

Case Study

Virginia POST: Improving Patient- Physician Communication about End of Life Care

by Christopher Pile, M.D. and
Laura Pole, MSN, OCNS

Educational Objectives

1. Examine the complexities of medical decision-making at the end of life and the inadequacy of advance directives alone to affect care at the end of life.
2. Demonstrate how effective communication can facilitate medical decision-making and improve congruency between care received and patient goals, priorities, and values.
3. Discuss the National POLST Paradigm and the current status of POST in Virginia.

Introduction

“But my patient has a living will and a medical power of attorney. Isn’t that enough?” The answer is, “Probably not.” It is our intention to explain what Virginia’s POST

(Physician Orders for Scope of Treatment) is and how it came to be, noting its origins in the POLST Paradigm (Physician Orders for Life-Sustaining Treatment). Both the POST and POLST processes are intended to prompt timely advance care planning discussions for people who have progressive serious illness.

Background

A POST or POLST is a signed physician’s order for medical care that follows, reflects, and implements a patient’s wishes about his or her health care. A patient’s physician writes the POST based on the patient’s wishes, as identified in discussions that include the patient, the family, and the physician or a trained advance care planning facilitator. POST provides a framework for care-providers to put in place orders that ensure that seriously ill patients with life-limiting illnesses or advanced frailty receive the treatment they want and avoid the treatments they do not want.

Despite the intent of living wills to provide autonomy for patients beyond their ability to direct their

care, living wills alone have generally failed to achieve a difference in care at the end of life (Fagerlin & Schneider, 2004). This should come as no surprise. The premise that an uninformed patient should be able to conjure up medical decisions for a hypothetical future event with unidentifiable maladies and unpredictable treatments is unreasonable. Even patients and families with contemporary decisions about current illnesses can be overwhelmed by the medical decision-making process. Medical advances will likely further exacerbate the situation in the future.

Examining end-of-life care in this country, we find a number of problems with and barriers to providing care that is aligned with the patient’s wishes. In addition to the problem of a living will not providing enough guidance to the clinician at the bedside, there is also the problem of the advance directives not being reviewed and updated as the patient’s medical condition changes. Additionally, advance directives are often not available to clinicians at the time that medical care is delivered.

Inside This Issue:

VCoA Editorial, 6
VDARS Editorial, 8
Legislative Breakfast Recap, 10

ARDRAF Final Reports, 12
VCoA Focus: Bob Schneider, 15
Mental Health and Aging, 16

VERC Awards, 16
Fiber May Lower Stroke Risk, 17
Calendar of Events, 18

Assuming there are advance directives, frequently clinical staff within a facility do not know what and where a patient's advance directives are. It is also uncommon that the patient's written advance directives will follow the patient to another health care setting. Often, a transferring facility will fail to communicate patient's end-of-life care wishes and medical orders to the transport crew or the receiving facility.

Our current system of end-of-life care often fails to plan ahead for contingencies. If a patient loses decision-making capacity and the medical condition deteriorates, it is likely that he or she will be transferred to a hospital and possibly receive over-treatment and have unnecessary pain and suffering. If the patient has a DNR (do not resuscitate) order and loses decision-making capacity before orders are given for specific end-of-life care, the staff will likely assume that the patient would not want more than comfort measures, in which case the patient may be under-treated relative to his or her wishes, which were never elicited and/or communicated.

Research has verified that families caring for a seriously ill person nearing death are at risk for complicated grieving. That risk is compounded if they are forced into making complex decisions about medical care without being adequately prepared or informed about their loved one's preferences. The task of decision-making trumps the more critical need to tend to the emotions and extraordinary stress of losing a loved one (Wright, et al. 2008; Wendler & Rid, 2011).

History of National POLST

The POLST Paradigm originated in Oregon in 1991 after recognizing that advance directives were inadequate for patients with severe, chronic, and terminal conditions. A group of stakeholders developed a new tool for honoring patients' wishes for end-of-life treatment. After several years of evaluation, the program became known as Physician Orders for Life-Sustaining Treatment (POLST).

Although the POLST Paradigm began in Oregon, it quickly spread to other states, which tailored the paradigm to fit their unique legal, medical, and cultural contexts. Among the first states to develop POLST Paradigm programs were New York, Pennsylvania, Washington, West Virginia, and Wisconsin. These states, and others, have become leaders in improving the POLST paradigm and demonstrating its importance in achieving patient-centered outcomes.

The National POLST Paradigm is an approach to end-of-life care planning that emphasizes patients' wishes about the care they receive. It is both a method of planning for end-of-life care and a specific set of medical orders that ensure patients' wishes are honored. The POLST Paradigm is built upon conversations between patients, loved ones, and health care providers, during which patients can determine the extent of care they wish to receive. As a result of these conversations, patients may elect to create a POLST form, which translates their wishes into actionable medical orders. The POLST form assures patients that medical providers will

provide only the care that patients themselves wish to receive, and decreases the frequency of medical errors.

POLST is not for everyone. It complements but does not replace other advance directives that patients complete. It is most appropriate for people who are seriously ill with life-limiting (also called terminal) illnesses or advanced frailty characterized by significant weakness and extreme difficulty with personal care activities. For healthy patients, an advance directive is an appropriate tool for making future end-of-life care wishes known to loved ones.

Case Study #1

Mr. Jan was 71 years old with severe COPD and mild dementia. He was convalescing at a skilled-nursing facility after a hospital stay for pneumonia when his shortness of breath worsened and his level of consciousness decreased over 24 hours. The nursing facility staff called EMS who found Mr. Jan unresponsive and with poor respiratory function. Although Mr. Jan had discussed his desire to forgo aggressive, life-sustaining measures with his family and nursing personnel, the nursing facility staff did not document his preferences, inform the emergency team about them, nor mention his do-not-resuscitate order.

EMS wasn't able to intubate him at the scene. They inserted an oral airway, bagged him and transported him to a hospital emergency department. Mr. Jan remained unresponsive and was found to have marked respiratory compromise and be in

respiratory acidosis. The emergency department physician wrote, “full code for now, status unclear.” The staff intubated and sedated Mr. Jan and transferred him to the intensive care unit (Lynn & Goldstein, 2003).

This case illustrates the need for an enhanced system of advance care planning which: builds upon a person’s advance directives (most often created when a person is relatively healthy); provides for more focused advance care planning discussions if a person’s chronic illness or medical frailty worsen; and then translates the person’s values, goals, and wishes for end-of-life care into actionable medical orders which serve as a communication tool to be honored across health care settings.

Key Research about POLST

Unlike research on Living Wills, which has not demonstrated an impact on care received, the POLST Paradigm has substantial peer reviewed literature documenting its effectiveness. For example, a study of nursing homes in Oregon, West Virginia, and Wisconsin, which set out to determine how frequently treatment is consistent with wishes recorded on a POLST form, found that patient wishes recorded on a POLST form are honored 94% of the time in the facilities studied (Hickman, et al., 2011).

