

Case Study

Universal Design in Housing

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Educational Objectives

1. Show how an aging population increases the need for housing that is accessible and adaptable.
2. Define visitability, universal design, and accessible design.
3. Explain ways to approach universal design including key factors.
4. Illustrate how universal design can be used in both renovation and new construction.

Background

The correlation between aging and disability has been well-documented. The U.S. Census Bureau reports that only 4.1% of Americans aged 0–21 and 11.0% of those aged 21–64 had a severe disability, but the rate soars to 36.9% for those aged 65 and older (US Census Bureau, 2008). Among older adults, disability rates continue to increase with age. A study by the National Aging Information Center (NAIC)

of mobility and self-care limitations shows that people had one or both limitations at a rate of 9.65% for ages 60–64, 13.3% for ages 65–74, 25.8% for ages 75–84, and 49.8% for ages 85 and older (NAIC, 1996).

It is important to consider the implications of these statistics for housing and housing design. Smith, Rayer, & Smith (2008), writing in the *Journal of the American Planning Association*, find that over the course of the lifespan of a new house, there is a 25% chance that it will have a resident who needs full accessibility, a 60% chance it will have a resident who needs an adaptable house, and a 93% chance that the home will require visitability features. A 2005 study by the Brookings Institution, as reported by *The New York Times* columnist David Brooks (January 19, 2006), says that half of the homes in which Americans will live in 2030 have not been built yet. It is also by 2030 that the aging baby boom generation is likely to be experiencing substantial rates of disability. Studies show that the vast majority of people wish to remain in their homes. The use of universal design

in this not-yet-built housing will increase the likelihood that people will be able to remain in their homes longer and function better as they face aging-related disability.

What is Universal Design?

The housing concepts relevant to this discussion are visitability, accessible design, and universal design. All three apply to any type of housing, although visitability focuses primarily on single-family housing. **Visitability** is a newer concept emphasizing three elements required for a person with a mobility disability to visit a home: an accessible, no-step entry on an accessible route; an accessible travel path throughout the main level of the house; and a usable half or full bathroom on the main level. **Accessible design** refers to housing for with people with disabilities and usually assumes that the person uses a wheelchair or other mobility aides; special design features are in place at the time of construction or renovation.

Universal design is on the spectrum of housing concepts between visitability and fully accessible hous-

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ing. Universal design is often misunderstood; many erroneously assume it means that everything has to be made accessible, regardless of difficulty. Adaptive Environments Center, Inc. provides this definition: “Universal design asks from the outset how to make the design work beautifully and seamlessly for as many people as possible. It seeks to consider the breadth of human diversity across the lifespan to create design solutions that work for all users” (Valerie Fletcher, executive director of Adaptive Environments, Inc., 2002). An academic definition of universal design, used by design professionals, includes Seven Principles as developed by the Center for Universal Design at North Carolina State University. They are: Equitable use; Flexible design; Simple and intuitive use; Perceptible information; Tolerance for error; Low physical effort; and Adequate space for approach, reach and comfort.

Universal design makes housing safer and easier for everyone throughout a lifespan, while anticipating and designing for future needs. Any single home may contain various universal design elements; there is neither one universal design home nor a strict set of rules to build for. This flexibility is both an opportunity and a challenge.

Universal Design’s Key Elements

The essential universal design measurements are: Rooms must include a 60-inch (five-foot) turning radius for a wheelchair to turn, as well as a 30 x 48 inch clear space next to items that a person in a chair may need to use, such as appliances. All doorways and openings must be at

least 32 inches wide, 36 inches preferred. The design must account for a reach range of 18 to 54 inches, the low and high points a person using a wheelchair typically can reach. Any slopes, interior or exterior, shall be no greater than one to 12: for one inch of rise, the length of the walkway/ramp needs to be one foot (12 inches) long. This ratio is easiest to remember as “inches to feet,” thus a nine-inch rise requires a ramp at least nine feet long. Slopes greater than one to 20 require handrails. There are many other important measurements in terms of switches and controls, space at doorways, and other items.

When applying universal design to housing, the best approach is “Outside In.” This approach examines the design elements, ensuring the necessary features are in place, beginning from the exterior and continuing into and throughout the housing. Visualization of how a person with a disability would manage each part is often helpful.

Let us begin with the exterior design elements. The site should be as level as possible and avoid any major grade changes. An accessible travel path with no steps must connect to all necessary amenities, including parking, sidewalks, streets, and public facilities like laundry rooms and building offices. Slopes on the accessible route shall be within the limits previously described. The entry to the building itself should be covered and lighted. The level (no-step) entry is one of the most important design elements and is also a part of visitability. There must be adequate room to maneuver at the doorway and a place to set down packages. The

maximum threshold is ½ inch beveled and the entry door should be at least 36 inches wide.



Grading is the best way to achieve an accessible travel path with a minimal slope. If a ramp is necessary, consider incorporating it into a deck. Finally, automatic door openers are preferred for those who have trouble with opening and closing doors. Lifts are an option, but are not preferred for the primary entry.

Next, we move inside to look at the general interior design elements. This refers to the housing itself, not common areas in a multi-family setting. Doors should have lever handles and be at least 36 inches wide. Halls and openings should be at least 36 to 42 inches wide and provide easy travel paths that avoid trip hazards. Transitions should be smooth with no more than ¼ inch beveled. Consider the users both in layout and in materials and products used, e.g., low level carpet may be better for a person who walks with a cane and may slip, while smooth flooring is easier for a person in a wheelchair.

We now get to the most challenging area: the bathroom; it illustrates the distinctions among the three levels of design. Visitability only requires a usable toilet, which necessitates a wide door and adequate space to approach the toilet. Universal design and accessible design require those basics but also a sink with a single-lever handle faucet

and adequate turning spaces. Both design concepts require blocking in the walls for grab bars; however, accessible design would have the grab bars installed at the outset while universal design would have them installed as needed. Similarly, the sink area would be open underneath in accessible design, while universal design would simply make it possible for the sink area to be open underneath with the initial installation of removable doors. Other bathroom design features include a roll-in shower, pressure-balanced anti-scald valves, and an adjustable-height, hand-held showerhead on a 60-inch flexible hose.

Our next challenge is the kitchen. This room must be designed with consideration to multiple users and multiple functions. Key elements include adequate turning spaces at work areas, cabinets, and work surfaces of varying heights, and pull-out shelves and drawers. The kitchen should also include hardware and pulls that are easy to use and good lighting. Movable carts as part of the work space are also helpful. Sinks should have single-lever faucets and be open underneath or be able to be made that way. Appliances should include a side-by-side refrigerator and a range with front controls and smooth cooktop. Good space for a microwave is essential. There is no clear answer on ovens: both wall-mounted and under-counter options have pros and cons. Regardless of the oven choice, there should be shelves for hot foods near cooking areas.

This is not a full listing of all design considerations. Using the “Outside In” approach and consid-

ering all aspects of how a person functions in the housing helps ensure that all elements are included, whether one is a design professional or simply someone wanting housing to meet needs.

