

## Case Study

### TimeSlips: Creativity for People with Dementia

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#### Educational Objectives

1. Recognize the value of creative storytelling for people with dementia, with its shift in emphasis from memory to imagination.
2. Understand the impact of creative storytelling upon facilitators, storytellers, audiences, and readers.
2. Explore the potential mechanisms at work in creative storytelling.

#### Background

In 1996, I began volunteering in a locked “Alzheimer’s wing” of a nursing home. I had been writing extensively about the power of theatre to transform the way we perform aging (or “act our age”), and I wanted to test these ideas with people with profound disabilities. Taking on a new role through theater was clearly transforming the lives of older adults involved with the

senior theater movement. Could theater have the same transformative effect with people with the symptoms of Alzheimer’s disease? After many failed attempts with reminiscence exercises, I shifted toward “making it up” together. This shift toward the imagination had sudden and profound impact. My small group went from very little talking or eye contact to laughing, singing, and communicating in any and every way we had.

Those first storytelling circles revealed the power of improvisation with people with memory loss. When people feel safe to experiment with communication, they can express themselves in new ways and connect with each other. Isolated islands become connected archipelagoes. Over several years, I worked with care providers and people with memory loss to ritualize this imagination-based storytelling process until it was clear, concise, and easily replicable (Basting, 2009). This is how TimeSlips was born.

#### The TimeSlips Evolution

In 1998, a Brookdale National Fel-

lowship fueled the first study on replicating TimeSlips. I taught the method to students and staff in two adult day centers in Milwaukee and two in New York. Each site yielded dozens of creative, funny, poignant stories. The teams of staff and students shared the stories with families. Teams of artists shared the stories through professional play productions in both cities, aimed at sparking dialogue about the power of creativity to reach people with dementia. Since those early days, the TimeSlips team has created in-person and online trainings, and now certifies both individuals and organizations. In 2011, we created free, web-based interactive storytelling software that enables people to experience creative storytelling wherever they live ([www.timeslips.org](http://www.timeslips.org)). Our Master Trainers work with facilitators through the online training to coach them through any challenges they are having with the method as they practice it. With over 100 prompts on the website, visitors are invited to click on an image that leads them to a story page with open-ended questions. Storytellers can tell a story themselves, write one as a group, or invite a friend via e-mail

#### Inside This Issue:

VCoA Editorial, 6  
VDARS Editorial, 7  
SGS Call for Abstracts, 9  
APSC Workshop, 9

Changes to Virginia’s POST, 9  
ARDRAF Final Reports, 10  
Coogole GRITS Award, 13  
Intellectual Disabilities, 14

Caregiving Institute, 15  
Adult Day Services, 16  
Older Adults on Aging, 17  
Calendar of Events, 18

to tell it with them. Visitors to the web site can read thousands of stories from around the world. In addition, TimeSlips has collaborated with various artists to create works based on TimeSlips stories that inspire the general public to think differently about dementia, to consider and mine the strengths that remain. Our goal is to make TimeSlips, and the open-ended, person-centered improvisational approach it entails, a standard approach to care for and living with people with memory loss.

### Time Slips in Practice

TimeSlips exemplifies a participatory approach to creativity with people with dementia. It invites the person with memory loss to be the author of his or her own imagination. In groups or one-on-one, TimeSlips facilitators invite imagination-based responses to a prompt and accept any answers that are given. Facilitators are taught to ask open-ended questions based on a prompt (an object, a question, a song, and most commonly, an image) that invite imagination, rather than dictate or guide it. Facilitators echo all responses to demonstrate that they are truly hearing every component of the storyteller's answer, its tone, emotion, pitch, wording, gesture, and facial expression. Facilitators write down all responses and read them back as the story builds. It is a simple approach with considerable impact on all of those involved in the process. Over the past 15 years, TimeSlips has touched the lives of people with memory loss; those who facilitate the process (including staff, volunteers, students, and family members); and the myriad

others who witness the public sharing of the stories. We have hundreds of Certified Facilitators across the world, and a steadily growing number of Certified Organizations that include a historical society, care communities, and art museums. Our eight Master Trainers are located across the country and conduct our organizational certifications and provide feedback to our online Certified Facilitators.

### Sample TimeSlips Group Story in Response to a Prompt



*The Golden Guitar*

Portia is playing the guitar and singing! No one is listening. She is serenading herself and the birds. She is in a park in Mount Wilson. There are a lot of trees and leaves. It's autumn. She is singing "The Falling Leaves." Everybody sings, "The Autumn leaves drift past my window, the autumn leaves of red and gold." Portia lives there. It's her sanctuary. She is looking at her guitar because she is seeing bubbles coming from her guitar. She is hoping to record a long-playing CD. She is worried whether her guitar will keep working. Maybe somebody comes to teach her to play the guitar.

The birds come down and join her. She throws her guitar on the ground because it won't work properly. She jumps on it. She feels sad. She goes

there to play guitar and she is waiting for her boyfriend. You can see her friend's reflection in the guitar. Her friend steps out of the guitar. She is a fairy godmother who fixes the guitar and everything is happy again. *(This story was created by Mena, Mary, Win and Elvira in the Calvary Rehabilitation Ward on July 29, 2013.)*

Because of the challenges of doing large-scale research on creative engagement interventions for people with dementia, very little data exist about the mechanisms behind the anecdotal/experiential success stories that are so clear to the people who work in the field. There is growing momentum to support research on creative engagement, which is promising. Until then, however, we can only guess. My best thoughts on the mechanisms is that creative engagement builds communication and enables people with memory loss to reconnect to others in a non-judgmental way. It can also make people feel useful and important, contributing to a sense of purpose and meaning. Improving attitudes of people who surround the person with memory loss can help enrich the environment and conditions of care. These factors can reduce anxiety and increase a sense of pleasure/purpose in life, which might, in turn, be linked to improved cognition.

Improving the quality of life of people with dementia demands that we change the way we think about and act toward people with dementia. We should certainly continue to explore bio/chemical interventions. But reducing the toxicity of the care environment can also have an immediate effect on the quality of

life of people with dementia. The following cases look at the various ways in which TimeSlips can contribute to improving the social conditions in which one experiences dementia.

### **Case #1: Family Caregivers**

Several years ago, I conducted a training workshop on TimeSlips in Sheboygan, Wisconsin, at the John Michael Kohler Art Center. We had a small but dedicated group of folks, many of whom had flown in from other states specifically for the workshop. The structure of the training workshop (and online training) is simple. First we focus on what creativity feels like for ourselves. We play and enjoy. Then we shift toward understanding how to facilitate creative expression with people with memory loss, and practice the elements of the method. Finally, we imagine how we might share the stories with others to help them understand that the imagination can be a point of connection and communication for people with memory loss.

As we turned the corner from playing to learning the specific steps of the method, a gentleman who was part of the training group started to look uncomfortable. His grimacing continued for a few minutes until I finally had to ask him, "Are you okay?" He paused. Then he said slowly, as if discovering the meaning as the words came out, "I'm just realizing -- that for the last year I have been driving my wife away." He went on to explain that he would constantly correct the wrong words, dates, and names. He was finding a way back to her, simply by shifting to a shared sense of

imagination and away from an insistence on fact and literal language. He has since gone on to work with his daughter (a pastor), to create a family foundation that models TimeSlips to other family caregivers. "Instead of insisting on calling ketchup by the right name," his daughter wrote me in an e-mail, "now we make up new names for it. Now we play together. And my son loves it too."

