophy, or another eye disease. Eyeglasses do not help the individual see any better. The ophthalmologist or optometrist may have said to them, "There is nothing more I can do for you." This means "medically" there is nothing more they can do. But, even before that point is reached, there is something that can be done.

A referral can be made (with the individual's permission) by the ophthalmologist, optometrist, the individual with the impairment, a family member, physician, social worker, etc., to an agency serving people with visual impairments. In the U.S., these services tend to fall under a Division of the Department of Rehabilitative Services, a state Department for the Blind specifically serving people with visual impairments, the Department of Veterans Affairs- Blind Rehabilitation Services, or a private agency for the blind. A listing of the resources available in your area (including Canada) is at the end of this article.

The professionals who can help individuals with visual impairments are called Vision Rehabilitation Therapists (VRT)* and Orientation & Mobility Specialists (O&M Specialists)**. Look for these credentials when searching for help. If the professional is certified, there will be a "C" in front of the VRT or O&M.

Vision Rehabilitation Therapists provide direct instruction in activities of daily living. If one is totally blind or has low vision, how does one put toothpaste on a toothbrush, sign a check, use a computer, use a telephone, read the newspaper, identify colors or coins and currency, use the stove, play Bingo, operate the digital microwave, distinguish between two identically shaped cans of food, identify medications, or watch *Jeopardy*? VRTs teach adaptations for performing tasks in the areas of personal and home management, organizational skills (for medication management/ paperwork/clothing, etc.), adaptive computer technology, leisure activities, communication skills (Braille, typing skills), the use of low vision aids (magnifiers), and other life skills.

Orientation & Mobility Specialists provide direct instruction in traveling safely and independently in the home/work/community environment. If one is totally blind or has low vision, how does one negotiate the steps at home, get to work (yes, people who are blind can still work), cross at a traffic light without getting killed, walk around the neighborhood without getting lost, or locate the bus stop? Mobility lessons may include instruction in the use of a red/white support cane or red/white long cane, orientation to the work/home/community environment, negotiating street crossings, use of public/paratransit transportation, self-advocacy skills when traveling, and use of GPS devices.

Other components of a comprehensive rehabilitative program could include professionals who specifically address the areas of **low vision, assistive technology, and vocational rehabilitation.**

Low vision. There are optometrists and low vision therapists who specialize in determining what low vision aids/magnifiers might improve the vision of the individual when prescription glasses no longer provide enough clarity. These aids are available in various catalogs, but one never wants to buy a magnification device from a catalog without it first being prescribed by a low vision specialist. There are many aids available (hand-held, lighted, mounted, etc.) and one does not know, without having a thorough functional vision assessment and low vision evaluation, what magnification device would work best for the individual due to the variation in visual acuities, visual fields, contrast sensitivity, and eye diseases. Low-level magnification devices (those that magnify items two and four times) are available in local stores, but usually individuals with severe visual impairments need a higher degree of magnification. If an individual needs low vision aids/magnification devices, the person usually would also benefit from other services that agencies offer. Therefore, a low vision exam and subsequent provision of low vision aids should be considered just one component of the entire package of services that would benefit the individual with

low vision.

Assistive Technology. Another possible component of services that can improve an individual's independent living skills is assistive technology. This includes accessibility options/installed software on computers that enlarges font size, reads the text aloud, or modifies the screen's color contrast. In the media communications area, access to mobile/smart phones, computers, GPS, and printed matter are necessities for individuals who are visually impaired. Professionals within agencies for the blind can address this large subject area.

Vocational Rehabilitation. If the individual still desires employment, vocational rehabilitation counseling offers another component of relevant services. Rehabilitation counselors may be available within agencies; they can assist in job location and accommodations on the job.

To start the process of obtaining services, one usually needs an updated eye exam (performed by an ophthalmologist or optometrist), with the results being sent to the organization providing services. Since rules vary, contact the agency first to see what information is required to make a referral.