Research to evaluate differences in outcomes between POLST conversations and traditional methods of communicating treatment preferences indicated that patients with POLST forms had a greater number of recorded end-of-life care preferences and were less likely to have

orders for life-sustaining interventions against their preferences (Hickman, et al., 2010).

Perhaps the most revealing data on the POLST Paradigm were presented in a *JAMA* research letter (Fromme, et al., 2012) reporting findings from Oregon that assuage the unfounded concern of some that the PO(L)ST form is biased toward steering patients to limit care. Researchers, analyzing all active forms signed and submitted from December 2009 through December 2010, investigated the populations using the POLST registry and compared the preferences for treatments among persons with DNR orders and those with attempt CPR orders. There was significant heterogeneity in orders, meaning that many patients, including those who did not want to be resuscitated, chose to have additional limited or full interventions and/or tube feedings. Clearly, the POLST form is a neutral form and meets the intent of honoring the freedom of persons with advanced illness or frailty to have or limit treatment. Another critical implication of these results is that a DNR order alone is a poor predictor of the medical care that dying patients want. It is not uncommon for health care professionals to assume that patients who do not want to be resuscitated would choose to have only comfort measures (Fromme, et al., 2012).

The POST Process

The POST process in Virginia, based on the POLST Paradigm, originated in the Roanoke Valley in December 2009 and now is being piloted in 10 regions in the state. The Virginia POST Collaborative, a

diverse group of health care, legal, legislative, advocacy, and lay members, is aiming to become endorsed by the National POLST Paradigm. This endorsement means that our POST process and form are available as a uniform, legal, and portable communication tool; one that is recognized as the standard of medical care for advance care planning for people who are seriously ill with life-limiting (also called terminal) illnesses or advance frailty characterized by significant weakness and extreme difficulty with personal care activities. The Medical Society of Virginia in 2012 passed a resolution to support efforts that lead to the recognition and adoption of the "Physician Orders for Scope of Treatment (POST) form as a uniform, portable and legal document in the Commonwealth of Virginia."

POST, like POLST, can be used to guide decisions to attempt CPR and decisions about other medical interventions such as hospitalization, antibiotic use, and artificially administered nutrition and hydration. The physician signs the form and notes with whom it was discussed and the care setting where it originated. The patient (or his or her authorized representative) signs the form to document consent to the orders.

POST provides a framework for crucial conversations among the patient, the family, and the health care providers about goals of care and intensity of care. The POST process guides the conversation, increasing the likelihood that patients will express their wishes and have those wishes honored. After the provider reviews the

patient's goals, the choices on the POST form allow a patient to document specific decisions. The patient may choose either less or more invasive treatment and begin to consider each treatment individually in terms of its benefits and burdens. The POST then translates these patient decisions into a signed physician's order that reflects the patient's wishes regarding the treatment they want and the treatment they want to avoid.

"POST is designed to honor the freedom of persons with advanced illness or frailty to have or to limit treatment across settings of care" (Tolle, 2013). POST is entirely voluntary, for no one has to complete a POST; it provides the choice to have or to limit treatments. A POST form may be revoked or changed at any time; comfort measures are always provided. The POST system of communicating patients' wishes for end of life care is the "last step" along the continuum of advance care planning: a continuum that should begin with a young, healthy adult completing his or her advance directive, then continues with the individual updating that advance directive periodically until such time as the individual is diagnosed with advanced illness or frailty. At this point, a POST advance care planning discussion should take place which results in completion of a POST form to reflect his or her preferences and care needs based on the current medical condition. If health status changes, the POST form is reviewed and, if necessary, a new one is completed to reflect the change in the patient's wishes for care. All along this continuum of advance care planning, the goal is to have the conversation before

the crisis, and have a communication tool to convey these wishes across care settings.

Quality Improvement Data in Virginia

The first POST pilot project was conducted in the Roanoke Valley. Between December 2009 and May 2011, nearly 100 residents in two nursing homes had completed POST forms. The Roanoke pilot group conducted quality improvement chart reviews of these patients with POST forms in order to determine the congruency of POST orders with the care delivered. The project found that POST orders were congruent with care in about 98% of the cases, a figure slightly higher than congruency figures in a large national study (Hickman, et al., 2011).

This pilot study found that 75% of the residents were never transferred to another care setting during this 18 month period. Of those who were transferred, three went to the emergency department for evaluation and then returned to the facility, one went to an assisted living facility, and two were admitted to the hospital for symptom control. Of the latter, one returned to the nursing home and the other died in the hospital on the oncology unit. One resident was transferred to a Palliative Care Unit at a nearby medical center.

From additional data provided by one participating facility, we were able to compare the final place of care for patients with and without POST forms who died during these 18 months. We found that 25% of patients without a POST form died

in an acute care setting in a hospital. All of the patients who died and had a POST form had requested Comfort Measures, which included not being transferred to the hospital; of these patients with POST forms, all died in the facility, or, if transferred, died in either assisted living, home with hospice, or an inpatient palliative unit. None died in a hospital.

Let's take a look at a case in Virginia which illustrates how POST prevents situations like Mr. Jan's and leads to patients receiving the care they want and not receiving care they don't want. This case will also demonstrate how the POST process and form are a catalyst for timely and substantive advance care planning discussions.

Case Study #2

Mrs. West was a 92-year-old widow who lived on a long-term care unit at a large nursing care facility in Virginia. She had chronic renal disease, heart failure, diabetes, hypertension, and a recent stroke. Her heart failure and renal disease were progressing, making it clear that she was not likely to live more than a year. A social worker at this facility, trained as a POST Advance Care Planning Facilitator, informed Mrs. West and her daughter that they could avail themselves of a process of advance care planning that would result in a doctor's order sheet that would serve as a communication tool both within and outside the facility. The daughter, who had Mrs. West's medical power of attorney, was particularly interested because her brother tended to press their mother to have more interventions than Mrs. West wished. In the

POST Advance Care Planning session, Mrs. West said she did not want to be resuscitated when she stopped breathing and her heart stopped beating. She added that, in addition to aggressive comfort measures, she wanted some limited medical interventions, such as cardiac monitoring, less invasive airway support, and transfer to the hospital, if indicated, but asked that health care providers avoid putting her in the ICU. Mrs. West's primary care physician reviewed the POST orders with Mrs. West and her daughter and signed the form to activate the orders.