### **Case #2: A Person with Memory Loss**

Roger's wife had seen a story on the local news about a new storytelling program at a day center and quickly called to see if there was a spot for him. There was, so she brought him in, driving over an hour to get there. Roger had been a postal carrier, with a pattern of enchanting his family and the residents of his delivery route with stories and jokes for years. By the time his growing changes and symptoms led to a diagnosis of dementia, he had practically stopped talking altogether. On Thursdays, however, when he joined the storytelling group, he started to open up again, adding jokes, names, quips, and votes of confidence in the answers of other participants. "That was terrific!" he told Irma when she gave a particularly witty contribution to the story. He was the life of the story nearly every week. At the end of our storytelling project, we held a celebration in which we read stories and presented hand-made books of stories to the storytellers and their family and friends. Roger grabbed my arm before the reading was to begin. "You know why this works?" he asked me with a sense

of urgency. "Why, Roger?" "It ain't cheap," he replied. His meaning was clear. We took the storytellers seriously. We valued them and their answers. When we handed him the book, which had been lovingly designed by one of our art students, he teared up.

### **Case #3: Students**

Our online training enables TimeSlips to be incorporated into classrooms as a "service-learning" element of courses ranging from Psychology to Theater, from English to Social Work. At the University of Wisconsin Milwaukee, the Center for Community-based Learning, Leadership, and Research coordinates undergraduate volunteers from all across campus to train in the method and team up to practice it at six different care communities (see [www.creativetrustmke.com](http://www.creativetrustmke.com) for more information on this program). Over the years, simple pre-post surveys on attitudes toward dementia and aging have helped assess the impact of the service learning programs on students. Recently, Dr. Daniel George published a study about his use of TimeSlips in service learning with 22 fourth-year medical students at the Penn State College of Medicine (George et al, 2011). Dr. George found preliminary evidence suggesting that learning to communicate in the open, positive model of TimeSlips improved the students' attitudes about engaging with people with dementia.

"In talking with my students, they consistently express their anxieties about medical school training them to see patients as a diagnosis rather than as a fully-fledged person,"

George said. "An activity like TimeSlips, which emphasizes the creative spirit in people with fairly advanced dementia, helps give students a richer sense of who the person was and what made them tick." (*Science Daily*, June 18, 2013).

The challenge of recruiting students to work with older adults is well known in academia. We hunger for geriatric social workers, nurses, dentists, and physicians. The meager financial reward for such work is certainly a disincentive, one that is difficult to change. But the attitude that working with older adults is "depressing" can be changed by creating positive experiences through interventions such as TimeSlips for students in all disciplines.

#### **Case #4: A Staff Member**

Over the past 15 years, TimeSlips Master Trainers have conducted hundreds of training sessions. These involve an on-site demonstration of the method with residents of that care community. It can be unnerving to go into a new setting and work with people you've never met and hope that the magic of improvisation works yet again. At one training in Saint Paul several years ago, the training coordinator arranged for a live web feed of my demonstration session in the nursing unit to be screened in the training room where nearly 100 people were gathered. There was a staff member of the nursing unit who helped arrange the storytellers in a semi-circle and then helped me by echoing some of the answers that I couldn't hear from across the circle.

The magic of improvisation flowered yet again; storytellers were laughing and responding with ease as they collectively wove a fantastic story. When I went back down to the training room, I asked the trainees to tell me what they observed and what questions they had. One person asked, "How do you choose who should participate?" Before I could answer, the staff member who had helped me on the unit said, "Can I answer that? Pick the names out of a hat." She explained that she was embarrassed that before the session she had assumed some of the people in the group were "too far gone" to participate, and she didn't expect anything from the session. "But instead, they were the leaders of the whole group," she said, with a tone of astonishment. "I will never look at them in the same way again."

In a 20-nursing home study, our team of researchers found that on the 10 units in which TimeSlips was embedded, the quality and quantity of engagement between staff and residents improved. The person-centered, engagement-based approach models a positive way to engage with people with dementia that spills over to improve the relationships even of those who did not participate in the training or the storytelling groups themselves (Fritsch et al., 2009).

#### **Case #5: Audience Members**

The TimeSlips team has coached the creation of hundreds of storytelling celebrations over the years. Many are quite simple: care communities will create books of the stories and share them with families over punch and cookies. Others are

more elaborate, and involve setting songs to music or collaborating with a local dance company to interpret the stories.

TimeSlips has also been involved directly in the creation of several plays and art exhibits over the years, including venues such as HERE Arts Center and the New Museum in New York City. At all of our events, we invite audience feedback to assess if the exhibit or performance changed what they thought about people with dementia. The data suggest that the performances do, indeed, improve the attitude that people with dementia can be creative, but of course, sample sizes are small and changes in attitude are difficult to link to changes in behavior. Perhaps the best evidence of larger societal changes in attitudes toward dementia is that the performances at the New York production of the TimeSlips play, staged in the month following the 9-11 disaster, were sold out for the majority of the run. And that the New Museum (Time of our Life exhibit) and John Michael Kohler Art Center (Hiding Places, Memory in Art) invited our participation in their exhibits. People are growing more open and receptive to engaging with representations of memory loss.

In the Milwaukee production of the TimeSlips play in 2000, one audience member's response suggests a reason why the work was effective. The play itself depicted characters from the stories created by a group of people with dementia at two local adult day centers. One character was Ethel Rebecca, a pilot who was flying in an open air plane all the way to Seattle with Dizzy



Gillespie in the back seat. She was singing “Cera luna mezza mara mama mia mi mari dari,” an old Italian-American favorite. The character was played by local jazz vocalist Adekola Adedapo, who ran full sprint up a ramp and into the audience to belt out her first song. On opening night the husband of the woman who contributed that song to the storytelling session sat right at the end of that ramp. I was terribly nervous that the experience would be too much for him, but didn’t have the time to get to him to see if he preferred to change seats. After the show, I found him and asked him what he thought. “I just loved it. It was as though she was right there with me.” I was relieved. And then he asked, “Is it okay if I come again tomorrow?”

## Conclusion

With appropriate study designs and adequate funding for research on creative engagement techniques in dementia care, we can work toward answering the question of what mechanisms are at play with the experiential evidence we observe in the field. For now, these easy to learn approaches have no side effects and existing data suggest that they have a positive impact on improving the entire 360 degree circle of care surrounding the person with dementia, from students, family caregivers, audience members, staff, and, most centrally, people with dementia themselves. No pill can do that.

The playfulness at the root of the TimeSlips improvisational storytelling technique can teach us to focus on the person with dementia, to recognize the person's capacity

for growth, meaning, engagement, and, perhaps most importantly, their ability to teach us valuable lessons about life.

## Study Questions

1. One family caregiver tells stories about things in the refrigerator. How might you incorporate imagination-based approaches like TimeSlips into activities of daily life? And what benefit do you think it might have?
2. What prompts might be around your house or work place?
3. What steps might you take to invite someone to participate in creative storytelling?