Other Resources. Where do you turn for help? Start by checking out these resources/websites:

VisionAware™ (Resources for Independent Living with Vision Loss): www.visionaware.org provides a state by state (including Canadian provinces) thorough listing of organizations that provide specific services to individuals with visual impairments. The site also contains practical information helpful to individuals with a vision loss and their families/friends.

Department of Veterans Affairs: www.va.gov/blindrehab

Virginia Department for the Blind & Vision Impaired: www.vdbvi.org or call (800) 622-2155. Again, note that the various states have equivalent agencies.

So, go ahead! Change someone's future quality of life and level of independence. Please refer them.

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*Other similar titles include: Independent Living Skills Instructor, Rehabilitation Teacher. Occupational Therapists (OTs) are also trained in teaching adaptive living skills but not necessarily to individuals with a visual impairment.

** Another similar title would be Travel Trainers; however, these professionals are trained to work on traveling issues of those individuals with various disabilities except visual impairments. Physical Therapists (PTs) teach individuals how to use canes, walkers, etc., but are not usually trained to work specifically with individuals with a visual impairment in the use of a long cane or other orientation & mobility instructional areas such as street crossings.

Audrey A. Dannenberg, M.Ed., M.A., is a Certified Orientation & Mobility Specialist and a Certified Vision Rehabilitation Therapist.

Lori Phillippo Receives National Caregiving Award

Circle Center's Chief Executive Officer, Lory Phillippo, was recently recognized by the National Adult Day Services Association with its *2012 Ruth Von Behren Award.* The award is NADSAs highest national honor and recognizes from among more than 5,000 facilities nationwide the personal achievements of one individual who has done the most to advance adult day care services in the United States.

Ms. Phillippo is a pioneer in adult day care, having been part of Circle Center since 1980, and at the forefront of developing the adult day care industry in America. When Ms. Phillippo started at Circle Center, there were just a few hundred adult daycare centers nationwide. Adult day care is now an established, more cost efficient alternative to traditional nursing home care, with more than 5,000 facilities across the United States.

In addition to her role at Circle Center, Ms. Phillippo is a Clinical Assistant Professor in the Department of Occupational Therapy at the Medical College of Virginia.

With 10,000 baby boomers turning 65 every day for the next 20 years, long term care and adult day care, specifically, are playing an ever increasingly important role in assuring the dignified aging of older Americans.

Bring the Vote Home Campaign

Every day, the home health community treats patients who are unable to leave their homes and participate in community activities, such as voting in the upcoming November elections. Realizing the opportunity that it has to help patients and their families, the home health community is offering a voluntary initiative to assist older adults and other home health recipients to exercise their right to vote.

Overview of the Campaign

The Bring the Vote Home (BTVH) campaign aims to help the 3.5 Million homebound patients who receive Medicare home healthcare services delivered by some half million skilled home healthcare professionals to participate in state and federal elections. It is a national effort to support and enable patients, their families, and home healthcare employees to make their votes count. The campaign's website, at www.bringthevotehome.org, provides an overview on the campaign, answers to frequently asked questions, and state-specific information through an interactive map of all the states.

Bring the Vote Home is being supported by 28 state home care associations, including that in Virginia. It is important to note this campaign is not targeted toward any particular party, candidate, ideology, or issue. Nor can it assist patients with completing, collecting, and mailing election registration or application documents. The campaign will, however, remind patients that they have an opportunity to participate in the election process and encourage them to vote.

Voter registration services are available without regard to political preference. Information and other assistance regarding registration or voting will not be withheld or refused on the basis of support for or opposition to particular candidates or a particular party.

The Bring the Vote Home website provides the following documents for every state:

1. A voter registration form as allowed by your state. Requirements and procedures vary by state.

2. An absentee ballot request form. Again, please see state-specific requirements.

Home healthcare agencies direct their staff not to discuss the elections or provide any materials specific to a candidate, in order to ensure that the campaign is completely independent. This campaign is open to the public, too. Each home health agency should inform its employees about the campaign and the opportunity for them to register and participate, as well. The same forms may be used by patients, the public, and home healthcare employees. Campaign sponsors are eager to help their patients participate in the election process this year and exercise their right to vote.