Case Study #1

After a year in a rehabilitation facility following a brain injury, 58-year-old Gary had made significant progress and would soon be able to continue his rehab at home. Now using a wheelchair, he needed help with several activities of daily living. His wife, Ann, sought renovations to their condo so that Gary would be able to function in his current condition, improve his functioning, and still allow Ann to be comfortable in their home.

Using the “Outside In” approach, their first challenge was giving Gary access to their two-story condo. The main entry was on the upper level with a full flight of exterior stairs and a large deck shared with three other condos. Weather, especially snow and ice, was a consideration. The best solution was to enter from the underground garage that included a parking space near the basement door that would be protected from the weather. However, there were two barriers: the five-inch threshold at the door and the stairs from the basement to the main level. Ann decided on a six-foot long, portable ramp for the threshold because it minimized expenses and could travel with them as needed. Although there was a clear travel path from the basement door to the foot of the stairs, there was no obvious space for an elevator, which would have also been too costly. The stairwell

was conducive to a stair lift and Gary is able to transfer from his wheelchair to the stair lift.

The main floor presented several challenges. The kitchen is small and, although Gary would not be cooking, he would need to travel through the kitchen to get to the dining area and would need room to be in the kitchen with Ann when she cooked. The doorways at either end of the kitchen were widened, which also removed a sliding door. The appliances and cabinets were not changed. Removing throw rugs and rearranging furniture created accessible travel paths for Gary.

The door to the master bedroom was reversed so it opened out and swing-clear hinges were added to provide additional clearance so Gary could enter the bedroom. A low-loop carpet was installed. The biggest challenge for Ann and Gary was the narrow and inaccessible master bathroom. After considering several options, they agreed to cut a new entryway in the wall separating the master bathroom and bedroom. The plan called for an exterior-mounted sliding door, but they eventually chose to use a simple privacy curtain. The interior of the bathroom was almost completely changed as well: the tub was replaced with a roll-in shower; a higher toilet was installed; fold-down grab bars were installed next to the toilet; the pedestal sink was replaced with a wall-hung sink; and a full-height wall between the sink and toilet was cut down to half-height to make it easier for someone to help Gary at the sink. This bathroom was then usable by both Ann and Gary.

Another modification enabled Gary, with assistance, to go out onto the main deck off of the living room and bedroom. The remodeler improvised a portable metal ramp that fit over the sliding door tracks with a nine-inch bevel on each side. After these renovations were complete, Gary was able to come home and function well. Except for some health setbacks, he has made excellent progress and has much-improved functioning.

Case Study #2

Multi-family housing for people with physical disabilities presents a special challenge, for the specific functioning levels of, and mobility aides used by, future tenants are unknown. The design must work over several years for multiple occupants who may have differing functioning levels and must also work for able-bodied family members. For this case, New Circle Vistas, additional challenges included an urban site with limited square footage and limited construction funds. This case study follows the “Outside In” approach and focuses primarily on design decisions related to the multi-family/multi-disability challenge.

We begin again with designing a fully accessible entry. The challenges include weather, differing modes of transportation, security, and the 24-hour nature of apartment living. Curbless pathways eliminate barriers and are usable for all tenants, regardless of disability. A porte-cochere covers the main entry and allows tenants comfortably to enter and exit vehicles. Automatic door openers on the entry doors remove the need to manually open

and hold open heavy doors. However, security concerns require that the tenants use key cards or fobs to open doors. This also keeps tenants with limited reach or low hand dexterity from having to maneuver keys. Visitors must be let in or be buzzed in via intercoms.

Next we consider the common areas. The lobby is spacious with windows so that tenants, either with or without their caregivers, can comfortably wait for transportation or visit with neighbors and friends. There is a patio area that features accessible picnic tables, grills, and planters that tenants can use. These large areas for tenants to socialize in, including a community room, are important as it is difficult for multiple wheelchairs to fit into an apartment. Hallways are six-feet wide, so that tenants who use wheelchairs can easily turn around or travel together and have a handrail to provide support to tenants who walk. A laundry room on each floor has front-loading machines and is centrally located, as is the trash room on each floor. Two elevators are centrally-located and have a large waiting area on each floor to accommodate multiple tenants and their companions.

Tenants spend the majority of their time in their units. A wide travel path with a five-foot turning radius and no steps or barriers allows tenants to easily maneuver through the unit and utilize each of the rooms, regardless of type of mobility aide used. Flooring is planned to be the most functional for the widest range of users: low-pile carpet in the living room is glued directly to the floor and vinyl composition tile in the kitchen and bedroom minimizes

tripping hazards and is easy for wheelchairs to roll over. Casement windows are only two feet from the ground and have easy-open handles so that tenants can see out their windows as well as open and close them without assistance.

Bathrooms must be designed so that a wheelchair user can function with or without assistance. They are spacious, with an integrated shower area that maximizes the turning radius throughout and leaves room for an aide to help with the shower. The shower has a hand-held adjustable shower head, enabling tenants, regardless of size and ability to stand, to wash themselves, and allows caregivers to assist them. The entire room has a pre-engineered, sloped floor with consistent drain-age and the walls are reinforced so that grab bars can be mounted anywhere needed. The bathroom is the most “institutional” room in the apartment, requiring the most adaptation by able-bodied users.

The kitchens must be very flexible because the tenants use different parts of the kitchen in different ways depending on their disability and who assists them. They are designed so that tenants can use them, from getting a glass of water to cooking a meal to cleaning, with as little assistance as possible. A side-by-side refrigerator allows easy opening and access to parts of both the refrigerator and freezer, as well as the in-door ice/water dispenser. Countertops are 34 inches high, allowing all tenants to use the counter comfortably, and an eight-inch high toe-kick keeps tenants from having to reach down very low to the bottom shelf. Pull-out

shelves and drawers are usable by all. The kitchen has a peninsula with a built-in table that is open underneath and provides additional counter space tenants can use as a table, kitchen work space, or a desk.



The electric range has front controls and a smooth-top that are easy and safe. The sink has a lever handle and is open underneath. All of these design features make a kitchen that both an able-bodied person and a person in a wheelchair can use easily.

The design process for this building included obtaining input from the people who will live in it. This proved to be an invaluable source of insights and design improvements, such as moving a closet wall by six inches and adjusting the bathroom layout. Involving future residents or others with similar disabilities in the design is essential.

Conclusion

By incorporating universal design, we can renovate or build housing that enables people to remain in their homes if they face disabilities, especially those some encounter in growing old. This helps keep communities stable by reducing vacant housing. Furthermore, in an era when governments are trying to reduce expenditures, allowing people to stay out of long-term care facilities should be a priority.

Implementing universal and accessible design is not difficult if one follows the approaches outlined here. However, it does require action now if such housing is to be ready by 2030. The housing industry is demand-driven. Just as people demand items like stainless steel appliances, they can demand universal design.