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## Recommended Resources

The Arts and Aging: Building the Science. Summary of a National Academies Workshop, Research Gaps and Opportunities for Exploring the Relationship of the Arts to Health and Well-Being in Older Adults. Downloadable at [www.nea.gov/pub/Arts-and-Aging-Building-the-Science.pdf](http://www.nea.gov/pub/Arts-and-Aging-Building-the-Science.pdf)

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

[www.TimeSlips.org](http://www.TimeSlips.org)

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## About the Author



Anne Davis Basting is Professor of Theatre at University of Wisconsin Milwaukee where she teaches courses on storytelling and community-engaged arts practices. She is the founder of TimeSlips Creative Storytelling and author of two books, including *Forget Memory: Creating Better Lives for People with Dementia*. She collaborated with Sojourn Theatre on the two-year Penelope Project ([www.thepenelopeproject.com](http://www.thepenelopeproject.com)) to create and stage an original play in a long term care community inspired by Homer's Odyssey. She is currently working to develop a sustainable system to bring creative engagement to older adults living alone (Islands of Milwaukee). Contact her at [basting@uwm.edu](mailto:basting@uwm.edu).

## Editorials

### From the Director, Virginia Center on Aging

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Edward F. Ansello, Ph.D.

#### *Being in the Moment*

I observed a number of instances recently where, arguably, the participants did not seem to *be there*, in that experience I watched. Here are examples. Two young adults are walking side by side, each talking on a cell phone to someone else. I have seen this countless times, with persons of various ages. Two people are physically close but mentally apart. It's similar to what Piagetian psychologists studying cognitive development in children call "parallel play," as distinguished from later more mature interpersonal communication.

A family of four sits at a restaurant table awaiting their food, each on his or her electronic device, playing games, checking messages, surfing the Internet...anything but talking to each other. They were there together but not really.

Some might say that these are instances of multi-tasking, and I do not necessarily disagree. But making the most of a moment, squeezing everything from it, is different than when people are not being in that moment in the first place. Another recent experience demonstrates what I mean.

At a different restaurant in a different city, I was seated on the side of our table facing the length of the adjacent long table where a family of five was having dinner and con-

versing. At the end of this table, profile to me, sat a teen age boy seemingly engaged in the conversation, smiling and looking at the other four, having two of his fingers of each hand atop the table, while his thumbs out of sight were busily texting on his smart phone, the teenager dexterously deceitful in his really *not* being with his family.

All around there seems to be a disconnect between the moment in time and really experiencing it.

We don't usually pay attention to this disconnect unless there are consequences, as when there is a bad accident because someone was on the cell phone or texting while driving.

I may be way off base but, nonetheless, these observations reinforced a growing sense that many of us older adults are not really where we are, that is, in old age, or perhaps I should say *into* old age, as in "he's really into sports."

Perhaps this goes along with the loss of privacy affecting so many of us because of the immediacy and omnipresence of social media, smart phones, and other means of always being connected and potentially always being interrupted. I don't mean to sound like a Luddite bemoaning technological progress. But I hope that we see, especially those of us in later life, some of the costs, psychologically and socially, of a lifestyle of constant connectedness to someone or something elsewhere, away from myself at the moment.

Perhaps this is the root of it. I know that many of us don't want to be

just ourselves in later life. We may want to continue being who or what we were early in life or to maintain the activity or achievement levels of our mid-lives. I recall the findings of a fairly recent survey of the membership of a large aging advocacy group: the majority of 65 year old respondents self-described as "middle aged." If someone wants to deny old age, who am I to say otherwise?

Still I wonder, if not in later life, where is the time for reflection? The one thing an old person has in abundance is accumulated experience. Appraisal takes time but for many older adults their time switch is constantly turned to "forward" mode, like the neuronal connections in the brains of those with attention deficit disorder. Many of us are becoming addicted to an unrelenting inflow of experiences, without taking or allotting the time to appraise these experiences.

Later life means that one has already lived a long time. This may seem ridiculously obvious. But denial of old age, busily trying to be somewhere else, is common. If you look, you can readily see examples of people not being truly in the moment, not being engaged in where they are. Not just in daily life, but also in the life course.

I have recently read Daniel Klein's *Travels with Epicurus* (2012). It's a slim book fat with aging-related insights, written by the author of 25 other books, many of which enjoyably translate to everyday language the deep thinking of various renowned philosophers. Klein has been visiting a small Greek island for years and he's now in his late

## Editorials

70s or early 80s. The island's rural, non-motorized pace has apparently been ideal for the introspection and integration of life experiences that, he says, used to be common in late life.

Klein introduces a small cast of characters who frequent the local taverna and through his interactions with them comes to appreciate the lost benefits of old age. He notes that reflecting on accumulated experiences may be essential to achieving wisdom, historically one of the associations most often made with old age. As in wise old man or wise old woman. Instead of seeing older adults engaged in this time-taking, he sees us incessantly trying to finish one experience before hurriedly starting another, seeing time as a void into which we must pour activities. With time growing shorter, some of us quicken the pace rather than pausing. Lacking an awareness of the depth of accumulated experiences, we try to pile on new events, trips, things.

Klein maintains that pondering the big questions is one of the "principal callings of an authentic old age." Questions like: What is the purpose of late life? Why did I live the life I did? And making sense of our lives is one of the tasks and one of the privileges of later life. Not that our memories are objectively "accurate." How can they be?; we live subjectively. Memory, after all, is a mix of the "story truth versus the happening truth," as Tim O'Brien so powerfully elucidated in his work on the Viet Nam war, *The Things They Carried*. This mix is inevitable in trying to figure out one's own life for oneself alone.

We may "sift through our memories for themes and then search for memories that validate them." We may discover memories filled with regret and despair but nonetheless come to an acceptance of ourselves. We may come out from reflection with a sense of the thread of our own life.

Some sociobiologists suggest that there really isn't a script for later life after the survival of the human species has been assured through procreating, rearing, and launching the next generation. This may reinforce the expansion of differences among us as we age, what we've called the process of individuation. Clearly, then, there are huge differences in how we each face old age, and reflection and life-integration are not for everyone, perhaps not even for the majority.

I would join with Klein in arguing that, in the past, there used to be a script: if one were privileged to reach late life, take time to be in that moment, rather than trying to avoid it; take advantage of having so many accumulated experiences, sift through them to try to make sense of them. This returns us to the observations of being in the moment and having the full experience of it. I think that reflection is a gift to be opened in late life.

## From the Commissioner, Virginia Department for Aging and Rehabilitative Services

Jim Rothrock

### *The Importance of Tension in Advocacy*

Recently, I was fortunate to attend the Home and Community Based Services conference sponsored by the National Association of State Units United for Aging and Disabilities. The workshops were worthwhile and the networking and learning from other states were very helpful, but the highlight was the keynote speech offered by Kathy Greenlee, our leader at the Administration on Community Living.

One of her themes resonated with me: the importance of advocacy that generates tension, optimally a creative tension that is a catalyst for systemic change. Change is so often uncomfortable and when opinions and people clash, tense situations abound. Yet without this tension, we risk becoming stuck in a *status quo* environment that tends to serve few, if any, who look to these systems for assistance.

As we go about our daily work in educational programs, community-based private nonprofits, governmental agencies, like DARS where I work, or the myriad of other entities that compose the network of programs serving Vintage Virginians and Virginians with disabilities, we need to be aware of the role we all play as advocates. Ed Roberts, who was central to the creation of

## Editorials

the Independent Living movement, responded to the question "What are the three most important and critical elements of Independent Living?" with this answer: "Advocacy, advocacy, and advocacy!"

When Secretary Greenlee polled her audience of about 1,000 as to whether they were advocates, virtually every hand in the room went up! Advocacy at its core embraces at least two points of view and sometimes many more. Without solid advocacy, little would change. The services many of us offer would be far too inadequate to meet the ever increasing needs of those who benefit from what we do.