How Wills Fail

by Orrin Onken, Esq.

(This piece originally appeared as a column of the TGB Elderlaw Attorney on the blog *Time Goes By* (www.timegoesby.net) and is excerpted and printed here by permission. The opinions are the author's.)

I got a call the other day from a woman who said that her mother needed a will. I told the caller I would be pleased to help her mother do some estate planning. I asked the daughter to tell her mother to call my office to set up an appointment. The woman explained that her mother was too ill to come to my office and asked if I would come out to the house. I told her that I sometimes go to the homes of my elderly clients and that I would be pleased to discuss it when her mother called me. My offer was not good enough. The daughter said that her mother was too ill even to call me and was relying on her to arrange everything.

When I suggested that a person who is too ill to even call me was probably too ill to do estate planning, the daughter became indignant and said that, if I wouldn't do the job, then she would go on the internet to *LegalZoom* and do it herself. I said that was probably for the best.

Variations of this conversation happen to me a lot. I turn down these cases because I do more than write wills and trusts. I also go to court to get wills and trusts declared invalid. I know that simply getting a

signature on the bottom of the document is not enough.

Wills and trusts fail for the following reasons.

The most common reason wills fail is because they are not properly signed and witnessed. The rules governing the proper signing of estate plans vary from state to state and country to country. You must comply with the rules that apply in the jurisdiction where you live when you sign the document..... Do-it-yourself folks mess it up all the time.

Wills also fail because the person signing the will did not have "testamentary capacity." That normally means that the person was so disabled with dementia that he or she signed the will without understanding what it was. It doesn't take much to have testamentary capacity. You have to be able to name your children (or the people to whom you would ordinarily leave your money). You have to be able to describe what you own. You must know that you are signing a will and you must know what effect the will have.....but I have met many elders who, when taken away from the friends and family who provide them with cues and direction, cannot do it.

When I contest a will, I get to look at the files of the lawyer who wrote it. By looking at those files, I find out what the lawyer did to ensure that his client had capacity. I learn who selected the lawyer and who made the appointment. I search out who came with the elder to the lawyer's office and who was in the room when the estate plan was discussed and signed. In a will contest, a legal action in which someone is challenging the validity of a will, the lawyer's file often determines whether or not the will survives.

When I write wills, I think about the lawyer who might end up looking at my file. Depending on how frail the elder is, I write notes, dictate impressions and, in particularly difficult cases, hire experts. I want more than a signature at the bottom of the document. I want a file that will hold up under examination when the client is dead.

The woman who called me about the will for her mother wasn't worried about such things. She was a free spirit. I am not. In practice, wills written by lawyers and signed in law offices are seldom successfully challenged on the grounds that the elder did not have capacity. The lawyer's testimony about capacity will convince most judges, and no lawyer ever testifies that he wrote a will for someone who couldn't name his own children.

A will can also be invalidated if I can prove it was signed as a result of undue influence. Briefly, undue influence is using a close personal relationship to wrongfully induce an elder to write a will or give away property. The law of undue influence varies a lot from state to state and is beyond what I can tackle in a column. I can say, however, that undue influence never happens in the lawyer's office. It happens in the elder's home and it involves people using relationships to steal.
Nearly all undue influence cases involve unusual gifts. Most people give their estates to their children in equal shares. Childless people tend to give their money to either charity or nieces and nephews. When a person deviates a long way from this pattern, say, for example, by giving everything to the hospice nurse, lawyers are going to examine the estate plan very carefully. If I am asked to write a will in which an elder gives large amounts to a person that just recently arrived in the elder's life, I either decline to do it or hire a whole busload of psychologists to examine the elder and be ready to testify in the will contest that is almost sure to come.