Study Questions

1. What are the similarities and differences among universal design, visitability, and accessible design?
2. How does using the “Outside In” approach benefit the design process?
3. What are some differences between using universal design for a known individual and for an unknown future resident?
4. How will using universal design in housing now help with aging-in-place two decades from now?

References

National Aging Information Center. Older Persons with Mobility and Self-Care Limitations. Retrieved from: http://www.aoa.gov/AoARoot/Aging_Statistics/Census_Population/census1990/mobility.aspx

Smith, S. K., Rayer, S, & Smith, E. A. (2008). Aging and disability: Implications for the housing industry and housing policy in the United States. *Journal of the American Planning Association*, 74 (3), 289-306. Available online at <http://dx.doi.org/10.1080/01944360802197132>

U.S. Census Bureau. (2008). Americans with Disabilities. Retrieved from: www.census.gov/prod/2008pubs/p70-117.pdf

Resources

Assist Utah. The ASSIST Guidebook to the Accessible Home. Found at: www.assistutah.org/docs/guidebook_v6.pdf

Center for Universal Design at North Carolina State University. Found at: <http://login.npwebsiteservices.com/mil/NCV%20Accessibility%20Features.pdf>

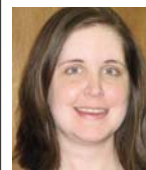
Maximum Accessible Housing of Ohio. Distinctive Accessibility Features of New Circle Vistas. Found at: <http://login.npwebsiteservices.com/mil/NCV%20Accessibility%20Features.pdf>

Visitability Information found at <http://www.concretechange.org/>

About the Authors



Steve Hansler, M.S.W. from Rutgers University, has been Executive Director of Maximum Accessible Housing of Ohio (MAHO) since 1984. He has developed five fully accessible apartment communities for people with mobility disabilities. He was a member of the State Housing Plan Advisory Board for the State of Ohio.



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Editorials

From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

Falls

Falls bedevil the lives of older adults, for they are common, have many possible causes, and can have life-altering consequences. The specter of falling is present so much in the minds of some older adults that there is a research area focused on “fear of falling” and its contributors. At the same time, the major risk factors for falls are well established and many risks are modifiable. For these reasons, our Virginia Geriatric Education Center (VGEC) has been working to develop an evidence based curriculum to train health care practitioners to better understand, assess, and prevent falls among older adults.

The VGEC is a consortium of three institutions of higher education, Virginia Commonwealth University, the University of Virginia, and the Eastern Virginia Medical School, which are partnering to increase geriatrics training for current health care providers and students and to institute more lasting changes in the professional training of providers through programs of faculty development and curriculum modification. The enterprise is inter-professional, engaging faculty from these three institutions and, within them, from medicine, pharmacy, nursing, social work, and physical therapy. Falls is the first target in what will eventually become a broad, multi-focused 160-hour curriculum that is grounded in

establishing knowledge- and skills-competencies.

So, what is considered a fall? Surprisingly, there are numerous definitions used and misused in health care. Our VGEC adopted an existing one: “A fall is an unplanned descent to the floor (or an extension of the floor) with or without injury to the patient.” This definition precludes stumbles where one catches oneself or a dizziness that motivates one to sit down; either of these may be a precursor to a fall, but descent to the floor is our criterion. Furthermore, our strategy will be to prevent the recurrence of falls among those who have already experienced a fall. To accomplish this best, there should be inter-professional interventions.

Falls are common, affecting about one third of community-dwelling adults over age 65 and about half over age 80. In hospitals and nursing home settings, where older adults are likely more frail, confused, or have multiple problems, the numbers are higher; some 40% fall repeatedly. Falls have serious consequences, what is termed morbidity in the health care literature. They may be a signal of functional decline and do predict nursing home placement. More serious still, falls account for about two-thirds of accidents among older adults, and accidents are a leading cause of death. When fear of falling emerges as an issue for some elders, they are likely to reduce their activities, thinking that this will reduce their risk, and isolation and depression can ensue.

There are multiple risk factors for falling. Some are considered

“intrinsic” or within the person; others are considered “extrinsic” or within the environment. Common intrinsic risk factors may include physical weakness, especially in the legs and feet; gait and balance problems; difficulties with vision; urinary incontinence; depression; dizziness, perhaps from a vestibular (inner ear) condition or orthostatic hypotension (low blood pressure when rising). One can see just from this sampling of risk factors that there are teaching roles for nurses, physicians, and physical therapists in sharing with other professions how to assess gait, vision, or dizziness. For a number of intrinsic risk factors, once properly assessed, may be modifiable. Interventions may include strength and balance training, cognitive and dementia screening, assistive devices, and exercises before arising. Others, such as age above 80 or female sex, are non-modifiable risk factors.

Extrinsic risk factors for falling include environmental hazards inside and outside the home, such as carpeting, broken sidewalks, and faulty bathroom design; also, a regimen of multiple medications (sometimes called polymedicine or polypharmacy) taken because of several concurrent conditions, like high blood pressure, emphysema, arthritis, and diabetes, or inappropriate medications may be considered extrinsic, for the presence of the medications is due to actions by providers. Again, one can see teaching roles here for medical social workers and pharmacists to share expertise with other professionals. Many extrinsic risk factors are modifiable, such as through changes in lighting, railings, and furniture or installation of grab bars

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and high toilet seats in the bathroom, or through changes in medications prescribed, in order to reduce adverse drug effects.

As can be seen, the risk factors for falling are complex. At the same time, falls may themselves be a signal for other troubling conditions and, moreover, can be exacerbated by circumstances all too common in later life, like transitions in where one lives and the piling on of more prescribers when one manifests additional health problems. Falls and falling are anything but a static issue.

Our VGEC is adapting the seminal work of Mary Tinetti and colleagues, who demonstrated effective intervention in risk for falling. We have embraced a team-building approach in our planning meetings, which are frequent and lengthy but which have produced significant inter-professional results. Our training curriculum features not only rationale and mechanics of multi-disciplinary risk assessments but also inter-professional interventions that work. The team approach values integrated clinical care, the division of labor around common goals, shared responsibility, open communication, re-evaluations, and an outcomes orientation. We believe that the complexity of the problem of falls requires the different skills of an inter-professional team. We are launching the first of our evidence-based training programs in May, 24 content hours, with both face-to-face sessions and learner-directed use of a menu of resources that we have identified.

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

Jim Rothrock
Commissioner, Virginia Dept. of
Rehabilitative Services (DRS)
and
Rebecca Wilkens
Blueprint Coordinator

Legislative Success + Emerging Blueprint = Great Potential for Livable Communities

As the dust settles and time allows for a review of the details, Virginians across the Commonwealth again benefited from another successful and productive session of the Virginia General Assembly. Several bills passed by the legislature will complement a community planning effort that is postured to assist all who share a commitment for making our neighborhoods more welcoming to older Virginians and Virginians with disabilities.