Shortly thereafter, Mrs. West developed fluid retention in her abdomen and her lower extremities. Her physician, not certain if this was due to her known chronic illnesses, recommended sending her to the hospital emergency department (ED) to be evaluated. The daughter did not want her mother to go to the hospital, but Mrs. West consented to her doctor's recommendation. She was admitted to the hospital after evaluation in the ED. The hospitalist urged her to go on dialysis. Mrs. West adamantly refused but the hospitalist persisted. The daughter called the nursing home social worker who supported their decision and encouraged them to be firm and clear with the hospitalist. The daughter repeatedly assured the hospitalist that they'd thought this through in the POST advance care planning process. Mrs. West summed it up, "I'm 92 years old. I've lived a long and good life. I don't want to spend the rest of my life dependent on being hooked up to a dialysis machine. If this is all you have to offer me, then I don't need to be at the hospital. I want to

go back to the nursing home where I live."

Mrs. West returned to the nursing home two days later and the POST form was reviewed, voided, and a new one completed with the change from "Limited Medical Interventions" to "Comfort Measures." Mrs. West was moved to a palliative care room and hospice became involved. She died comfortably three weeks later.

Mrs. West's case illustrates how proactively and effectively the POST Advance Care Planning discussion helped her think through, identify, and communicate her values and goals of care to her family and to those providing her medical care. It beautifully highlights that the advance care planning process is dynamic and fluid. As a person's medical condition changes, it's necessary to review the POST form and see if the person's wishes for treatment have changed.

Summary

POST/POLST can help to clarify and resolve what can be a confusing, even frightening time, a time of urgent, competing, and well-intentioned demands. Physicians in Virginia who have been working with the POST process are now connecting some very important dots. They are seeing the link between appropriately-timed, skillful advance care planning discussions and delivering compassionate care that is in line with patients' wishes. These physicians are asking the Virginia POST Collaborative to help them create a normalcy around advance care planning, a normalcy that communicates that "in our practice (or in

our setting), we don't wait for a crisis to talk to you and/or your medical decision-makers about goals of care. We are offering a communication tool that others will recognize and honor, even when you can no longer speak for yourself."

POST can help free individuals who are frail or near the end of their lives and their loved ones to live life as fully as possible until the final celebration of life.

Study Questions

1. What went wrong in Mr. Jan's situation? Can you think of examples from your own life or practice where people did not receive the end-of-life care they said they wanted to receive? What contributed to this incongruity?
2. If you are a health care provider, what barriers exist in your system which impede your honoring the freedom of persons with advanced illness or frailty to have or to limit treatment across settings of care? Which are the most critical barriers to address first?
3. What are the key features of and benefits from a POST/POLST form?

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Resources

www.polst.org
www.virginiapost.org

About the Authors



Chris Pile, M.D., specialty boarded in Hospice and Palliative Medicine since 2003, has been a physician leader in several hospice teams in Central and Southwest Virginia. Currently the Associate Medical Director for Good Samaritan Hospice in Roanoke, he has been the lead physician for the POST Project in Virginia since 2007 and is the Chairman of the Executive Committee for the Virginia POST Collaborative. You can reach him at cpile@goodsamhospice.org.



Laura Pole, MSN, an Oncology Clinical Nurse Specialist, is Coordinator of POST Pilot Projects for the Palliative Care Partnership of the Roanoke Valley and Secretary of the Virginia POST Collaborative. She has dedicated 33 years in nursing to improving care for persons with serious, life-limiting illness, including serving as End of Life Care Educator for the Virginia Association of Hospices. You can reach her at lpchef@earthlink.net.

Editorials

From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

Dreams and Wonder

Very advanced age is the field of aging's mother lode. Many of us mine this area hoping to glean nuggets of wisdom. Some of my colleagues have spent a good portion of their professional gerontology lives studying centenarians. Multi-year studies in New England, Georgia, and Okinawa, for example, have presented vast amounts of data but, surprisingly, there are relatively few relevant generalizations from the lives of centenarians to the rest of us. People who live to 100 years or more are remarkably varied, even among the select "convenience samples" that researchers carefully study. Heterogeneity increases, a phenomenon we have been calling *individuation*, i.e., we grow less alike.

My friend, Dr. Lennie Poon, Professor Emeritus at the University of Georgia, having conducted years of research among these age-privileged few, suggests caution in making sweeping generalization. He notes that centenarians are distributed bi-modally, meaning that there are two large groups of them: those who have escaped or delayed the disabilities that commonly affect older adults and are now performing well and those who are quite frail, dealing with these disabilities and now at the end of their lives. It's from the former group, more readily accessible, that centenarian studies tend to obtain their data.

Editorials

There are a few takeaways, nonetheless; some of which may be helpful to us who are younger and some probably not. The latter include the finding that the very long-lived often come from very long-living families, with the New England studies reporting about half of the centenarians having siblings, near relatives, and grandparents who are/were very old, suggesting a family clustering of longevity. And the New England researchers note that women who had a child after age 40 are much more likely to survive to 100 than women who do not. Around the world, female centenarians outnumber male counterparts about five-to-one, reaching this landmark from different economic, educational, racial, ethnic, and dietary backgrounds. Well, for many of us, these findings just aren't much help.

Other generalizations, also to be taken with a grain of salt, confirm some basics about aging that educated adults already should know: it's rare for centenarians to be obese or to have smoked substantially; centenarians may have had good support systems throughout their lives and a tendency among centenarians toward extraversion may have helped draw/maintain others in this system and have helped them to cope with stress better.

My own limited and admittedly non-scientific experiences suggest some attitudinal and behavioral characteristics that may be helpful to those of us far from age 100. Since the late 1970s, I have interviewed, very informally, dozens of people in their 90s and a few over 100. These interviews were true convenience samples, happening at

churches, social gatherings, nursing homes, senior centers, through chance meetings and introductions, and so forth. As to be expected, most of the people with whom I spoke were women. Again, I was struck by the remarkable heterogeneity of those I interviewed, from a woman in Okinawa eating twice-cooked pork in a restaurant to another at a senior center in Maryland doing crewel embroidery work.

Over the years, I have identified a fairly common set of traits among the very long-lived people I have met. I hasten to say that what follows is neither prescriptive nor universal, and it is hardly quantitative research. But I have been impressed by how many have dreams and a sense of wonder. I don't know if dreams and wonder have been characteristic all their long lives or if very advanced age had triggered these. All I can say is that at the time when I have met folks in their 90s and 100s, many held a dream, something they wished to accomplish, and/or demonstrated a sense of wonder, an amazement at a discovery or delight in an unexpected experience. The dreams being held by the super-aged may have been to learn to play an instrument, learn a language, understand the computer, travel to some never-visited or long-favorite destination, do something physically, and the like. The sense of wonder was expressed as delight in meeting a child especially good at drawing or music or puzzles, sheer pleasure to see patterns in a kaleidoscope lens, amazement with the night's stars, or even noticing a dramatic display of clouds or a rainbow.