The moral of this story is to not mistake the map for the territory. A signature on a document is an important piece of the picture, but so are the circumstances in which the document was signed. Putting all your attention on the document and not paying attention to the context may leave you with a nicely signed and witnessed estate plan that isn't worth the paper it was written on.

Orrin Onken is an elder law attorney licensed to practice in the state of Oregon. He also keeps his own blog, Oregon Elder Law at www.orolaw.com.

Calendar of Events

October 20, 2012
Caregiving: Journey Over the Years. Prince William Area Agency on Aging Annual Fall Caregiver's Conference. 8:30 a.m. - 4:00 p.m. City of Manassas Park Community Center, Manassas Park. For information, call (703) 792-6374.

November 1, 2012
Falling 4 U: Preventing Falls, Promoting Health. Presented by the Area Planning and Services Committee on Aging with Lifelong Disabilities (APSC). 9:00 a.m.-3:00 p.m. Eastern Henrico Recreation Center, Laburnum Avenue, Henrico. $15 registration includes boxed lunch. For information, visit www.apsc12.eventbrite.com or e-mail Eric Drumheller at drumhellere@rrsi.org.

November 1, 2012
2012 Estes Express Lines Conference on Dementia. Presented by The Alzheimer's Association Greater Richmond Chapter. 8:30 a.m. - 4:30 p.m. Crowne Plaza Richmond West. For information, call (804) 967-2580 or visit www.alz.org/grva.

November 4-7, 2012
Annual Meeting & Exposition of the Gerontological Society of America. Charlotte, North Carolina. For information, visit www.geosociety.org.

November 5-6, 2012
29th Annual Conference and Trade Show of the Virginia Association for Home Care and Hospice. The Homestead, Hot Springs. For more information, visit www.vahc.org.

November 5-6, 2012
Aging and Society: An Interdisciplinary Conference. 2012 Special Theme: Cognition in Aging. UBC Robson Square, Vancouver, Canada. For information, visit http://agingandsociety.com/conference-2012.

November 6, 2012
Vote & Vax Virginia 2012. Providers across the United States are running flu clinics at polling sites on Election Day. For information and to find a clinic near you, visit www.voteandvax.org.

November 8, 2012
Best Practices in Dementia Care. 11th Annual Education Conference of the Alzheimer's Association Central and Western Virginia Chapter. Hotel Roanoke & Conference Center. For information, call (800) 272-3900 or visit www.alz.org/cwva.

November 10, 2012
Art for All Ages. Silent auction of affordable works of art from local artists to benefit Circle Center Adult Day Services. 7:00 p.m. - 9:30 p.m. Circle Center Adult Day Services, Richmond. $25/Ticket. For information, contact thecenter@circlecenterads.org or (805) 355-5717.

November 14-18, 2012
65th Annual Scientific Meeting of the Gerontological Society of America. San Diego Convention Center, San Diego, California. For information, visit www.geron.org/annual-meeting.

January 23, 2013
Virginia Center on Aging's 27th Annual Legislative Breakfast. St. Paul's Episcopal Church, Richmond. 7:30 a.m. - 9:00 a.m. For information, call (804) 828-1525.

February 28 - March 3, 2013
Waves of Change: Charting the Course for Gerontology Education. 39th Association for Gerontology in Higher Education Annual Meeting and Educational Leadership Conference. Hilton St. Petersburg Bayfront, St. Petersburg, Florida. For information, visit www.aghe.org/am.

April 3-4, 2013
Virginia Assisted Living Association's Annual Spring Conference. Holiday Inn Koger Conference Center, Richmond. For information, visit www.vala.alfa.org.

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Call for Presentations

34th Annual Meeting
April 4-7, 2013
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The theme of the upcoming Annual Meeting, ***Transitions***, encourages us to consider changes in our economy, life expectancies, intergenerational relationships, health care system, and long-term care; shifts in population characteristics and expectations; the evolution of the field of aging in academia and best practices; and more. Consider how your work related to this theme might inform others.

View the Call for Presentations and submit on-line at
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