Secretary of Health and Human Resources Dr. Bill Hazel is leading the ongoing statewide community planning initiative, overseeing an 18-member citizen advisory group to help develop ***Virginia's Blueprint for Livable Communities*** to be presented as an initial report to the General Assembly's money committees in June 2011. The Commonwealth's human services agencies are teaming up with transportation and housing agencies, private and non-profit service providers, local and regional governments and councils, academics, and advocates from the disability and aging communities to figure out how to "incentivize" change in

the direction of more livable communities for Virginians of all ages and abilities. The policies being developed as part of the *Blueprint* aim to make Virginia a national leader in preparing for the growing needs of an aging ***Baby Boomer*** population.

The June report will highlight regional best practices in livable communities planning already underway in Virginia; describe ongoing state initiatives and resources in transportation, housing, and long-term services, and in-home supports that can contribute to a more livable Virginia; it will propose recommendations for the Secretary to take up as the state delves deeper into the livable communities initiative.

One key livable communities measure passed during the recent General Assembly Session and awaiting Governor McDonnell's signature is the ***Livable Homes Tax Credit*** (HB 1950- Villanueva) which enables Virginians to apply for a tax break for building or remodeling their home to make it "visitabile." In an effort to enrich Virginia's supply of accessible homes and increase awareness of the social barriers to individuals with mobility challenges, the General Assembly approved the expansion of the Livable Homes Tax Credit eligibility from \$2,000 to \$5,000 per person, and also extended eligibility to homebuilders when previously only homebuyers had been eligible.

In another bill, (HJ 648- Plum), lawmakers also directed state agencies to study the need for changes to the Uniform Statewide Building Code that would compel attention

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toward providing accessible routes to public and private buildings and encourage universal design features in dwelling units. Both of these bills were recommendations from Governor McDonnell's Housing Study that highlighted these and other improvements in the state's housing programs.

As part of the livable communities initiative, our Commonwealth is fully engaged in an effort to promote livable communities by encouraging and educating community leaders to assess the ease with which any person, especially those experiencing significant financial or mobility barriers, can locate and remain in adequate housing, navigate the community, and receive necessary supports that will enable achieving the greatest independence while living in the community environment. The initiative is person-centered in its approach, taking the concept of universal design for housing and expanding it to macro levels, from neighborhood to locality, region, or state.

For example, improving the "walkability" of a neighborhood by promoting policies favoring mixed-use, mixed-income development, safe sidewalks and streets, and resisting suburban sprawl can contribute to the improved health of all Virginians, while reducing demands on scarce public dollars for transportation assistance by introducing walking as a viable option in some areas. Even without making any changes to its infrastructure or design, a community can improve livability by convening service providers and encouraging coordination to reduce service overlap and identify places to change or expand

coverage, so that more Virginians can be served with conservative use of funds.

In Culpeper, the Rappahannock–Rapidan Community Services Board and Area Agency on Aging has convened more than 100 organizations from the surrounding five-county region in the *Aging Together Partnership*. With a 13-member core leadership team and leadership teams in each of the five counties, the Partnership has made extensive headway in creating new programs and expanding services to older adults and people with disabilities living in this rural area, simply by identifying opportunities for coordination among public, private, and non-profit service providers. Initiatives that have evolved due to this special long-term partnership include county-based volunteer transportation networks, a medication prescription program for low-income persons, and regional supports for individuals with dementia and their caregivers, among many others.

As another example of livable communities planning, Fairfax County has established a "*50+ Action Plan*" through the Fairfax County Board of Supervisors' Committee on Aging. The 2009 written report offers guiding principles for development and planning to improve community preparedness for the coming Age Wave. More specifically, the plan lays out a framework for assessing housing and transportation livability, community safety, engagement, diversity, caregiver support, health, and service capacity, and establishes a "scorecard" to track progress in meeting community livability goals.

Abundant guides and resources are available which lay out the initial planning process so that a group of any size, background, and experience level can take up the cause and make meaningful gains in the livability of their community. One source of particular noteworthiness is the *Transportation and Housing Alliance Toolkit*, a "how-to" guide for an organized livable communities planning initiative developed and available through the *Thomas Jefferson Planning District Commission* in Charlottesville (www.tjpd.org). Localities and regions across the Commonwealth have already instituted livable communities preparedness as part of their comprehensive plan development, and others have taken up the cause at a grassroots level by advocating for awareness of desirable features, such as accessible bus stops, better local enforcement of the Americans with Disabilities Act, and easier access to parks and public recreational spaces.

It is exciting to see the convergence of efforts from both the Executive and Legislative branches of state government with initiatives at the most important local level that result in having communities improve their capacity to meet the needs of "Vintage Virginians" and Virginians with disabilities. The communities that share this vision and successfully act will assuredly be the most healthy and successful communities of the future.

Jane Stephan, VCoA's long-time Assistant Director of Education, has retired. We wish her the best.

Older Blind Grant Program: Help Maintain Independence

The goal of the Older Blind Grant, which is managed by the Virginia Department for the Blind and Vision Impaired, is to provide and arrange for services that enable individuals **aged 55 or older with a severe visual impairment** to gain or maintain independence within their homes and communities.

This grant provides many services, including:

- information and referral
- advocacy
- low vision exam
- low vision glasses and aids
- physical therapy, occupational therapy, and speech therapy
- assistance with housing location
- adaptive equipment
- sighted guide instruction
- transportation
- orientation and mobility services
- reader/interpreter services
- volunteer services
- peer counseling/mental health/family/individual counseling
- independent living skills training
- local independent living training workshops for consumers and their family members

For more information about this grant, contact Jane Ward Solomon, Program Director, at (800) 622-2155 (Voice/TTY) or Jane.Ward@DBVI.virginia.gov or visit www.vdbvi.org.

The Health of U.S. Counties

There's a new, highly informative tool available on the Web. It is called the County Health Rankings (www.countyhealthrankings.org).

Based on a model of population health used for years by the University of Wisconsin Population Health Institute, and with funding from the Robert Wood Johnson Foundation, the rankings consider factors that "make communities healthier places to live, learn, work and play." There are four types of factors considered: physical environment; social and economic; clinical care; and health behaviors. These include programs and policies in the county on environmental quality and the built environment; resident attributes, such as education, employment, income, community safety; access to clinical care and the quality of the care in the county; and health behaviors of residents, like diet and exercise, alcohol and tobacco use, etc. The model is interactive; one can click on a map of the United States to hone in on a specific state and then can examine how individual counties stand on the indicators. The site explains its ranking methods, suggests action steps to improve county health, and invites visitors to share their stories. County Health Rankings is a welcomed addition for health-minded individuals and for advocates of well-being.

Community-Based Emergency Response Series

Emergency Planning for Home Care Support Providers

Attendees will learn:

Continuity of Operation Planning (COOP), how COOP can benefit you and your clients, the importance of teaching "personal preparedness," how to communicate effectively with different audiences, and the elements of a COOP plan.

Target Audiences Include:

Providers of:

Home healthcare

Behavioral health supports

Home support services

Home medical supplies

Dates/Locations:

Loudoun, May 3

Stafford, May 4

Richmond, May 5

Abingdon, May 17

Roanoke, May 18

Danville, May 19

All sessions are from 9:30 a.m. - 4:00 p.m. Working lunch will be provided.