I recall vividly an evening when I met a 98-year old woman who so clearly typified this sense of wonder. I was to speak at a church's adult ministry meeting one weekday night. I was unfamiliar with the location of the meeting, so I arranged to meet the evening's hosts at a convenient location and to have me follow them to our destination. When we met, the hosts persuaded me to ride with them so we could talk in advance of the evening's session. But first, they said, we had to pick up the 98-year old church member.

It was a summer early evening and there had just been a sudden and intense thunderstorm. The post-storm air was humid but fragrant in ways summer storms can create. When we arrived at the older woman's house, she was standing on her front walkway bent over, apparently staring intently at something. We approached and she pointed out a large web formed by a spider in the crook of the downspout at the corner of her house. The web had captured a number of raindrops and they glistened opalescently in the setting sun. She marveled, "Look at God's creation. How wonderful."

This happened about 15 years ago. Sometimes, after a summer storm, I recall her, bent over to look closely at that glistening spider's web. While it may not be scientific and may fall more appropriately under the heading of story-telling, this experience spoke to me about super longevity. Many of the very old possess dreams that push or pull them; these seem to act as goals still ahead. Perhaps this orientation to a future impels their continu-

Editorials

ation. More importantly for me, their future is not mere existence, but rather a time of vibrant appreciation of the world around and within them, an openness to the talents of others and the handiwork of God or nature.

Dreams and wonder can, I think, be cultivated before one is super-aged. Having aspirations, however plain, and learning to open oneself to others and to other things would seem to be part of the plasticity and malleability of the human experience.

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From the Commissioner, Virginia Department for Aging and Rehabilitative Services

Jim Rothrock

Care for the Caregivers

With the increasing numbers of Virginians needing a little bit of help to a whole lot of help to stay in their homes, we see a growing phenomenon. Recently, I attended an event where the speaker noted that the primary common denominator among those in attendance was that they would in almost every case either be:

someone needing to be cared for,
OR
someone who would provide informal care giving to a member of his or her family.

A growing fact of life is that almost all of us will be engaged in some form of caregiving. And for those involved as a caregiver, we need to look at ways to support their efforts.

Virginians spend an estimated **739 million hours** each year serving informally as caregivers to their adult family and friends, at an average lifespan cost to each caregiver of \$635,000 in lost wages and pension. With an estimated 700,000 Virginians serving as informal caregivers at any one time, the lifetime opportunity cost to family caregivers will total at least \$400 billion in lost wages, pension, and Social Security in Virginia alone, not including the state tax revenue that

those earnings would have produced. Furthermore, these statistics refer only to caregivers of older adults and do not include the tens of thousands of Virginians who care for children with temporary or life-long disabilities and special needs. (McDonnell, Robert F., *Certificate of Recognition of Family Caregivers Month* (November 2010). Retrieved May 30, 2011, from www.governor.virginia.gov/OurCommonwealth/Proclamations/2010/Caregivers.cfm.)

Additionally, it is estimated that each year in the U.S., caregivers spend \$450 billion in out-of-pocket expenditures, a staggering sum. On any given day, there are 65 million Americans engaged in informal caregiving. When asked, caregivers note that they need help, but do not know where to go.

As the Commonwealth's newest state agency, the Department for Aging and Rehabilitative Services, evolves, it has been my pleasure to see the state address this issue. The "old" VDA worked with the Virginia Caregiver Coalition on several effective measures, but this year we took a new small but dynamic step. A cross-age and disability team of DARS employees came together to craft a successful proposal which was funded by the almost equally new federal agency, the Administration on Community Living. The *Virginia Lifespan Respite Program* provides reimbursement for the cost of temporary short-term respite for home-based caregivers who provide care for family members with disabilities (children and adults) and Vintage Virginians. The funding is limited to a total of \$400 per family.

Editorials

As of mid-March, there were more than 300 requests and the majority of the limited funds were already approved for processing. One of the more illustrative aspects of this program is the quotes from some of the applications noting the dire need for this help:

• *I only wish this were a permanent program... I had no idea just how badly I needed rest.*

• *My husband and I were able to take a mini "vacation" this weekend and feel so rejuvenated! We are back now taking care of our precious daughter, but that was all we needed.*

• *Oh my goodness, thank you SO much! That was fast! I'm re-reading your message and can't believe I'll be able to join my friends for a little weekend vacation in April. It's been over 20 years since I have taken a fun trip on my own. It doesn't seem real...I'm tearing up as I write this. Thank you all very, very much!!*

• *This is such a nice surprise. I can't tell you how much good it did for me to just submit the application and document my personal need for respite care. It will be so nice to take a few guilt-free days to spend with my family visiting colleges. The financial compensation is extremely helpful, as caring for a family member with Alzheimer's or any long-term illness is so costly, but it is also very nice to feel that there is a supportive organization that is attempting to assist caregivers.*

• *Thank you so much, I so very-very badly need a break; he requires 24-*

hour care and I can't go shopping, Laundromat, or even take a bath much longer than I care to tell you. This is a Godsend.

• *Thank you, this is awesome...This is the first vacation I have had in 21 years!*

• *So often, family caregivers feel worn down in the often unanticipated role of caring for a loved one, that the very thought that someone has recognized that we too need care can bring us to tears!*

The above quotes note the dire need for this programming that is not only responsive to the needs of our caregivers, but also supports an incredibly cost effective volunteer program. It boggles the mind to consider how any state would or could be able to receive the transfer of these costs of this caregiving community to the state bureaucracy. Any and all we can do to support our caregivers is time and effort well spent.

Some useful guidance to all in a caregiving role can be found below:

- Seek support from other caregivers. You are not alone!
- Take care of your own health, so that you can be strong enough to take care of your loved one;
- Learn how to communicate effectively with physicians and other health care professionals;
- Be open to new technologies that can help you care for your loved one; and
- Give yourself credit for doing the best you can in one of the toughest jobs there is!

I hope that each of you will learn

more about respite services and resources. This is important because the likelihood of our needing this help is almost as sure as taxes in April.

2013 VDARS Meeting Calendar

Commonwealth Council on Aging

(Wednesdays)

July 10

September 25

Alzheimer's Disease and Related Disorders Commission

(Tuesdays)

May 14

August 27

October 15

Public Guardian and Conservator Advisory Board

(Thursdays)

June 13

September 12

November 21

The Virginia Center on Aging's 27th Annual Legislative Breakfast

VCoA hosted its 27th annual breakfast on January 23, 2013, 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.