Recognizing that confession is good for the soul, I often feel that advocates create tension and make my little span of control uncomfortable. I know I often mutter under my breath and bemoan the fact that some advocates don't value the array of services that are already there BUT I should get over it and embrace the tension. Without it, there would be no growth, no change.

Moreover, I know, more confession here, that too often I look to folks who *represent* others, ignoring real people who actually receive the services. Our colleagues in Independent Living always note their mantra, "nothing about us without us." I need to do better remembering this, and I bet some of our readers may be in the same boat as I.

A colleague of mine just this week reflected on a situation he is dealing with where his relative, more than 90 years of age, is in a hospital after a nasty fall. Her age makes the sit-

uation more complex. Family members have gathered and opinions about their relative abound. Doctors have opinions, nurses, social workers, and relatives all have opinions, each knowing exactly what the next steps should be; but, unfortunately, there is more than one idea about the best next step. My colleague found himself alone in the room with the older relative and heard her bemoan the fact that nobody has asked her what she thinks is best. This happens all too frequently. We don't hear the ones who can offer invaluable information and direction about themselves.

In our work, I know I will try to embrace the tension that is the core of many advocacy efforts, as uncomfortable as it may be, and look to strategies to get more *real* people involved in boards, commissions, advisory bodies, and other groups that can guide me and DARS in what we do.

I challenge you to do the same.

### 2013/2014 VDARS Meeting Calendar

#### Commonwealth Council on Aging

(Wednesdays)  
January 22, 2014  
April 9, 2014  
July 9, 2014  
September 24, 2014

#### Alzheimer's Disease and Related Disorders Commission

(Tuesdays)  
March 25, 2014  
May 20, 2014  
August 5, 2014  
December 2, 2014

#### Public Guardian and Conservator Advisory Board

(Thursdays)  
November 21, 2013  
March 20, 2014  
June 12, 2014  
September 18, 2014  
November 20, 2014

For more information about these meetings, call (800) 552-5019 or visit <http://vda.virginia.gov/boards.asp>.

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## SGS Call for Abstract Submissions

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### *Building the Bridge to the Future: 21st Century Families*

SGS celebrates its 35th Annual Meeting (**April 3-6, 2014 in Little Rock, Arkansas**) by revisiting the mission of the organization when it was first conceptualized: "SGS provides the bridge between research and practice, translating and applying knowledge in the field of aging." Thus, our conference theme this year is focusing on building that "bridge" from research into practice, not just for the present, but also for the future.

So what is the future of aging research and senior services? No one can know for sure what new technologies are around the corner. However, trends show that family is going to be a major player in the lives of senior adults. Grandparents raising grandchildren, the sandwich generation, boom-a-rang kids and healthcare power of attorney. These are just a few examples of the variety of roles family plays in both giving care and receiving care.

Plan to attend the SGS 2014 Annual Meeting and be welcomed by colleagues in aging-related teaching, direct service, and research from across the South.

Submit your abstract online at [www.southerngerontologicalsociety.org](http://www.southerngerontologicalsociety.org)

## Creative Options for Staying Active

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The Area Planning and Services Committee on Aging with Lifelong Disabilities (APSC) is sponsoring a training workshop *Creative Options for Staying Active*, to be held at the Eastern Henrico Recreation Center, 1440 North Laburnum, Richmond, **November 14, 2013, 9:00 a.m.-2:30 p.m.** The workshop is intended to inspire service providers, program managers, and others to break out from the "same old same old" when developing activities for and with clients. Sessions include:

Chair Yoga: Adapted for Special Populations, with Sarah Humphries, Experienced Registered Yoga

Maintaining An Active Lifestyle: Tips and Strategies for Staying Active, with Alison Clarke, CTRS, Community Recreation Services Director, and Stephanie Goode, ATC, Aquatic/Fitness Manager, Sheltering Arms Physical Rehabilitation Centers

Outside the Box: Rethinking Recreation and Art to Help Expand Your Programming, with Kelly Davis, Senior Therapeutic Recreation Specialist, Chesterfield County Parks and Recreation

Music Therapy, with Melissa Owens, Board Certified Music Therapist, VCU Medical Center

Registration fee of \$20 includes materials, refreshments, and lunch. For more information, visit [www.apsc13.eventbrite.com](http://www.apsc13.eventbrite.com).

## Changes to Virginia's POST

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POST (Physician's Orders for Scope of Treatment), a valuable health care tool to improve communication during end-of-life care which was featured as the case study in the spring 2013 issue of *Age in Action*, has been updated. The Executive Committee of the Virginia POST Collaborative announced a new form effective this September. The process of revising this form was said to have been diligent and intense, with input from both within the state and the National POLST Paradigm.

The POST form, printed on bright yellow paper and inserted within the patient's on-going charts, clarifies the patient's wishes for (A) Cardiopulmonary Resuscitation (CPR), (B) Medical Interventions (Comfort Measures, Limited Additional Interventions or Full Interventions), and (C) Artificially Administered Nutrition (No feeding tube, Feeding tube for defined period or Feeding tube long-term).

Some key changes to the form include permitting NPs and PAs to sign the form, if it is within the scope of their practice agreement, and clarifying who may revoke a POST form. (If the patient signed the POST form and requested a DNR, others cannot revoke this.)

One may request a POST form and/or a slide presentation explaining the revisions and implications for advance care planning discussions from Laura Pole, Virginia POST Collaborative, at [lpchef@earthlink.net](mailto:lpchef@earthlink.net).

## COMMONWEALTH OF VIRGINIA

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

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#### 2012-2013 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 2012-2013 round of competition are given below. To receive the full reports, please contact the investigators or the ARDRAF administrator, Dr. Constance Coogle, at (804) 828-1525 or [ccoogle@vcu.edu](mailto:ccoogle@vcu.edu).

#### **UVA Inchan Kwon, PhD and Erik Fernandez, PhD**

##### **“Revealing the Effect of Food Dyes on Amyloid-Beta Structure-Cytotoxicity Relationships”**

Modulation of amyloid-beta (A $\beta$ ) peptide aggregation is considered a promising therapeutic strategy to cure Alzheimer's disease (AD). Although several U.S. Food and Drug Administration (FDA)-approved drugs temporarily reduce symptoms, no treatment exists that slows or stops progression of AD. There is a need to discover more potent molecules and elucidate their relationship to AD pathology. In the search for safe, effective aggregation modulators, the investigators have examined FDA-approved food dyes and their close analogs. They previously reported that erythrosine B (ER) and brilliant blue G (BBG) reduce A $\beta$  neurotoxicity by modulating A $\beta$  aggregation. These exciting results suggest that ER and BBG could be promising lead compounds for AD therapy. For this project, the researchers explored the structural basis for ER and BBG (and their analogs) A $\beta$  binding and the subsequent reduction of cytotoxicity. The preliminary results obtained indicate that a BBG analog, Brilliant Blue R, could be a promising candidate to proceed with *in vivo* testing in an animal model of AD. In addition, the immunoassays revealed the 10-16 amino acid sequence of the A $\beta$  peptide as a potentially important binding region for aggregation modulators/inhibitors. This work could open the door for structure-based design of molecular or peptide inhibitors that specifically target the 10-16 amino acid sequence of A $\beta$ . Lastly, the immunoassays described in this work provide an economical template for researchers to obtain residue level information without the need for nuclear magnetic resonance spectrometers or other costly apparatus. (Dr. Kwon may be contacted at (434) 243-1822, [ik4t@virginia.edu](mailto:ik4t@virginia.edu); Dr. Fernandez may be contacted at (434) 982-2658, [ejf3c@virginia.edu](mailto:ejf3c@virginia.edu).)