For information, visit

www.vdh.

virginia.gov/epr/cbers.htm or

contact Patrick Bridge, VDH,

at (804) 864-8235 or

eprtraining@vdh.virginia.gov.

The Virginia Center on Aging's 25th Annual Legislative Breakfast

VCoA hosted its 25th annual breakfast on January 26, 2011, at St. Paul's Episcopal Church in Richmond. Again this year, we drew a large attendance, including members of the General Assembly, their staffs, the Executive Branch, state departments, Councils, and colleagues in agencies and organizations across Virginia. They participated in a special recognition for VCoA Director Emeritus Bill Egelhoff, who inaugurated these Breakfasts 25 years ago. Delegate John O'Bannon read a Joint Resolution passed by the General Assembly commending Bill and this annual event that has become so important to those in aging-related service.

VCoA hosts this breakfast to inform the General Assembly, which created it in 1978, of its progress in meeting its three fundamental mandates: interdisciplinary studies, research, and information and resource sharing.



Top left: Joseph Hoyle, VDA, Ed Ansello, VCoA, Henry Rhone and Cecil Drain, both of VCU

Top Right: Lisa Furr, VCoA, Erika Yssel and Adrienne Johnson, both of SeniorNavigator

Bottom left: Sherry Peterson, Alzheimer's Association, Bill Kallio, AARP, and Bill Peterson, VDA

Bottom right: Paul Izzo, of Thompson-McMullan and Chairman of the VCoA Advisory Committee, is Master of Ceremonies



Top left: Sheldon Retchin, VP Health Sciences at VCU, welcomes attendees
Top right: Delegate John O'Bannon, Henrico-Richmond, and Bill Egelhoff, following presentation of the Resolution
Bottom left: Sara Link, United Way of Richmond and Petersburg, Lynne Seward, A Grace Place, and Lisa Furr, VCoA.
Bottom right: VCoA staff at the registration tables



Top left: Senator John Miller, Newport News, and Keith Hare, Deputy Secretary of Health and Human Resources
Top right: Bob Schneider, VCoA Advisory and AARP, Bill Egelhoff, and Bob Blancato, Commonwealth Council on Aging
Bottom left: Gene Ecton Davis, Charlottesville, Marilyn Maxwell, MEOC, and Bill Davis, Charlottesville
Bottom right: Ruby G. Turner, Citizens of Greater Richmond Against Gun Violence, and Paula Kupstas, VCoA

Focus on the Virginia Center on Aging

Cecil B. Drain



Dean Cecil B. Drain, Ph.D., CRNA, FAAN, FASAHP, is a valuable member of VCoA's Advisory Committee. He has

been Dean of VCU's School of Allied Health Professions since April 1997. He had served as the Interim Dean of the School for a year and, before this, had been Chairman of the Department of Nurse Anesthesia since 1993.

Dr. Drain had a distinguished 27-year career in the U.S. Army. He was selected for the first class of the two-Phase Anesthesiology Nursing Course and was a distinguished Honor Graduate of the Phase II portion of the course in 1971. After graduation, he became a staff anesthesiologist and then acting Chief Nurse Anesthetist at the 121st Evacuation Hospital in Seoul, South Korea; while in Korea, he served as the Commander of the 43rd MASH hospital. This 43rd MASH hospital had been the model for the movie "MASH." Later, while at Brooke Army Medical Center, Cecil wrote the first edition of the text *The Recovery Room*, which is now in its fifth edition and is regarded as the "Bible" of Post Anesthesia Nursing. In recognition of the book's long history of success, its publisher, Elsevier Publishing Company, has decided to retitle the book *Drain's Perianesthesia Nursing: A Critical Care Approach*, for the sixth edition and all future editions. Elsevier, the

largest publishing company of medical books and journals, has given this naming distinction to only three other authors of nursing books.

In 1980, Cecil returned to the Academy of Health Sciences to become the Assistant Program Director and Acting Program Director of the U.S. Army/State University of New York at Buffalo's Nurse Anesthesiology Course. He graduated from the U.S. Army Command and General Staff College, and in 1983 was assigned to Texas A&M University where he earned the Doctor of Philosophy degree in educational curriculum and instruction in higher education.

Cecil returned to Brooke Army Medical Center in 1986, and served as the Special Project Officer to the Commander, along with providing anesthesia in the Department of Anesthesiology. In 1989, he was reassigned to the Academy of Health Sciences, where he served as a Branch Chief and Director of the U.S. Army/University of Texas at Houston Program in Nurse Anesthesia. He also served on the faculty of the University of Oklahoma School of Medicine, Baylor University Program in Health Care Administration, and Texas Wesleyan University in Allied Health Professions. Cecil retired from the Army in 1993 at the rank of Colonel.

Cecil's awards and decorations include the Legion of Merit, the Order of Military Medical Merit, and the "A" Army proficiency designator, which is comparable to the full professor in the academic community. He was the 1981 winner of the Federal Nursing Service Award, which was presented by the Associ-

ation of Military Surgeons of the United States. He remains the only Nurse Anesthetist to have received that research award. He was inducted into the American Academy of Nursing as a Fellow in 1988, only the second Nurse Anesthetist in the country to be so honored, and in 2002 was inducted as a Fellow in the Association of Schools of Allied Health Professions. Additionally, Cecil has authored four books, over 60 professional articles, has presented at over 100 state and national conventions, and serves on four editorial boards and one research foundation.

Academia has similarly recognized Cecil's accomplishments. He has been the alumnus of the year at Yankton College, the University of Arizona, and Texas A&M University. He served on the Board of Regents for Yankton College from 2000 until 2009. He has served on many committees for the Association of Schools of Allied Health Professions (ASAHP) and was its treasurer from 2002 to 2004, as well as serving as treasurer of the Southern Association of Deans of Allied Health Professions at Academic Medical Centers. Cecil received the Helen Lamb Life-Long Achievement in Education Award, presented by the American Association of Nurse Anesthetists in 2007, and the Darrell Mase Life-Time Achievement Award in 2009.

Cecil is married to the former Cynthia M. Phaff of Waseca, Minnesota. They have three children: sons Timothy and Stephen, who reside with their wives Holly and Sharine in Texas, and daughter Kathryn, who lives in Virginia; and they have eight grandchildren.

The Consequences of Unequal Wealth Distribution

by Saul Friedman

(Saul Friedman, Pulitzer Prize winner, whose columns reached many people, including readers of Age in Action, over his decades of passionate journalism, died this past December 24th. He was an unabashed advocate for people, especially the disadvantaged. His commentaries seldom pulled punches and he aroused readers on every side of the political spectrum. The following column appeared in August 2010. With Saul's permission, Age in Action will be publishing abridgements of some of his last columns in our 2011 issues.)

There is a new book that has become the rage among social scientists and activists in Europe, especially Britain. It's called *The Spirit Level: Why Greater Equality Makes Societies Stronger*, written by British public health researchers Richard Wilkinson and Kate Pickett, who have produced an unprecedented rediscovery of the causes of so much of today's anger towards the institutions of government and finance.