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: Kathy Vesley, Bay Aging; Marilyn Maxwell, Mountain Empire Older Citizens; Kathy Miller, Senior Connections, Capital Area Agency on Aging

Top Right: Terri Lynch, Arlington Agency on Aging; Bill Hazel, Virginia Secretary of Health and Human Resources; Senator Ralph Northam

Middle Left: Mark Smith, Government Relations, VCU, and Mike Guy, District Three Governmental Cooperative

Middle Right: Amy Marschean, Virginia Department for Aging and Rehabilitative Services, and Roberto Quinones, Commonwealth Council on Aging

Bottom Left: Frank Jordan, Foster Grandparents Volunteer, and Ivan Tolbert, Senior Connections



Top Left: VCoA's Catherine Dodson (l) and Paula Kupstas (r) with Senator Frank Wagner

Top Right: Tina King, New River Valley Agency on Aging, and Susan Williams, LOA-Area Agency on Aging

2nd Row Left: Lynda Sharp Anderson, Senior Center of Greater Richmond, and Sandra Rollins, South Richmond Adult Day Care Center

2nd Row Right: Senator Emmett Hanger and VCoA's Ed Ansello

3rd Row Left: Jim Bennett, Parkinson's Disease Research Center at VCU, and VCoA's Bert Waters

3rd Row Right: Rose Williams and Pat Giesen of Senior Connections; Sara Link, United Way of Greater Richmond and Petersburg

Bottom Left: Carter Harrison, Alzheimer's Association, and Courtney Tierney, Prince William Area Agency on Aging

COMMONWEALTH OF VIRGINIA

Alzheimer's and Related Diseases Research Award Fund

2011-2012 FINAL PROJECT REPORT SUMMARIES

The Alzheimer's and Related Diseases Research Award Fund (ARDRAF) was established by the Virginia General Assembly in 1982 and is administered by the Virginia Center on Aging at Virginia Commonwealth University. Summaries of the final project reports submitted by investigators funded during the 2010-2011 round of competition are given below. To receive the full reports, please contact the investigators or the ARDRAF administrator, Dr. Constance Coogle (ccoogle@vcu.edu).

VCU **Malgorzata Dukat, Ph.D. and Galia R. Abdrakhmanova, M.D., Ph.D. "Small Molecules as Negative Allosteric Modulators of $\alpha 7$ nAChRs"**

Both agonists and antagonists of $\alpha 7$ nAChRs (i.e., nicotinic acetylcholine receptors) have been shown to be of value in the treatment of AD. Agonists might desensitize the action of ACh at these receptors, thereby reducing cholinergic transmission, and antagonists block ACh transmission. An entirely novel approach is to identify negative allosteric modulators (NAMs) of $\alpha 7$ nAChRs that can selectively, but indirectly, block the effect of ACh at $\alpha 7$ nAChRs without acting at $\alpha 4\beta 2$ receptors. The investigators previously identified one of the first small-molecule NAMs of $\alpha 7$ nAChRs, namely MD-354. Because this compound is a 5-HT₃ (serotonin) receptor agonist, the investigators modified its structure to abolish that action, and thereby develop "selective" $\alpha 7$ nAChR allosteric modulators. They synthesized a series of MD-354 analogs and evaluated them in functional assays to determine what structural features are required, and to optimize the pharmacological actions by eliminating affinity for 5-HT₃ receptors. The present study delivered proof of the concept that small molecules, the guanidines, represent a novel class of $\alpha 7$ nAChR NAMs. Furthermore, the investigators demonstrated that small structural changes to MD-354 diminished or abolished its 5-HT₃ receptor affinity, while retaining its $\alpha 7$ nAChR activity. All the NAMs examined display antagonism action at $\alpha 7$ nAChR with half maximal inhibitory concentration (IC₅₀) values ranging from 1.3 – 34.8 μ M. To eliminate possible competitive antagonism or channel blocking action, MD-354 and one of the newly synthesized agents were evaluated in voltage-dependence inhibition of ACh experiments and both proved to be $\alpha 7$ nAChR NAMs. In addition, they were assayed for antagonistic activity at $\alpha 3\beta 4$ and $\alpha 4\beta 2$ nAChRs and were found to be inactive, suggesting their selective action at $\alpha 7$ nAChRs. The most potent NAM, was further evaluated in radioligand binding assays for its selectivity among cloned nAChRs (i.e., $\alpha 2\beta 2$, $\alpha 2\beta 4$, $\alpha 3\beta 2$, $\alpha 4\beta 2$, $\alpha 3\beta 4$, $\alpha 4\beta 2$, $\alpha 4\beta 4$) and was found to lack binding affinity at all seven (i.e., K_i > 10,000 nM). This is the first study identifying guanidine analogs as small molecule $\alpha 7$ nAChR NAMs. In contrast to current ACh inhibitors that are limited to symptomatic treatment of cognitive function, these new agents offer the potential for slowing the progression of AD. (Dr. Dukat may be contacted at (804) 828-5256; mdukat@vcu.edu and Dr. Abdrakhmanova may be contacted at (804) 828-1797; gabdrakhmano@vcu.edu.)

GMU **Jane M. Flinn, Ph.D., Nathalia Peixoto, Ph.D., and Daniel N. Cox, Ph.D. "Behavioral and Inflammatory Changes in a Mouse Model of Late-Onset Alzheimer's Disease"**

The investigators used their mouse model of late onset AD, where the gene APOE4 is important, to examine behavioral and inflammatory changes in mice modeling early onset and late onset AD, together with controls. They examined circadian rhythms, nest building, memory, and the levels of cytokines. Surprisingly, the mice carrying the APOE4 gene performed slightly better than the early onset mice, although less well than controls, on measures of circadian rhythms and nest building. (Memory scores were difficult to compare as the controls performed less well than expected.) Their measures of inflammation were also intermediate between those of the controls and the early onset mice. There was a significant correlation between measures of circadian rhythm disruption and inflammation. These were younger mice, suggesting that APOE4 may not be a risk factor at a

younger age, and measures of inflammation and circadian rhythm could be useful early indicators of Alzheimer's disease. (Dr. Flinn may be contacted at (703) 993-4107; Dr. Peixoto may be contacted at (703) 993-1567; Dr. Cox may be contacted at (703) 993-4971.)