#### **Marymount Julie D. Ries, PhD, PT**

##### **University “Balance Training Program Designed for Individuals with Alzheimer's Disease: The Effect on Balance and Falls”**

Individuals with Alzheimer's disease (IwAD) experience more frequent and more serious falls than their age-matched peers. Balance training is effective in improving balance and decreasing falls in cognitively intact older adults. This study was developed to analyze the effects of a balance training program designed specifically for IwAD, with specific guidelines for communication/interaction and deliberate structure of training sessions. Thirty participants with AD were recruited from three adult day-center programs; twenty-two of them completed at least one post-test session. Balance and mobility tests were administered immediately before and after the three-month program and again three months later. Balance training sessions were 45 minutes, twice per week and were characterized by functional, relevant activities, with considerable repetition, and with sessions consistently formatted with blocks of time dedicated to different tasks. Participants were up on their feet the majority of each session and were individually challenged as much as possible. Although most IwAD did not remember participating in the program week to week, or recognize the researchers after the three-month program, they demonstrated statistical-

program, although participants did maintain some improvement three months after the training. Fewer participants experienced falls the six months following program initiation (n=5) than the six months prior to initiation (n = 9). This upright and intensive balance training program shows promise for improving balance and potentially decreasing falls in IwAD. (*Dr. Ries may be contacted at (703) 284-5983; [jries@marymount.edu](mailto:jries@marymount.edu).*)

**VCU Vladimir Sidorov, PhD**

**“Identification and Characterization of nAChRs Clustered in Cell Membrane Lipid Rafts Using Novel Patching Technique with Chemically Modified Electrodes”**

Neuronal nicotinic acetylcholine receptors (nAChRs) are critical to cell functioning and essential in the development of Alzheimer’s disease. The function of alpha4beta2 and alpha7 subtypes of nAChRs is regulated by association of the receptors with rigid areas of neuronal membranes, known as lipid rafts. The overall goal of this project is to develop a novel technique that allows identification and characterization of the functional properties of nAChRs based on selective patching of the raft and fluid areas of cell membranes with a chemically modified borosilicate electrode. During this initial stage of the investigation, a robust chemical procedure for surface modification of borosilicate electrodes was developed for use in the planned electrophysiological experiments. The procedure allows tethering of a synthetic macromolecule, cyclen 2, which serves as a selective binding agent for the fluorescent dye pyranine. The binding phenomenon is readily observed due to the fluorescence quenching. In order to utilize these electrodes, a series of lipid conjugates with pyranine have been synthesized. The confocal microscopy imaging experiments revealed that the cholesterol-pyranine conjugates rapidly partition into the dynamic areas of cell membranes consistent with the ordered domains (rafts). While being in a rapid lateral motion, the fluorescently labeled cholesterol remained fully accessible for interactions with cyclen 2 attached to the glass surface. Future undertakings will test the hypothesis that the functional behavior of nAChRs is directly affected by their localization in the ordered membrane domains. Such characterization of nAChRs docked in the raft areas of membranes may lead to better understanding of key factors in the development of Alzheimer’s disease as well as to the methods for treatment of this condition. (*Dr. Sidorov may be contacted at (804) 828-7507; [vasidorov@vcu.edu](mailto:vasidorov@vcu.edu).*)

**Ferrum Megan M. St. Peters, PhD**

**College “Who Forgot the Hippocampus? Potential Involvement in the Neural Circuitry of Attentional Control”**

The ability to focus on important stimuli and ignore irrelevant stimuli in our environment is essential to the “top down” control of attention. It is suggested that the memory of what is important in an environment is essential to this top-down control, and recent research suggests that attentional impairments may precede or largely contribute to the memory problems associated with dementia of the Alzheimer’s type (DAT). Yet studies examining the brain pathways involved in attention have failed to examine the role of the hippocampus, a brain region commonly associated with memory loss and DAT. The current pilot study tested a rodent model with cholinergic deafferentation of the hippocampus in an operant sustained attention task. Task parameters enabled the introduction of irrelevant distractors in order to assess top down control of attention. Although there was a relatively small sample size (n = 6 per group), the data suggest no effect of lesion. However, several parameters (toxin site location, concentration, and task) can be further explored in future research to better understand the potential neural interplay between memory and attention. (*Dr. St. Peters may be contacted at (540) 365-6947; [stpeters@ferrum.edu](mailto:stpeters@ferrum.edu).*)

- continued on page 12

VCU

**Dong Sun, MD, PhD**

**“Excessive Inflammation in Aging Population Following Brain Injury Impairs Hippocampal Neurogenesis and Cognitive Function: Implication for AD”**

Recent evidence suggests that impaired neurogenesis in the hippocampus is a critical event and may underlie cognitive deficits in AD. Aging and traumatic brain injury (TBI) are the leading risk factors in the development of AD. This project tested the hypothesis that under neuropathological conditions, aging produces excessive inflammatory responses which impair hippocampal neurogenesis and cognitive function. In Aim 1, serum and brain tissue homogenates from young and aged rats at different time points following TBI were assayed to measure the expression levels of 24 cytokines/chemokines. Another group of animals was used to assess the level of hippocampal neurogenesis. In Aim 2, minocycline and 7,8-DHF were used to target neuroinflammation and neurogenesis for improved cognitive function in animals following TBI. At the early time point, several pro-inflammatory cytokines/chemokines were expressed at high levels in both serum and brain, and the aged animals had a higher expression compared to their younger counterparts. At three days post-TBI when the inflammatory mediators were expressed at high levels, a decreased number of newly generated neurons were found in the injured aged brains as compared to age matched sham controls or their younger counterparts. Short term minocycline treatment at the acute stage post-injury significantly attenuated TBI-induced inflammatory cell responses in the brain and the production of several pro-inflammatory cytokines particularly in the aged rats. The administration of 7,8-DHF at the same stage improved cognitive function. These studies suggest that targeting inflammation and neurogenesis may have therapeutic potential to improve cognitive recovery in aging populations. (Dr. Sun may be contacted at (804) 828-1318; [dsun@vcu.edu](mailto:dsun@vcu.edu).)

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## **Arthritis Foundation’s 2013 Jingle Bell Runs**

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Chosen as one of the *Most Incredible Themed Races*, The Jingle Bell Run/Walk for Arthritis is a fun and festive way to kick off your holidays by helping others!

Wear a holiday themed costume. Tie jingle bells to your shoelaces. Raise funds to fight arthritis, the nation's leading cause of disability. Run or walk a 5K with your team members and celebrate the season by giving.

The following is a list of runs in Virginia and local contact information. You may also visit [www.arthritis.org/programs-events/jingle-bell-run](http://www.arthritis.org/programs-events/jingle-bell-run) for more information.

**Newport News**

November 16, 2013  
Contact: Angela Courtney  
(757) 456-1119

**Norfolk**

November 23, 2013  
Contact: Angela Courtney  
(757) 456-1119

**Richmond**

December 7, 2013  
Contact: Tanya Scott  
(804) 665-9954

**Metro DC**

December 7, 2013  
Contact: Shaina Bonuccelli  
(202) 787-5337

**Roanoke**

December 14, 2013  
Contact: Tanya Scott  
(804) 665-9954

**Charlottesville**

December 14, 2013  
Contact: Laura Boone  
(804) 665-9954

**Fredericksburg**

December 15, 2013  
Contact: Katy Walker Ahmed  
(571) 277-1818





## SGS Honors Coogle with GRITS Award



The Southern Gerontological Society (SGS) has recognized VCoA's Constance (Connie)

Coogle, Ph.D., with its GRITS (Gerontologists Rooted in the South) Award, inducting her into the GRITS Hall of Fame for 2013. The honor "seeks to recognize individuals who have made important contributions to the Southern Gerontological Society (SGS) and to the field of gerontology through research, teaching, administration, advocacy, or applied practice.....and to honor past and present members who serve as role models for future generations interested in the advancement of knowledge and practice in the field of aging." This honor is well-deserved.

