

# age in action

Research in geriatrics and gerontology education and research  
Virginia Center on Aging  
Virginia Geriatric Education Center  
Virginia Department for the Aging

## Case Study

### ElderFriends: Relieving Loneliness Among Elders

by Kiersten Seeger Ware  
and Sarah Coble

#### Educational Objectives

1. To discuss social isolation among older adults.
2. To promote awareness of the ElderFriends program, an intervention newly established in greater Richmond
3. To seek friendly visitors for the ElderFriends program.

#### Background

Social isolation among elders has long been recognized as problem that diminishes their well-being, one associated with problems of low morale, poor health, and the risk of premature institutionalization (Bennett, 1980). Social isolation also frequently leads to depression and a variety of related health

problems, such as compromised neuroendocrine or immune functioning (Sorkin et al., 2002). Loneliness has been linked to cardiovascular disease as well, through a variety of physiological processes. In addition to biological linkages, lonely people are more likely to suffer from cardiovascular disease due to the deleterious health effects of their own lifestyles, such as little to no exercise, unhealthy eating habits, and alcohol abuse (Sorkin et al., 2002). Because of their isolation, people experiencing loneliness may not exercise sufficient self-care, being unmotivated themselves and lacking the social contacts that encourage them to do so (Sorkin et al., 2002). From self-care activities to cardiovascular disease to depression and loneliness, social isolation is a complex problem that affects every aspect of a person's life: biological, psychological, social, and spiritual. Strong and consistent evidence points to an

important association between social network involvement and better physical health among older adults (Seeman et al., 1993; Tucker, et al., 1999). Feeling love and support from others helps encourage individuals to maintain physical health, preventing further need for medical attention. Intervention strategies at personal and community levels can improve quality of life for older adults (Blazer, 2002).

#### Mission

ElderFriends was founded in Seattle in 1996 on the principle that connection to others and to one's community is just as important to the well-being of older people as nursing care and medicine. ElderFriends Richmond began in the Fall of 2005 as a pilot program. Its mission is to help elders remain independent for as long as possible and to reduce isolation and loneliness among low-

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income, shut-in elders by pairing them with younger volunteers who provide companionship, outreach, and advocacy. These intergenerational relationships are key to the program's success.

**ElderFriends has the following goals and objectives:**

1. To relieve isolation and loneliness
2. To help elders to remain independent for as long as possible
3. To improve lives through social interaction
4. To improve caring interactions between and among children, youth, adults, and elders
5. To look for signs of neglect or abuse of elders and help identify appropriate services for victims
5. To advocate through community networks that focus on low-income elderly populations.

**Program Components**

Elder Participants

The target population for ElderFriends participants is frail elders living independently in their own apartments or homes who report feeling isolated and lonely. These "shut-in" elders have the desire to continue to live independently, but need more social contact and connection with their community to do so.

Intergenerational Relationships

ElderFriends provides companionship, outreach, and

advocacy through intergenerational relationships. Volunteers of all ages are offered the opportunity to join elders in friendship and an intergenerational celebration of life, while giving isolated elders the chance to develop rewarding relationships and enjoy increased social interaction. These relationships often lead to caring friendships between youths, adults, and elders. Visiting volunteers and their families develop ongoing relationships with elders in the community that encourage emotional well being.



Volunteers

ElderFriends believes that the social networks of

isolated older adults who are still living independently can be expanded and strengthened by properly trained and supported on-going volunteer visitors.

Volunteers typically visit their elder friends four times a month and maintain frequent contact with them through letters and phone calls. All volunteers participate in training on the ElderFriends philosophy, processes of aging, communication skills, and relevant community resources that helps them understand their roles as friendly visitors and makes them aware of existing services.

ElderFriends volunteers make a commitment to keep in contact with ElderFriends staff regarding the progress of the relationship with their elder and his/her

needs, and changes in either's circumstances. Through consistent communication and training opportunities, volunteers are able to assist their elder in meeting needs by working together with them, the social services network, and ElderFriends staff. Volunteers knowing about community-based resources encourage elders in self-advocacy by connecting them with potentially beneficial services. Often, elders simply are not aware of existing community services. ElderFriends strives to assist participants by broadening their knowledge and connecting them with these services.