VCU Aron H. Lichtman, Ph.D. and Laura E. Wise, Ph.D. "Targeting the Endogenous Cannabinoid System to Treat Alzheimer's Disease"

In vitro studies have shown that cannabinoid receptor activation can inhibit or reduce the deposition of beta-amyloid plaques and decrease inflammation, critical features of Alzheimer's disease. While these findings indicate that cannabinoids may be beneficial in attenuating the neuropathology associated with Alzheimer's disease, very few studies have evaluated if stimulation of the endocannabinoid system can attenuate cognitive deficits and neuropathology in *in vivo* models of Alzheimer's disease. The goal of the funded studies was to examine whether elevating endogenous levels of the endocannabinoid anandamide, via inhibition of its primary degradative enzyme fatty acid amide hydrolase (FAAH), would have beneficial effects on memory impairments and neuropathological markers in APP/PS1 transgenic mice, an *in vivo* model of Alzheimer's disease. The investigators found that repeated administration of the FAAH inhibitor PF-3845 improves memory performance in APP/PS1 transgenic mice, but not control mice, in the Morris water maze. They also found that acute treatment (i.e., drug administration only before water maze testing) with PF-3845 improves memory performance in APP/PS1 transgenic mice, but to a lesser degree than repeated PF-3845 treatment. Immunohistochemistry studies are currently underway to evaluate A β plaque formation and the presence of activated microglia in the dorsal hippocampus to determine whether repeated treatment with PF-3845 decreased neuropathological markers associated with Alzheimer's disease. It is apparent, however, that PF-3845 improves memory performance in an *in vivo* mouse model of Alzheimer's disease. These findings suggest that FAAH inhibition may have beneficial effects on memory impairments in Alzheimer's disease. They furthermore provide proof of principle that the endogenous cannabinoid system represents a potential target for medications to treat AD. (Dr. Lichtman may be contacted at (804) 828-8480; Dr. Wise may be contacted at (804) 828-7264.)

GMU Robert H. Lipsky, Ph.D. "Functional Characterization of Promoter Polymorphisms of the Human GRIN2B Glutamate Receptor Gene Associated with Altered Memory Functioning in Older Adults"

Mild cognitive impairment (MCI) is a clinical diagnosis that describes a small but measurable decline in an individual's cognitive abilities, including memory. A person with MCI is at greater risk of developing Alzheimer's disease. Currently, there are no methods for early detection of MCI or to predict the outcome of MCI or its progression to Alzheimer's disease. FDA-approved drugs for treating symptoms of Alzheimer's do not seem to benefit MCI patients, underscoring a need to understand the underlying mechanisms leading to MCI. Using a method that combines an understanding of human genetics and brain imaging, the investigators discovered a variant of the GRIN2B gene, a gene critical for learning and memory that may be a marker for MCI. The funded study determined how this genetic variant controls the GRIN2B gene at the biochemical and cellular level. They found a protein, Elk-1, that binds the DNA of the GRIN2B gene variant, called the A allele. The A allele also activates genes introduced into neuron-like cells maintained in the laboratory. These results support their previous observation that the A allele of the GRIN2B gene is linked to a specific pattern of brain activity seen when older adults (who were otherwise matched for age, gender, and cognitive ability) performed certain memory tasks. Taken together, these results are the first to support the role of a GRIN2B gene variant associated with human memory performance based on molecular and cellular function. They constitute the first genetic association between a functional NR2B gene variant and an endophenotype, a characteristic that is more closely related to pathophysiology of AD than diagnostic markers. (Dr. Lipsky may be contacted at (703) 993-5140; robert.lipsky@nova.org.)

COMMONWEALTH OF VIRGINIA

Alzheimer's and Related Diseases Research Award Fund

ADDITIONAL 2012-2013 ALZHEIMER'S RESEARCH AWARD FUND RECIPIENT ANNOUNCED

The Alzheimer's and Related Diseases Research Award Fund (ARDRAF) was established by the Virginia General Assembly in 1982 to stimulate innovative investigations into Alzheimer's disease (AD) and related disorders along a variety of avenues, such as the causes, epidemiology, diagnosis, and treatment of the disorder; public policy and the financing of care; and the social and psychological impacts of the disease upon the individual, family, and community. The ARDRAF competition is administered by the Virginia Center on Aging at Virginia Commonwealth University. The additional grant award for 2012-2013 is as follows:

UVA Inchan Kwon, Ph.D. and Erik Fernandez, Ph.D. "Revealing the Effect of Food Dyes on Amyloid-Beta Structure-Cytotoxicity Relationships"

While modulation of amyloid-beta aggregation is considered a promising strategy to cure Alzheimer's disease (AD), no such therapeutic is yet available. Recently, the investigators' research group discovered that erythrosin B (ERB) and brilliant blue G (BBG), the popular food colorings approved by the Food and Drug Administration, effectively modulate amyloid-beta aggregation and cytotoxicity. However, knowledge on how ERB and BBG affect amyloid-beta aggregation remains very limited. This project will address this issue by measuring how much and which part of the amyloid-beta aggregates is accessible to amyloid-beta binding proteins. The research will reveal the structural features of amyloid-beta aggregates remodeled by ERB and BBG. This will set the stage for the development of ERB and BBG as candidate therapeutics or imaging agents for AD. Just as important, the approaches developed here will be generally applicable to investigating interactions between other aggregation modulators and amyloidogenic proteins.

Be Medication Smart



70% of people who abuse medications get them from family or friends. Older adults generally have multiple medications and can be an unknowing source for abusers. Here are some tips to keep you and your medications safe:

Don't Share. Not only is it illegal, it can be dangerous to take medications not prescribed for you.

Lock Up. Keep medications in a locked cabinet or container.

Properly dispose of unneeded or expired prescriptions. Bring them

to a medication take-back so they can be incinerated, preventing trace drugs from contaminating surface and ground water.

Safely dispose of them at home.

- Do not flush them down the toilet or sink unless the instructions on the bottle tell you to.
- Take the drugs out of their original containers and mix them with an undesirable substance, such as used cat litter or coffee grounds.
- Put the mixture into a disposable container with a lid or a sealable bag.
- Cover with marker or remove any personal information, including the prescription number, on the empty containers.
- Place the sealed container and the

empty drug containers in your household trash.

Don't mix your medications with alcohol. Look for warning labels that tell you not to drink alcohol while taking that medication. If you are taking medications for sleeping, pain, anxiety, or depression, it is unsafe to drink alcohol.

Get Help. If you or someone you know may be abusing medications, get help!

This information is provided by **Chesterfield SAFE: Preventing Substance Abuse Together**. For more information, visit their website at chesterfieldsafe.org or call (804) 796-7100.

Focus on the Virginia Center on Aging

Robert L. Schneider, Ph.D.



Dr. Robert (Bob) L. Schneider has been a member of the Virginia Center on Aging Advisory Committee since 1997 and currently serves as its Chairperson.

Bob is Professor Emeritus (1974-2008) in the School of Social Work at Virginia Commonwealth University (VCU). His roots in gerontology at VCU run deep, having served on the Advisory Committees of VCU's initial Gerontology Department (1975-80) and Geriatric Education Center (1987-97). He was also the advisor to the School of Social Work's Certificate in Aging Studies program for 19 years. In 2001, he and other faculty colleagues secured a \$500,000 W.R. Hearst Foundation Endowed Scholarship Fund in gerontology for Master students in social work.

Bob was born in Grand Rapids, MI and began his education in a rural schoolhouse where a large iron heating grate in the middle of the room allowed him to dry his mittens after a snowy recess. His family rarely traveled out of state, but, thanks to Scouting, Bob developed his own wanderlust. Israel, Uganda, Cuba, China, Italy, and Bosnia are among the recent trips that he and his wife, Anita, have taken.