Connie is a native of Virginia. A trained experimental psychologist and gerontologist, she is the Associate Director for Research at the Virginia Center on Aging, administering the Alzheimer's and Related Diseases Research Award Fund for the Commonwealth of Virginia, and Director of Evaluation in the Virginia Geriatric Education Center, a consortium of interdisciplinary faculty from Virginia Commonwealth University, Eastern Virginia Medical School, and the University of Virginia.

Connie has been an active member of SGS for more than 20 years, has received its prestigious Gordon Streib Academic Gerontologist Award, and was elected its President for 2006-2007. She has given

time and expertise to various committees and leadership positions within the organization, including membership recruitment, nomination, special interest groups, finance, annual program chair, co-editor of the *Southern Gerontologist* newsletter, and the board of directors; she currently serves on the editorial board for *The Journal of Applied Gerontology*. Connie is also a Fellow in the Gerontological Society of America (GSA) and serves on the editorial board of GSA's *The Gerontologist*. She has served on various Committees for the Association for Gerontology in Higher Education, and has worked extensively on the editorial board for the journal *Gerontology and Geriatrics Education*. She is a prolific author, lecturer, workshop organizer, web seminar presenter, and trainer, with research interests that include geriatric substance abuse and gambling, medication misuse and abuse in older adults, the direct care workforce crisis, and Alzheimer's family caregiving, especially in rural and African American communities.

While those who nominated Connie for the GRITS Hall of Fame recognized these scholarly assets, they made special note of her gentle spirit and embracing humanity, characteristics that have mentored many aspiring gerontologists she has met, both within SGS and across the broader range of academia.

Nominators wrote that Connie "adopted me and several of us who were new, attending for the first time. At the registration table she introduced herself and set about to allay our fears and anxieties" and

"she made me and members of my group of presenters feel welcomed and confident in getting through our first workshops at SGS." Another, a newly minted junior faculty member, detailed the interpersonal style that has fostered the professional growth of so many gerontologists: "She attended my (first) paper session. She had assured me I would do well; however, I think she was very aware that underneath my composed appearance, my knees were knocking, my hands started to shake, and my mouth went dry like the Gobi desert! But out in the audience, I glanced up and looking around the room, I saw her and her reassuring smile. I knew I could get through to the end. After the session, which seemed to go on like an eternity, she came up and reassured me I had done an outstanding job!! Her kind words, actions, and encouragement have resonated in me to continue and advance in my university career."

Those of us who work with Connie regularly can second all of these observations. She is both a resolute researcher, committed to maintaining rigorous methodology and analyses, and a sensitive colleague to novice and seasoned associates, whether they be in academic, community service, or health care settings. One GRITS nominator referenced her "engaging laugh and smile" as emblematic of her interpersonal style. We all agree that hers are the most valuable of characteristics for gerontologists and congratulate Connie on receiving this fitting recognition.

## Intellectual Disabilities and Dementia



Adults with intellectual disabilities, including Down Syndrome, are living to later life in unprecedented numbers. Yet

health care practitioners seldom are prepared, having received little or no training on the needs and characteristics of this diverse population. As a result, adults with intellectual disabilities often reach later life without adequate support from or interaction with practitioners in the health care system. And so, practitioners often lack a point of reference or baseline when examining individuals with intellectual disabilities, which, in turn, may lead to mistaking lifelong patterns as new ailments or may complicate timely diagnosis and treatment of dementia.

A new consensus statement, derived from expert opinion, published in the *Mayo Clinic Proceedings* (August 2013) addresses the challenges of evaluating and managing dementia in older adults with intellectual and developmental disabilities, such as Down syndrome or brain injury.

Julie A. Moran, DO, previously with Beth Israel Deaconess Medical Center in Boston, and colleagues Michael Rafii, MD, PhD, Seth Keller, MD, Baldev Singh, MD, and Matthew Janicki, PhD, members of the National Task Group on Intellectual Disabilities and Dementia Practices (NTG), recommend a

series of screening techniques that clinicians can use in primary care settings and during the Medicare-authorized Annual Wellness Visit. The National Task Group on Intellectual Disabilities and Dementia Practices (NTG), was formed in response to the National Alzheimer's Project Act, signed into law in 2011, specifically to speak to the multiple needs of these patients and their caregivers. NTG represents the combined efforts of the American Academy of Developmental Medicine and Dentistry, the Rehabilitation Research and Training Center on Aging with Developmental Disabilities at the University of Illinois at Chicago, and the American Association on Intellectual and Developmental Disabilities. NTG's charges include, according to the Mayo Clinic article, creating "an early detection screen to help document suspicions of dementia-related decline...practice guidelines for health care and supports...and models of community-based support and long-term care of persons with intellectual disabilities affected by dementia."

Researchers recommend a nine-step approach for assessing health and function. These include:

1. Gather a pertinent medical and psychiatric history, with particular attention to "red flags" that potentially influence premature dementia, such as history of cerebrovascular disease or head injury, sleep disorders, or vitamin B12 deficiency.
2. Obtain a historical description of baseline functioning, with family members or caregivers who know the individual well present at the interview.

3. Obtain a description of current functioning and compare with baseline, noting such key features as reported memory loss or impairment, marked changes in personality, and decreased performance in expected tasks or skills.

4. Perform a focused review of systems, noting dysfunctions that are common with age and also with possible emerging dementia.

5. Review the medication list thoroughly, particularly those that are psychoactive, sedating, or anti-epileptic, and paying attention to symptoms that may suggest an adverse drug effect, such as sleepiness and gait instability.

6. Obtain a pertinent family history, with special attention to a history of dementia in first-degree relatives and its early onset (before age 50).

7. Assess for other psychosocial issues or changes, especially destabilizing events such as leaving the family home, witnessing the declining health or death of a parent, loved one, or friends/housemates which could trigger mood disorders.

8. Review social history, living environment, and level of support, thinking proactively in anticipation of ever-changing and increasing needs.

9. Synthesize the information, cross-referencing the information with the criteria for a dementia diagnosis and building evidence for or against the diagnosis.

Moran and colleagues recommend conducting a comprehensive

physical examination of the person with intellectual disabilities and a cognitive assessment, stating that “Many instruments have been developed and validated for the diagnosis of dementia in this population, including the Dementia Scale for Down's Syndrome, the Dementia Questionnaire for People With Learning Disabilities, the Cambridge Examination for Mental Disorders of Older People with Down's Syndrome, the Down's Syndrome Mental State Examination, and the Test for Severe Impairment. Regardless of the clinician's choice of instrument, the focus should be on recognizing change and decline in relation to a pre-morbid baseline.”

The NTG has plans to publish additional recommendations regarding screening techniques and how to provide additional support for these patients.

The complete *Mayo Clinic Proceedings* article may be accessed at: [www.mayoclinicproceedings.org/article/PIIS0025619613003716/fulltext](http://www.mayoclinicproceedings.org/article/PIIS0025619613003716/fulltext).