Community Organizations

ElderFriends collaborates with other organizations that provide relevant services, such as primary health care, home chore services, home health care, transportation, and legal assistance. ElderFriends volunteers work directly with a variety of case managers in human services to help elders to access other services outside of ElderFriends itself. This inter-organizational pattern explains why the majority of referrals of elders to the program are from health care agencies which provide services to these individuals. These agencies are eager to work with ElderFriends because doing so links these older adults to already available services rather than duplicating them.

### **Case Study #1 (From Elderfriends Richmond)**

Diane is a 99-year-old widow, a former dancer who was facing an unusual situation when her 80-year-old son's wife had a mini-stroke which resulted in his having to spend more of his time caring for her and less of his time caring for his mother. Diane had moved to Richmond from New York City when her husband became ill and died. Although she could somewhat care for herself, her failing eyesight prevented her from getting out much and from cooking her own meals. In addition, Diane simply felt isolated and lonely. When she reported these feelings, and a desire to get out of the house with a companion, to her Meals on Wheels representative, that representative referred her to ElderFriends. It, in turn, matched her with a friendly visitor named Fanny, a middle-aged graduate student living far from her own family in India.

For the past six months, Diane has been enjoying a close relationship with Fanny. Fanny visits in home and takes Diane out, which gives Diane something to look forward to. Fanny also occasionally cooks special food from her home country for Diane. These meals give Diane a break from her routine Meals on Wheels dinners. Diane reports that she sees Fanny as the daughter she

never had. She says that she is kind, considerate, eager to please and she "doesn't look annoyed at an old woman." Diane's son is still needed and able to help her with instrumental tasks, such as taking her to her doctor's appointments, but her loneliness is at least somewhat alleviated through her weekly visits and phone calls from Fanny and her weekly phone chats and occasional visits from the ElderFriends coordinator. The relationship is reciprocal, as Fanny reports that she gains a lot from her relationship with Diane as well.

### **Case Study #2 (From Elderfriends Seattle)**

Bob is a 76-year-old former handyman who was referred to ElderFriends by a local human services agency. He is a low-income male who lives alone in his own apartment and cares for himself independently. The case manager completed an intake referral form that indicated Bob's physical and emotional difficulties/challenges. Among them were vision and hearing losses, does not go out, history of stroke, wants a friendly visitor, isolated and lonely. Brian, a young Seattle resident, participated in the ElderFriends annual Thanksgiving Day Event, one of many large-scale events ElderFriends Seattle offered to older adults and volunteers (which ElderFriends Richmond is working toward adopting). He

enjoyed the experience so much that he committed to become trained for the "Adopt a Grandparent" friendly visitor opportunity. Brian and Bob were matched on a trial basis of two to three visits, during which time several check-in phone calls were made to both men. Each check-in was positive and both elected to commit to develop an ongoing friendship.

More than three years later, Brian and Bob were still going strong. According to Brian's quarterly reports, they had in-person visits four times a month and spoke on the phone once or twice weekly. Bob is no longer considered to be house-bound. He and Brian go out regularly. In Brian's words:

*Bob has lived in Ballard for eight years. The first five years he spent all his time caring for his very ill wife May. May died three years ago and Bob hadn't really gone anywhere since. He lives within three-quarters of a mile of the Ballard Locks and had never been there. Since I have been visiting Bob, we have walked to the Locks and had dinner together, taken two cruises with ElderFriends, gone to see "A Christmas Carol" with outing tickets from ElderFriends, had pizza picnics on the common outdoor area at his apartment and taken drives. We went out to Winlock,*

*Washington because he wanted to look for the farm his family lived on 30 years ago. Bob now gets out, unlike the seven years before we met. I look forward to many years of weekly visits with him." ... Brian Pankow.*

Their friendship exudes a mutual exchange of respect and trust. Both men have expressed their gratitude to ElderFriends for introducing them and supporting their friendship. They anticipate having a lifelong friendship.