The book was called to my attention by a Canadian reader, Dr. Rob Dumont, a PhD, from a prominent and wealthy family. In a reply to one of my pieces on poverty, he quoted from the book to tell me that according to its central thesis, the growing gap in many countries between the haves and the have-nots is responsible for more than the misery of poverty. According to

the book, such health and social problems as "Obesity, Mental illness, drug and alcohol abuse, homicides, imprisonment rates, lowered life expectancy, overconsumption of resources, teen pregnancy and the lack of social mobility," all have in common strong links to inequality of wealth.

Interestingly, the authors, who have exhaustively documented their work, do not denounce the wealthy. Rather they point out that the most affluent citizens as well as the wealthiest countries also suffer from these ills. Their analysis mocks the American Declaration of Independence which proclaimed, "All men are created equal." The original sin of slavery gave lie to that promise and the lack of equality has taken a toll in this nation even today.

As one knowledgeable Amazon reviewer, Dr. Nicholas P. G. Davies, a Briton, wrote, "Inequality issues are often presented as being about the poor, but this book shows we are all poorer for living in more unequal societies. Inequality is as bad for the rich as it is for the poor. Society is poorer as inequality becomes greater."

As Wilkinson and Pickett make clear with dozens of graphs, which rate the nations based on the problems that come with inequality, "The impacts of inequality show up in poorer health, lower educational attainment, higher crime rates, lower spending of social capital, lower cooperation with and trust of government."

One graph that shows the "health and social problems are worse in

more unequal countries," makes these points: "The U.S, Portugal, and the United Kingdom rate high in the amount of income inequality. For the U.S., low taxes (by international standards), a weak trade union movement, low minimum wage and a tradition of individualism have resulted in a high level of income inequality."

Indeed, the U.S., with its obsession with the market economy, has modest social programs, Social Security and Medicare, while most of the other 20 nations listed are social democracies with a broad array of social insurance benefits, including universal health care. Canada is roughly in the middle of the pack, along with France, Spain, and Switzerland. Japan and the Scandinavian nations have the lowest income inequality, offering cradle-to-grave social programs.

Some critics suggest that the book cherry picks its statistics and the alleged problems to prove their point. But who could argue with the graph that puts the U.S., the richest country, almost off the charts in showing the relationship between a huge income gap, perhaps the highest among civilized countries, and such health and social problems as infant mortality (higher than most European nations), homicide and imprisonment rates (the highest in the world), obesity, child well-being (poverty among children has reached new heights), and drug and alcohol addiction?

Any thinking American can verify the sad truth in another graph that shows these health and social problems are worse in more income-unequal states... Today, several

Southern states “have high levels of income inequality and much poorer outcomes in the health and social areas.” These states also have the highest levels of poverty and the lowest levels of education attainment; and in the last couple of years, income inequality has become worse throughout the United States, especially in the industrial North, as a result of the 2008-9 recession, which has increased home foreclosures, personal bankruptcies, and the numbers of Americans, nearly 50 million, struggling against poverty or near poverty.

Yet at the same time, the rich are becoming obscenely richer. Michelle Singletary, reported in the *Washington Post* (in July 2010) that, while the average income for the top one percent of earners rose 281 percent, or about \$973,000 more per household, in the last decade, the bottom fifth saw their incomes increase 16 percent, or \$2,400 per household.

Former Labor Secretary Robert Reich, who wrote the forward for the American edition of *The Spirit Level*, noted that today’s CEOs are paid more than 350 times that of the average worker. Surely we’ll see the results of such inequality in health and social problems in the next few years. In his inaugural speech, President Obama said, “The nation cannot prosper long when it favors only the prosperous.”

Find out more about *The Spirit Level: Why Greater Equality Makes Societies Stronger* at the excellent British website, The Equality Trust (www.equalitytrust.org.uk), which supports the messages in the book.

Age Wave Ready Communities

by Henry C. Simmons, PhD
Volunteer for Older Adult Initiatives, United Way of Greater Richmond and Petersburg

The United Way of Greater Richmond and Petersburg is leading an initiative to prepare our region for the huge increase in persons over 60, numbers expected to double between now and 2030. Our region includes the city of Richmond, the town of Ashland, and the counties of Charles City, Chesterfield, Powhatan, Goochland, Hanover, Henrico, and New Kent. *This demographic increase is incremental.*

This demographic shift is a classic case of “changing a bicycle tire while riding full speed.” Right now there are seniors who are volunteering effectively in ways that are beyond roles usually assigned them. There are also fragile seniors who need and are receiving (in varying degrees) services and support now, and will continue to need services and support in increasing numbers with the passing of the years.

This demographic increase happens in contexts: local, governmental, and social.

Local: The differences of history, race, class, education, denomination, demography, and geography that mark our region are not always immediately visible. Some of these differences cross all regional boundaries; some are specific to counties that lack the population density to support public transportation.

Governmental: This sector has a history both of regional cooperation and regional isolation, in particular the legislated isolation of the City of Richmond¹. Fortunately, regional cooperation is increasing, as awareness grows that, without it, no entity will reach its potential.

Social: This sector mirrors national trends and stresses, but also includes social contexts particular to our region and even to individual localities. The largest social context is one that is both quite difficult to pinpoint and the most pervasive, namely, that we are aged by culture. It may be that Boomers will lay bare the web of ageism that marks our society. It is also true that media, pop culture, literature, and even publications geared toward the over 50s skew their attention and favor toward the young, the productive, the well. It is striking that most people pictured or featured in magazines aimed at Boomers are wealthier, healthier, and having more fun than most of us and the people we serve. It is in these regional and local contexts that the United Way and Senior Connections (C-AAA) are leading an initiative to prepare “Age Wave Ready” communities.

Where is the focus? We define an Age Wave Ready Community as being Stable, Well, Livable, and Engaged. Our current working descriptions are these:

A Stable Community has jobs that pay adequate wages for people of all adult ages to live and to maintain healthy, productive lifestyles. In a stable community, seasoned workers are retained and new employees across generations are

recruited through flexible work place policies.

A Well Community has structural supports, health management systems, and health services that provide for the changing needs of a growing population.

A Livable Community is able to meet the infrastructure and mobility needs of all its residents, in terms of housing (affordable, accessible, safe, and repairable), transportation (affordable, dependable, and accessible), and community design (ADA accessible, comprehensive, and fostering personal mobility).

An Engaged Community offers individuals opportunities to give back to their communities through active citizenship, volunteerism, resource and nonprofit capacity. Individuals are involved and engaged in activities that include education, recreational and cultural opportunities, social and networking forums, spiritual enrichment, and local, regional, and national politics.

Why is the United Way of Greater Richmond and Petersburg leading this initiative? Mission and Experience: The United Way's mission is to lead the community to a better community by providing community leadership, developing solutions, and raising and leveraging funds for impact. The Age Wave needs engaged citizens, cooperative agencies and localities, and the best insights of local and national programs as this crucial demographic shift happens. Also, The United Way brings to the table the recent experience of initiative leadership in *Smart Beginnings, an initiative*

that brings people together in support of Virginia's youngest citizens, those under the age of five. (see www.smartbeginnings.org). *Smart Beginnings* engaged a wide range of stake-holders who are making this initiative a success.