## Improving Health and Wellness of Family Caregivers

SeniorNavigator, the statewide non-profit online resource for aging- and disability-related information, has received grant support to lead the development of a new *Institute for Innovations in Caregiving*. The Institute will develop innovations to strengthen family caregiving by leveraging best practices and technology that improve the physical and emotional health of family caregivers.

SeniorNavigator already provides free health and community support information and guidance to older adults, family caregivers, and health care professionals, in order to reinforce the individual's sense of independence, dignity, and quality of life. Designed as an award-winning service model combining information technology with community-building, SeniorNavigator offers a ‘high-tech’ and ‘high-touch’ approach to healthy lifestyle and long term care support. Seniors, caregivers, and adults with disabilities can find vital services and information through its websites at [SeniorNavigator.org](http://SeniorNavigator.org) and [disAbilityNavigator.org](http://disAbilityNavigator.org).

Funded by a private foundation that wishes to remain anonymous, the objective of *The Institute for Innovations in Caregiving* is to preserve and improve the wellness of family caregivers, with a special focus on the Alzheimer's caregiver. The Institute's ultimate goal is to improve caregivers' self-care and their ability to manage emotional stressors and tough decisions while

bolstering their access to the latest technologies and community resources.

The *Institute for Innovations in Caregiving* will bring together partners as an Advisory Council to facilitate out-of-the-box collaboration among both Virginia's academic programs in aging and key statewide service providers. This Council's activities are intended to enable special peer-to-peer connections that stimulate new thinking and practices that might not otherwise be created.

This Virginia-based Institute will be an arm of SeniorNavigator, with project management by its staff under the leadership of Adrienne Johnson, executive director. Two national experts in the field of aging, Dr. Richard W. Lindsay, Professor Emeritus of Internal Medicine and Family Medicine at the University of Virginia Health Sciences Center and founder and former Head of the Division of Geriatric Medicine at the University of Virginia, and Gordon Walker, retired CEO of the Jefferson Area Board for Aging (JABA), will serve as Institute consultants.

The Advisory Council includes the following Virginia-based organizations and institutions: Alzheimer's Association of Central and Western Virginia; Beard Center on Aging, Lynchburg College; Carilion Center for Healthy Aging; George Mason University, College of Health and Human Services; James Madison University, College of Integrated Science and Technology; Leaders Engaged on Alzheimer's Disease

- continued on page 17

## Adult Day Services: A Partnership with the Family

by Debbie Scott, MSG  
A Grace Place, Adult Care Ctr.



“Mom is becoming more difficult to handle.” “I am so tired,

but who will take care of Dad?” “I could never put my parents in a nursing home.” Do any of these phrases sound familiar? Every day, more than 10,000 Baby Boomers reach the age of 65, and this will continue for the next 19 years. More and more, families need affordable care for loved ones. One option to consider is Adult Day Services (ADS). ADS facilities, typically open from 7:00 a.m. to 6:00 p.m., Mondays – Fridays, provide a safe, stimulating, and fun place for participants while caregivers have time off. A nurse is on site to manage medicine and emergencies.

Most ADS have Alzheimer’s or Memory Care Units, which provide specialized activities for these clients. Some accept participants with Autism, Parkinson’s, Muscular Dystrophy, and Cerebral Palsy.

### How to Choose an ADS

When considering ADS, first determine location. Convenience is a must. Often, if a suitable facility is not available nearby, transportation services are available. Next, look at the hours of operation and determine if they fit into your schedule.

Cost is a third factor to consider, as

many options exist, ranging from private pay to non-profits who accept Medicaid, waivers, and scholarships. ADS are a cost effective alternative to nursing homes, retirement communities, and even in-home services, running about \$65/day currently.

The National Adult Day Services Association did a cost comparison of care options in 2010. ADS care costs about \$13,780 per year; Homemaker services \$37,758; Home Health Aide \$41,184; Semi-Private room in Assisted Living \$43,282; Semi-Private room in a Nursing Home \$65,7000; and a Private room in Nursing home \$73,000. Many families have found ADS to be a more affordable, life-enhancing arrangement.

Fourth, consider the population that the ADS serves. Some ADS will accept individuals 18 years and older, some accept individuals ages 55 years and older, and still others start at age 60-65. Assess the situation to make sure it is the best option for your loved one.

Next, consider licensure. Licensed facilities have standards they must maintain for accreditation. Quality staff, trained to handle difficult behaviors, can provide personal care, programming, and a healthy quality of life. Nurses, for example, will monitor participants’ health and alert caregivers before a condition becomes problematic.

Last, consider ADS exclusions. Many ADS have exclusions of care for certain population groups. For example: Mom has Alzheimer’s but is still continent and does not wander. Will the facility still allow her

to stay if she becomes incontinent and starts to wander? Ask “what if” questions when choosing an ADS. Some allow participants to move to another area within the facility when behaviors progress, while others might require patients to relocate to another facility. “What if” questions can provide important answers up front.

### When Is the Right Time for ADS?

If your loved one exhibits a few of the following, it may be time to consider ADS:

- Needs help with self-care
- Requires supervision
- Is socially isolated and lonely
- Is confused
- Has poor nutrition
- Requires medical supervision and care
- Is prone to wander
- Needs stimulation
- Needs quality of life despite disability/illness
- Needs assistance with life skills
- Needs temporary placement
- Has a family or caregiver who needs support and a break from care responsibilities.

### Caregiver Stress and Fatigue

ADS is good for participants, but is also helpful to caregivers who often experience headaches, anxiety, depression, guilt, anger, muscle tension, and sleeping and eating problems. Caregivers experiencing these symptoms need a break.

Some 23% of caregivers experience a decline in health. The reasons are clear. The stress of juggling family, work, and 24/7 caregiving responsibilities is exhausting. “Seventy percent of working caregivers suffer



work-related difficulties due to their caregiving roles: 69% report having to rearrange their work schedule, decrease their hours or take an unpaid leave in order to meet the caregiving responsibilities; 5% turn down a promotion; 4% choose early retirement; and 6% give up working entirely.” ADS can help.

Adult Care Services can be beneficial for loved ones and caregivers alike. They allow clients to have care during the day while the caregiver works without worrying about safety, security, loneliness, meals, or entertainment. There are many things to consider when you are a caregiver, but an ADS can make this job an easier responsibility with a more fulfilling outcome.

## **Improving Health,** *continued from page 15*

Coalition; LeadingAge Center for Aging Services Technologies; Riverside Center for Excellence in Aging and Lifelong Health; Riverside Health System; University of Virginia; University of Virginia Health System; Virginia Assistive Technology System; Virginia Caregiver Coalition; Virginia Center on Aging; Virginia Commonwealth University, Department of Gerontology; Virginia Community College System; Virginia Department for Aging and Rehabilitative Services; and Virginia Tech Center for Gerontology.

For more information, contact SeniorNavigator at (804) 525-7728; toll-free 866-393-0957; [info@SeniorNavigator.org](mailto:info@SeniorNavigator.org); or visit [www.CaregivingInnovations.org](http://www.CaregivingInnovations.org).

## **What Do Older Adults Think About Aging?**

The National Council on Aging (NCOA), UnitedHealthcare, and *USA TODAY* have jointly released results of their April-May 2013 United States of Aging Survey. Telephone interviews of nationally representative samples of 4,000 Americans ages 18-59 and 60 and above explored questions about their General Outlook, Health Preparedness, Financial Security, Community Support, Technology Usage, and more. The findings are both optimistic and problematic. Among them:

Older respondents were generally positive about their future. More than half (51%) expect their quality of life to stay about the same during the next five to 10 years, while 21% expect it to get much or somewhat better.