Armed with a baccalaureate degree in philosophy and a minor in French, Bob began a teaching career in 1965 that took him to New Jersey, Maryland, and France. The

1960s "Great Society" inspired him toward the field of social work and social change, so he enrolled at the Tulane University School of Social Work in 1971. He quickly became interested in community organizing, planning, and administration. In 1974, Bob arrived at the VCU School of Social Work as an Assistant Professor with all but one chapter written on his Ph.D. dissertation, a study of the establishment and maintenance of voluntary interdisciplinary teams.

Bob was the first President of the *Association for Gerontology Education in Social Work (AGE-SW)*, soon to become a national organization with liaisons in most schools of social work. *AGE-SW* continues to lead the profession today with over 238 individual members from across the US.

Governor John Dalton appointed him as a delegate to the 1981 White House Conference on Aging, and Governors Robb, Baliles, and Wilder appointed him to the Governor's Advisory Board (*now the Commonwealth Council on Aging*) to the Virginia Department for the Aging (VDA). He also was a Virginia Licensed Nursing Home Administrator from 1987-1999, completing his AIT at Westminster Canterbury House in Richmond.

Bob was principal investigator in 1984 for a major federal Administration on Aging grant to develop curricula for gerontology in social work. He served as lead editor of four volumes that were disseminated nationally. He achieved the status of Fellow in the Gerontological Society of America in 1985, and was a Senior Fulbright Lecturer

twice, in 1979-80 and 1989-90, in Israel, where he helped to develop an MS in Gerontology between Haifa University and Ben Gurion University. He received a Lifetime Achievement Award from *AGE-SW* in 2006.

Bob founded *Influencing State Policy (ISP)*, a group that would promote including policy advocacy at the state level into the curricula of all programs of social work education across the United States. He invested the next 11 years as national Chairperson, overseeing the expansion of his vision into over 80% of these programs. He developed website resources, created a five-part CD/video series on policy advocacy, sponsored a national contest for students who attempted to influence legislation in their states, and encouraged research among Ph.D. students on state policies. The Council on Social Work Education honored him with its Distinguished Recognition Award in 2002.

Bob has written and published extensively throughout his long career. Now retired, he is not one to sit still; he is currently tutoring students at John Tyler Community College in the Great Expectations program, designed to support foster children entering higher education.

Bob enjoys growing tomatoes and sunflowers in his home garden each summer. He loves reading biographies and driving his power boat off the shores of New Point, Virginia. He and Anita collect old sheet music and love to travel together. They have a son, Gabriel, and a daughter, Erika, both university graduates.

Mental Health and Aging Training Initiative Live Webinar Series II

These free* presentations are intended for staff from many levels, disciplines, and settings (both facility and home-based), including staff involved in providing long term care, as well as behavioral health staff who work with older adults. Additionally, staff from Adult Protective Services, home health, adult day healthcare, respite care, area agencies on aging, emergency department staff of hospitals, hospital discharge planners, and others serving older adults could benefit from the training.

Register online at <http://worldeventsforum.blogspot.com>.

Best Practices in Geriatric Psychiatry and Long Term Care

When: Monday, April 22, 2013, 1:30 p.m. - 2:30 p.m. Eastern Time

Panel: **Erin M. Morrison**, MD, Psychiatrist, Paradigm Health Services (panelist); **Ayn Welleford**, MSG, PhD, AGHEF, Chair, Department of Gerontology, Virginia Commonwealth University (moderator)

Objectives: At the end of this one-hour presentation participants will learn: A model for how geriatric psychiatry and telemedicine can help facilities to address more successfully the behavioral health needs of their residents, including discussion of cost reimbursement issues.

The Temporary Detention Order Process: What Staff Need to Know

When: Wednesday, May 29, 2013, 1:30 p.m. - 2:30 p.m. Eastern Time

Panel: **Sarah W. Bisconer**, PhD, Emergency Services Coordinator, Colonial Behavioral Health, and **James M. Martinez, Jr.**, Director, Office of Mental Health Services, Department of Behavioral Health & Developmental Services (panelists); **Ayn Welleford**, MSG, PhD, AGHEF, Chair, Department of Gerontology, Virginia Commonwealth University (moderator)

Objectives: At the end of this one-hour presentation participants will learn: Current statutes and procedures governing when and how the TDO process may occur; How to initiate the Preadmission Screening and TDO process; Practical considerations to keep in mind when initiating the TDO process (e.g., helpful documentation, timing, medical clearance, transportation, readmission to facility after treatment and stabilization).

*These events are made possible through a grant from the Virginia Center on Aging's Geriatric Training and Education (GTE) initiative and are supported by the Riverside Center for Excellence in Aging and Lifelong Health, the Virginia Geriatric Mental Health Partnership, and VCU's Department of Gerontology.

Virginia Elder Rights Coalition Award

Virginia Elder Rights Coalition (VERC) Mission

The Virginia Elder Rights Coalition (VERC) is a network of agencies and groups working to promote the rights and autonomy of older Virginians through statewide leadership and support. VERC aims to enhance education and training in elder rights; empower older persons to exercise their rights; provide legislative information in furtherance of elder rights; and advance administrative and individual advocacy to secure benefits under law.

VERC focuses on preserving rights while providing for needs. VERC is concerned with safeguarding the fundamental civil and legal rights of elders throughout the state.

VERC in Action

VERC cosponsors an annual conference with the Virginia Guardianship Association; participates in the Division for the Aging's Project 2025 to enhance legal resources for elders; sponsors a statewide elder rights listserv; convenes a Fall legislative forum on elder rights; and holds VERC meetings for the public with outstanding national and state speakers. VERC also gives an annual Elder Rights Award to an outstanding advocate.

VERC Elder Rights Award

The annual Elder Rights Award recognizes individuals who have significantly advanced the fundamental civil and legal rights of elders in

the Commonwealth, and the empowerment of older persons to exercise their rights. Here is your opportunity to recognize someone who is a strong advocate on behalf of elders – perhaps someone working at the grassroots level who previously has not been honored! (Members of the VERC Board are not eligible.)

To request a nomination form, contact kathy@vplc.org. **Nomination Forms must be completed and returned by June 15th.**

Marion Cotter King Scholarship Endowed

The VCU Department of Gerontology is proud to announce that the Marion Cotter King Scholarship has been fully endowed. It will be used to support the scholastic efforts of students studying elder leisure activities and optimal aging.

The scholarship was created by her son, J. James Cotter, Ph.D., associate professor of gerontology, and his sister, Patricia Duggan. "My mother was a travel nut," Cotter said. "She retired at 62 and never looked back." Because she loved traveling, this scholarship is for "students who start out in recreation or elder leisure."