Who is involved? The quick answer is: everybody who has been asked to, so far. We began by forming a leadership committee to articulate a vision and plan strategies; we set up four work groups (Stable, Well, Livable and Engaged) comprising experts from various disciplines, representatives of local governments, academics, United Way staff, and citizen volunteers. These work groups have met over the past year, refined these descriptions, and have set goals, strategies, and action steps.

Where is this initiative going? Next steps include: 1) community conversations, which are area dialogues with facilitators; 2) a statewide survey of Boomers conducted by the Older Dominion Partnership's Southeastern Institute of Research; 3) the ODP Summit II, to roll out the results of this survey and hold our regional Ave Wave Planning Forum; and 4) integrating feedback and developing a cohesive plan.

How is this initiative going to shape out, going forward? When we complete all the above, we will continue to seek partners to carry forward individual strategies and action steps. The United Way's role in Age Wave Planning going forward will be to identify, negotiate, and facilitate the work of community partners.

This is a huge undertaking. But it is

not bigger than the opportunity to work together to find solutions for a better community and to invest resources to help that happen. But, for these things to happen, we need you!

How to get involved? You can keep up with progress by visiting www.yourunitedway.org. You can: participate in the Community Building Forum for our region (date yet to be set); attend Summit II, showcasing the results of the Boomer Project Survey (May 19, 2011); and keep the topic of Age Wave Planning alive among your friends, family, and co-workers.

¹ Virginia passed a temporary annexation moratorium in 1987 that is still in effect; it expired in 2010 when it passed both houses but was vetoed by then Governor Kaine.

Faith-Based Resources on Domestic and Sexual Violence

The FaithTrust Institute, which describes itself as a “multifaith, multicultural training and education organization with global reach” and whose mission statement reads “working together to end sexual and domestic violence,” lists news commentaries and essays, training courses and locations, webinars, blogs, consulting services, bibliographies, statistics, and other information. There are books, pamphlets, and DVD programs available, some in languages other than English, such as Chinese, Korean, Laotian, and Spanish. Visit www.faithtrustinstitute.org.

Boomers, Obesity, Dollars, and BUCKAPOUND

by Mike Magee, MD
Health Commentary

Adapted with permission from the author.

Aging and obesity are two intersecting and compounding megatrends. In the United States, 130 million Americans are either overweight or obese. By 2050, the percentage of U.S. citizens over 65 will reach 20 percent. That's up from 12 percent today. But the real story is how these two emerging realities play off of each other, and are there cost effective strategies coming soon to address "boomer obesity"? The quick answer is "yes", which I'll get to in a moment. But first, the facts.

In 2004, the *Journal of the American Medical Association* published a landmark study entitled, "Relation of body mass index in young adulthood and middle age to Medicare expenditures in older age" (Daviglius et al., 2004). The study followed more than 39,000 Chicago citizens over age 18 and from 84 different area organizations between 1967 and 1973. Their overall health status and cost of care was monitored over the following three to four decades. Between 1992 and 2002, nearly 16,000, or 40 percent, of the original study group passed age 65 and received Medicare for more than two years. In this group, annual charges for care of cardiovascular disease and diabetes, in both men and women, revealed a strong positive correlation with their BMI

or Body Mass Index.

A BMI between 25 and 30 marks the individual as overweight. Over 30 is considered obese. In the study group, men with BMIs higher than 30 had health care costs exceeding non-overweight patients, controlled for age, race, education and smoking, by 42 percent. Women's rates of increase in health care costs were even greater. Those with BMIs higher than 30 had 54 percent higher costs than non-overweight women.

Lead author Dr. Martha Daviglius and colleagues from Northwestern University in Chicago noted that "...urgent preventive measures are required... to lessen the burden of disease and disability associated with excess weight...and to contain future health care costs incurred by the aging population."

What are the facts on aging and obesity? First, we know that people age 51 to 69 are the most vulnerable in terms of obesity and chronic disease. In this age group, rates of disease in obese people versus non-obese people are remarkable (Eckel & Krauss, 1998; Shaper et al., 1997). Heart disease is 19 percent in obese seniors and 14 percent in non-obese seniors. Diabetes is 24 percent in obese seniors and nine percent in non-obese seniors. High blood pressure: 58 percent versus 35 percent, and arthritis: 58 percent versus 45 percent, according to the report *Obesity among Older Americans* by Georgetown University.

Older adults who are obese are more likely to suffer from persistent symptoms of chronic disease, and the impact on daily living is obvi-

ous. Twenty-three percent of obese adults over age 51 have severe fatigue, 23 percent have shortness of breath, 15 percent wheeze, and 30 percent experience ankle swelling. Comparative rates are markedly lower among their non-obese counterparts. The same is true of mental health symptoms, e.g., obese seniors suffer feelings of worthlessness eight percent of the time versus five percent in non-obese seniors. All of these symptoms, in turn, translate into higher rates of disability. While three percent of those over 51 who are not obese need help with three or more activities of daily living, six percent of obese seniors are similarly dependent, according to the Georgetown University report.

What, then, is the takeaway? We need to face the facts regarding obesity and aging: First, BMI is a marker for chronic disease, disability, and symptoms of disease. Further, BMI has strong predictive power; it's not only able to point to a future cost in physical distress, altered lifestyle, and need for caregiver support in the later years, but it also signals an escalating expenditure of federal dollars.

The Solution

We need cost efficient, proven behavioral modification approaches to weight loss that are home based, controlled by overweight individuals themselves, but also capable of reinforcing existing relationships between these individuals and their health care professionals. Do such programs exist? The answer is yes.

One such web-based approach is BUCKAPOUND

(www.buckapound.com), whose trademarked motto is “Obesity is contagious. So is the solution.” Buckapound.com, which has just become available to the general public, allows participants to choose a range of behaviors themselves based on the research of obesity expert, Dr. George Bray, Chief, Division of Clinical Obesity and Metabolism at Pennington Biomedical Research Center at LSU, and Dr. Art Ulene, who pioneered the application of modern communication technology to advance public health challenges, such as high blood pressure, cardiovascular disease, and nicotine addiction.

The program recently completed an eight-week beta-test on 120 individuals, with these results:

- 17% lost 10-29 pounds
- 31% lost 5-9 pounds
- 34% lost 2-4 pounds
- 14 % lost 0-1 pound
- 4% gained weight

Accenting personal empowerment and “giving back,” the subscription program titled “BUCKAPOUND” includes a virtuous reinforcement cycle. Participants pledge one dollar for every pound they lose which is then donated to non-profit health organizations to advance public health. BUCKAPOUND’s “smart software” provides a modern day health-matching system. What do I mean? Each week, participants are asked to select a maximum of four strategies to focus on from a list of 30 plus evidence based, behavioral modification strategies to assist in reaching their self-proclaimed target weight. The site’s “smart software” and real-time data base are then able to share with the individu-

als strategies that have worked best for people like them, as defined by the intake questionnaire they originally completed.