The vast majority (84%) of older adults say it is not very or not at all difficult to perform regular activities independently. Few expressed concern about the status of their health today, with 60% expecting it to stay the same over the next five to 10 years, compared with 53% of adults ages 18-59. But many older adults are not investing in activities to help manage their health for the long term. For example, although six in 10 describe their health in the past year as “normal,” 65% report having at least two chronic health conditions. Yet more than half had not set any specific goals to manage their health in the past 12 months, with fewer than 20% receiving guidance to develop an action plan.

More than half (53%) of older adults are very or somewhat concerned about whether their savings and income will be sufficient to last the rest of their life, compared with 44% of those above age 80, 61% of low-income older adults, and 56% with three or more chronic health conditions.

Forty-one percent of working seniors indicate Social Security will be their primary source of retirement income, compared with 23% of adults ages 18-59. Two-thirds (66%) of older adults believe it to be very or somewhat easy to pay monthly living expenses, compared to half (52%) of adults ages 18-59.

While the majority of older adults agree that the community they live in is currently responsive to their needs, many lack confidence that their community is prepared to meet the needs of a increasingly aging population.

Older adults today are comfortable using technology and acknowledge its importance in helping to keep them connected to family, friends, and the wider world. Similar numbers of those ages 60 and above and those ages 18-59 say it is very or somewhat important for older adults to use technology (83% and 88%, respectively). However, lack of understanding and cost remain barriers to fuller adoption, with nearly 34% of older adults citing “I don’t understand how to use it” as a barrier that prevents them from using more technology.

To access the survey findings, visit [www.ncoa.org/UnitedStatesofAging](http://www.ncoa.org/UnitedStatesofAging).

## Calendar of Events

**October 31 -**

**November 3, 2013**

*National Association for Home Care and Hospice Annual Meeting and Exposition.* Gaylord National Resort and Convention Center, National Harbor, MD. For information, visit [www.nahc.org](http://www.nahc.org).

**November 1, 2013**

*2013 Estes Express Lines Conference on Dementia.* Presented by the Alzheimer's Association Greater Richmond Chapter. 8:30 a.m. - 4:30 p.m. Westin Richmond, 6631 West Broad Street. For information, call (804) 967-2580 or visit [www.alz.org/grva](http://www.alz.org/grva).

**November 5-6, 2013**

*30th Anniversary Annual Conference and Trade Show of the Virginia Association for Home Care and Hospice.* The Founders Inn, Virginia Beach. For information, visit [www.vahc.org](http://www.vahc.org).

**November 14, 2013**

*Continuous Improvement: Operationalizing Person Centered Care in a Healthcare Setting.* The VCU Department of Gerontology's Fall GeroSTAT Forum. Session offers five contact hours for healthcare professionals and is also open to caregivers and older adults interested in the topic. Cost is \$85. Location pending. For information, email [agingstudies@vcu.edu](mailto:agingstudies@vcu.edu).

**November 14, 2013**

*Creative Options for Staying Active.* Workshop presented by the Area Planning and Services Committee on Aging with Lifelong Disabilities. Eastern Henrico Recreation Center, 9:00 a.m. - 2:30 p.m. For information, visit [www.apsc13.eventbrite.com](http://www.apsc13.eventbrite.com).

**November 20-24, 2013**

*66th Annual Scientific Meeting of the Gerontological Society of America.* Sheraton New Orleans and New Orleans Marriott, New Orleans, Louisiana. For information, visit [www.geron.org](http://www.geron.org).

**January 22, 2014**

*Virginia Center on Aging's 28th Annual Legislative Breakfast.* St. Paul's Episcopal Church, Richmond. 7:30 a.m. - 9:00 a.m. For information, call (804) 828-1525.

**January 31, 2014**

*Emotional Health and The Older Adult.* Presented by Radford University's Waldron College and made possible with a grant from The King Foundation. The Hotel Roanoke. For information, contact [EmotionalHealth@aegisservices.com](mailto:EmotionalHealth@aegisservices.com).

**February 27 - March 2, 2014**

*Taking Educational Quality to New Heights.* Association for Gerontology in Higher Education's 40th Annual Meeting and Educational Leadership Conference. Westin Denver Downtown, Denver, CO. For information, visit [www.aghe.org](http://www.aghe.org).

**March 11-15, 2014**

*Aging in America.* Annual conference of the American Society on Aging. San Diego. For information, visit <http://asaging.org>.

**April 3-6, 2014**

*Building The Bridge to the Future: 21st Century Families.* Southern Gerontological Society's 35th Annual Meeting. Little Rock, AR. For information, visit [www.southerngerontologicalsociety.org](http://www.southerngerontologicalsociety.org).

**May 15-17, 2014**

*Annual Scientific Meeting of the American Geriatrics Society.* Walt Disney World Swan and Dolphin, Orlando, FL. For information, visit [www.americangeriatrics.org](http://www.americangeriatrics.org).

**May 19-22, 2014**

*Assisted Living Federation of America (ALFA) Annual Conference and Expo.* Session proposals are now open. Phoenix, AZ. For information, visit [www.alfa.org](http://www.alfa.org).

**June 11-14, 2014**

*2014 Annual Conference and Trade Show of the Virginia Association of Nonprofit Homes for the Aging (VANHA).* The Williamsburg Lodge, Williamsburg. For information, visit [www.vanha.org](http://www.vanha.org).

### **Age in Action**

Volume 28 Number 4  
Fall 2013

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*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: (804) 828-7905. E-mail [kivey220@yahoo.com](mailto:kivey220@yahoo.com).

**Winter 2014 Issue Deadline:**  
**December 15, 2013**



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## 12th Annual Alzheimer's Education Conference *Advances in Care and Research*

December 5, 2013, 8:30 a.m. - 5:00 p.m.  
Fitzpatrick Hall at the Jefferson Center, Roanoke

### Featuring Regional and National Presenters:

Paul Aravich, PhD, Professor of Anatomy and Physiology at Eastern Virginia Medical School. *The Universe Between Your Ears: The Mystery of Alzheimer's and Other Dementias.*

Paul Raia, PhD, VP, Alzheimer's Association, Massachusetts and New Hampshire Chapter. *Sleuthing the Triggers of Behaviors in Dementia Care.*

Charlotte Arbogast, MSG, Dementia Services Coordinator. *Virginia's Dementia State Plan: Tracking Progress and Next Steps.*

Aubrey Knight, MD, Professor of Medicine and Family and Community Medicine, Virginia Tech Carilion School of Medicine. *Alzheimer's: What's New and What's True - Diagnosis, Treatment and Prevention.*

Christopher Desimone, Esq. *Protecting the Vulnerable: 10 Free Things to Avoid Elder Financial Abuse.*

**Registration includes continental breakfast, lunch, and materials.** \$69 per person. Group Rate: \$55 each for five or more. Family Caregiver: \$35 each. There are limited scholarships available. CEUs will be available.

**For more information,** contact Ellen Phipps at (434) 973-6122, x103 or [ephipps@alz.org](mailto:ephipps@alz.org).

**Sponsored by the Alzheimer's Association, Central and Western Virginia Chapter.  
Program made possible, in part, by an award from the Health Resources and Services  
Administration, USDHHS, to The Virginia Geriatric Education Center.**

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