For more information on supporting the VCU Department of Gerontology's mission of *Improving Elder-care through Education*, please visit www.sahp.vcu.edu/gerontology.

Eating More Fiber May Lower Risk of First-Time Stroke



Eating more fiber may decrease the risk of first-time stroke, according to a British study just published in the American Heart Association journal *Stroke*. Dietary fiber is the part of the plant that the body doesn't absorb during digestion. Fiber can be soluble, which means it dissolves in water, or insoluble.

It has long been known that dietary fiber may help reduce risk factors for stroke, including high blood pressure and high blood levels of low-density lipoprotein (LDL), the "bad" cholesterol. In the new study, researchers found that each seven-gram increase in total daily fiber intake was associated with a seven percent decrease in first-time stroke risk. Seven for seven.

How would one add seven grams of fiber? One serving of whole wheat pasta, plus two servings of fruits or vegetables, provides about seven grams of fiber.

"Greater intake of fiber-rich foods, such as whole-grains, fruits, vegetables and nuts, are important for everyone, and especially for those with stroke risk factors like being overweight, smoking, and having high blood pressure," said Diane Threapleton, M.Sc., lead author of the study and Ph.D. candidate at the University of Leeds' School of Food Science & Nutrition in Leeds, United Kingdom.

She and eight co-authors analyzed eight studies published between 1990-2012. Studies reported on all types of stroke with four specifically examining the risk of ischemic stroke, which occurs when a clot blocks a blood vessel to the brain. Three assessed hemorrhagic stroke, which occurs when a blood vessel bleeds into the brain or on its surface. Findings from the observational studies were combined and accounted for other stroke risk factors like age and smoking.

The results were based on total dietary fiber. Researchers did not find an association with soluble fiber alone and stroke risk, and lacked enough data on insoluble fiber to make any conclusions. Total fiber intake seems to be the key.

The average daily fiber intake among U.S. adults is lower than the American Heart Association's recommendation of at least 25 grams per day. Six to eight servings of grains and eight to 10 servings of fruits and vegetables can provide the recommended amount. "Most people do not get the recommended level of fiber, and increasing fiber may contribute to lower risk for strokes," Threapleton said. "We must educate consumers on the continued importance of increasing fiber intake and help them learn how to increase fiber in their diet."

In the United States, stroke is the fourth leading cause of death, killing more than 137,000 people annually. Among survivors, the disease is a leading cause of disability.

Calendar of Events

April 16, 2013

Sixth Annual National Healthcare Decisions Day. To inspire, educate, and empower the public and providers about the importance of advance care planning. For information, visit www.nhdd.org.

April 29, 2013

Obtaining Convictions and Restitution for Adult Abuse. Presented by the Greater Augusta Coalition Against Adult Abuse, in partnership with the Family and Children's Trust Fund, and the Virginia Coalition for the Prevention of Elder Abuse. Plecker Workforce Training Center, Blue Ridge CC, Weyers Cave. Register at <http://fs21.formsite.com/ascott/form10/index.html?1358267517475>.

April 30, 2013

Best Practices in Person-Centered Dementia Care Conference. Presented by George Mason University Partners for Education in Gerontology, the Virginia Geriatric Education Center, and the Alzheimer's Association National Capital Area Chapter. The Hermitage, Alexandria. For information, visit https://fs18.formsite.com/Academic/form151/secure_index.html.

May 2, 2013

Circle Center Adult Day Services Open House and 37th Anniversary Celebration. 10:00 a.m. - 4:00 p.m. 4900 West Marshall Street, Richmond. RSVP to (804) 355-5717 or mmacbean@circlecenterads.org.

May 21-24, 2013

40th Annual Conference of the Virginia Association of Nonprofit Homes for the Aging. The Homestead, Hot Springs. For information, visit www.vanha.org.

May 29-31, 2013

19th Annual Conference of the Virginia Coalition for the Prevention of Elder Abuse. Virginia Beach Resort & Conference Center. For information, visit www.vcpea.org or call Lisa Furr at (804) 828-1525.

June 15, 2013

World Elder Abuse Awareness Day. For information, visit www.inpea.net/weaad.html.

July 24-27, 2013

2013 Annual Conference on Independent Living. Sponsored by the National Council on Independent Living. Grand Hyatt, Washington, DC. For information, visit www.ncil.org.

July 25, 2013

2013 Joint Conference on Adult Guardianship. Presented by the Virginia Guardianship Association and the Virginia Elder Rights Coalition. Four Points By Sheraton Richmond Airport. For information, visit www.vgavirginia.org.

July 27 - 31, 2013

National Association of Area Agencies on Aging's 38th Annual Conference & Tradeshow. Kentucky International Convention Center, Louisville, KY. For information, visit www.n4a.org.

July 30- August 2, 2013

Intergenerational Pathways for Strengthening Communities. 17th International Conference of Generations United. Washington Court Hotel, Washington, DC. For information, visit <http://guconference.wordpress.com>.

October 27-30, 2013

2013 LeadingAge Annual Meeting and Expo. Connect with thousands of aging services professionals who are facing the same triumphs and challenges that you face every day. Dallas, TX. For information, visit www.leadingage.org.

Oct. 31 - Nov. 31, 2013

National Association for Home Care & Hospice Annual Meeting & Exposition. Gaylord National Resort & Convention Center, National Harbor, MD. For information, visit www.nahc.org.

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.

Age in Action

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

James A. Rothrock
Commissioner, DARS

Kimberly S. Ivey, M.S.
Editor

Age in Action is published quarterly. Submissions, responses to case studies, and comments are invited and may be published in a future issue. Mail to: Editor, Age in Action, P.O. Box 980229, Richmond, VA 23298-0229, fax to (804) 828-7905, or e-mail to kivey220@yahoo.com.

**Summer 2013 Issue Deadline:
June 15, 2013**



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at Virginia Commonwealth University, Richmond, Virginia
www.vcu.edu/vcoa

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

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The Area Planning and Services Committee on Aging with Lifelong Disabilities (APSC)
presents its 2013 conference

Wellness Trends and Resources for Aging with Lifelong Disabilities

June 3, 2013

8:00 a.m. - 4:30 p.m.

Holiday Inn Select, Koger South Conference Center, Richmond

Topics Addressed Include:

- Affordable Care Act
- Spirituality and Spiritual Wellness
- Take Charge: Put Health, Nutrition, and Well-Being in Your Own Hands
- Family Caregivers Supports
- Hands-on Art and Yoga
- Chronic Disease Self-Management Education
- Navigating Available Resources: Senior-, Virginia-, and Disability-Navigator

Registration includes all materials, refreshment breaks, and luncheon.

Cost: \$35 early registration; \$45 on-site registration.

For more information, please e-mail eansello@vcu.edu.

Register online at <http://apsc2013conf.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.