Individuals also have access to forums and social networks to share successful strategies. One last point of empowerment: participants are asked to identify up to six individuals on the front end to serve as a “personal support network” for the journey to better health. Health professional involvement in the support network is encouraged. With their acceptance of this role, and the participant’s permission, their daily updates on the site are shared with supporters who can contribute onsite words of encouragement.

Participation appears to be one key to success. In the study group, the likelihood of losing weight during the test was strongly related to involvement with the program, as evidenced by these results:

1. Average number of website “check-ins” per week: Five times/week or more correlated with average weight loss of 8.4 lbs; while two times/week or less correlated with average weight loss of 2.5 lbs.
2. Comments posted on a blog at the website: Posted at least one comment to a blog correlated with average weight loss of 7.2 lbs; while never posting a comment correlated with average weight loss of 3.9 lbs.
3. Participation in a forum: Posted at least one Forum comment correlated with average weight loss of 8.6 lbs; while never posting a comment correlated with average weight loss of 4.2 lbs

Obesity is clearly the modern day marker for chronic disease. Most of the behavioral choices offered in BUCKAPOUND to address obesity are equally effective approaches to chronic disease management. The key is to empower individuals where they live, include their health professionals, encourage them along the way, and advantage technology to assure affordability and sustainability.

References

- Daviglus, M.L., Liu, K., Yan, L.L., Pirzada, A., et al. (2004). Relation of body mass index in young adulthood and middle age to Medicare expenditures in older age. *JAMA* (292), 2743-2749. <http://jama.ama-assn.org/content/292/22/2743.full>.
- Eckel, R. H. & Krauss, R. M. (1998). American Heart Association call to action: obesity as a major risk factor for coronary heart disease. *Circulation*. 97, 2099-2100. <http://circ.ahajournals.org/cgi/content/full/97/21/2099>
- Obesity Among Older Americans. Center on an Aging Society, Georgetown University. Available at: <http://hpi.georgetown.edu/agingsociety/pdfs/obesity2.pdf>.
- Shaper, A. G., Wannamethee, S. G. & Walker, M. (1997). Body weight implications for the prevention of coronary heart disease, stroke, and diabetes mellitus in a cohort study of middle-aged men. *BMJ*. (314), 1311-1317. <http://bit.ly/eHNHhU>.
- DISCLOSURES: Mike Magee, MD has served as an adviser to BUCKAPOUND and continues to consult to them for which he has received no compensation.

Calendar of Events

April 30, 2011

Keys to Caregiving: Unlocking the Mystery. Annual Caregiver Conference of the Prince William Area Agency on Aging. Westminster at Lake Ridge, Lake Ridge. 8:30 a.m. - 4:00 p.m. For information, call (703) 792-6374 or email leckhardt@pwcgov.org.

May 4, 2011

Chesterfield Triad Senior Day. Victory Tabernacle Church, 11700 Genito Road, Midlothian. 7:30 a.m. - 12:45 p.m. For information, call Senior Advocate at (804) 768-7878.

May 5 and August 4, 2011

Grandparent Connection Support Group. Group for grandparents and other kin raising a child. Juvenile & Domestic Relations Courts Building, 7000 Lucy Corr Boulevard, Chesterfield. 4:15 p.m. - 6:00 p.m. For information, call Senior Advocate at (804) 768-7878

May 6, 2011

Collaborative Outcomes: Defining Your Role in the Future of Healthcare. A Caring Conversations Healthcare Symposium. The Jefferson Hotel. Franklin & Adams Streets, Richmond. For information, visit www.partnersva.com.

May 17, 2011

Join the Alzheimer's Association as we storm Capitol Hill. Tell Legislators why additional federal funding for Alzheimer's care and research programs is urgently needed. Bus transportation available. Food and drinks on bus provided. Lunch is on your own. Cost: \$25. Please e-mail fran.foster@alz.org if interested. Money must be received by May 10th to reserve your place.

May 21, 2011

Seniors Managing Aging: Resources and Transitions. A free "SMART" forum for older adults, their family members, and caregivers. St. Ann's Catholic Church, 17111 Jefferson Davis Highway, Colonial Heights. 10:00 a.m. - noon. Sponsored by Lutheran Family Services of Virginia (LFS) and Sterling Geriatric Care Management. For information, call Christina Dhir of LFS at (804) 288-0122, ext. 238, or Mary Ann Hamilton at (804) 943-4565.

May 24, 2011

Aging Well in Mind, Body, & Spirit. Presented by the Beard Center on Aging at Lynchburg College in partnership with Centra Health. Lynchburg College. 8:00 a.m. - 5:00 p.m. For information, call (434) 544-8456 or e-mail scruggs.dr@lynchburg.edu.

June 1-3, 2011

17th Annual Conference of the Virginia Coalition for the Prevention of Elder Abuse. Virginia Beach Resort & Conference Center. Pre-conference workshops June 1st. For information, visit www.vcpea.org.

June 3, 2011

The 1st Conference on Promoting Mobility Among Older Adults. Larrick Student Center, Virginia Commonwealth University, MCV Campus, Richmond. 11:00 a.m. - 4:00 p.m. Registration is free but limited. For information, call (804) 628-4058 or visit agingmobility.org

June 13, 2011

Art and Dementia. A workshop for those who work with people diagnosed with dementia diseases. Markel Plaza, 4600 Cox Road, Glen Allen. 9:00 a.m. - 5:00 p.m. Attendees will receive training and techniques for offering art to participants using paint, music, and fabric. Registration is required. For information, call (804) 967-2580.

November 8-9, 2011

Virginia Association for Home Care and Hospice Annual Conference and Trade Show. The Boars Head Inn, Charlottesville. For information, call (804) 285-8636 or visit www.vahc.org.

Age in Action

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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 to (804) 828-7905, or e-mail to kivey220@yahoo.com.

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Livable Communities: Aging with Lifelong Disabilities

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**Holiday Inn Select, Koger South Conference Center
Richmond**

The Area Planning and Services Committee (APSC) on Aging with Lifelong Disabilities invites you to attend and participate in its annual conference. This year's theme is *Livable Communities*, highlighting those aspects of daily life that make each of us feel comfortable, productive, and important members of the larger society.

Sessions include:

Models of inclusive communities
Universal design and accessible housing
Work opportunities for adults with lifelong disabilities
Money Follows the Person, and life outside of institutions
Brain injury and cognitive prosthetics
Livable Communities: Blueprints for Virginia
Chronic disease self-management programs

Registration includes refreshments, lunch, and materials. Registration cost is \$35 until June 1st, \$45 after June 1st and on-site (if space is available).

For more information, please contact Eric Drumheller at (804) 358-2211, ext. 33
or Ed Ansello at (804) 828-1525, or register on-line at www.apsc2011.eventbrite.com.

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