### Conclusion

ElderFriends offers a model for positive action in cases of isolation and associated problems. The newly launched ElderFriends program in Richmond has halfway met its 2006 goal of 12 matches, currently supporting six elders and friendly visitors. We are in the process of matching an additional four volunteers with isolated elders from the Family Lifeline program. ElderFriends is constantly seeking new volunteers and isolated elders to serve. We provide training sessions for volunteers regularly and monitor partnerings in order to maximize the benefits of the intergenerational relationship. For more information, to refer an older adult, or to volunteer, please call (804) 828-6059 or email [elderfriends@vcu.edu](mailto:elderfriends@vcu.edu).

### Study Questions

1. What are some common problems associated with social isolation?
2. What impediments might a friendly visitor program face?
3. How does friendly visitation play a role in preventative healthcare?

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### About the Authors



Kiersten Seeger Ware has been in the nonprofit and education fields for the last 16 years.

Prior to her appointment at VCU as director of administration and faculty member for the Theatre Department, Kiersten founded and directed ElderFriends in Seattle, Washington. Her work with ElderFriends earned it the "Best New Organization Award" in 2000. She is currently enrolled in the VCU Master of Science program in Gerontology.

Sarah Coble is the part-time Advocate Coordinator for ElderFriends. She is a master level student in VCU's Gerontology Program. Ms. Coble runs the day-to-day ElderFriends operation. Ms. Coble has a BS in Gerontology from Missouri State University and has worked locally at the William Byrd Community House as a Senior Program Assistant.

## Editorials

### From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

#### *A Midyear Appraisal*

The extraordinary delay in passing a budget for the Commonwealth, just signed by the Governor June 30th, the day before the new fiscal year, caused me to think long and hard about our own stewardship of state dollars, or General Fund (GF) appropriations in legislative parlance. New geriatric training responsibilities that will accompany new GF appropriations added further to this introspection. So, what have we done and what will we do with our allotment?

As many know, we try to leverage our appropriations through partnerships with other organizations and we try to fill niches where our expertise and a previously insufficient focus on that issue meet. In this way, we can bring expertise and multiple resources to subjects in need of attention. Here's a sample of what we've been doing so far this year.

#### **Domestic violence in later life.**

Domestic abuse, exploitation, and family violence deserve and receive public attention but too little notice is taken of older women who are victims. Domestic violence shelters and interventions tend to orient toward younger women with children and older victims often do not identify with them or, indeed, may not self-identify as a victim. We have been partnering successfully for years with the Central

Virginia Task Force on Older Battered Women in conducting grant-funded training of those who work with victims. Last month, for example, we offered trainings of law enforcement officers and hospital personnel in identifying and responding to later life domestic violence, and held focus groups on sexual assault. We have jointly submitted a proposal to the U.S. Department of Justice to mount extensive trainings for judges, commonwealth attorneys, police officers, sheriff's deputies and others across several jurisdictions; Hanover County alone is involving 13 of its agencies. Once trained, participants will be the catalyst for positive ripple effects. We thank VCoA's Aly Cooper and Paula Kupstas for their leadership.

#### **Aging with lifelong disabilities.**

The Area Planning and Services Committee (APSC) that we helped to launch in 2003 has become a vital player in maximizing opportunities and creative initiatives that speak to the unprecedented aging of our fellow Virginians with lifelong disabilities, such as mental retardation or intellectual disabilities. The APSC, as a virtual organization, is using the collective energies of some 20 organizations and agencies and caregiving parents to develop social and recreational programs for these adults, training programs for caregivers and service providers, and conferences for people across different fields and different levels of responsibility. The APSC's late May conference, *The Road to Wellness: Best Practices for Persons Aging with Lifelong Disabilities*, drew almost 200 people from across Virginia to sessions on nutritional health,

preventative measures and rehabilitative therapies, and more. We also unveiled an APSC-developed assessment tool for charting the health status of these adults, as they grow older.

**ARDRAF awards.** The Alzheimer's and Related Diseases Research Award Fund (ARDRAF) is arguably the country's most effective state-funded seed grant program for dementia research. Since we began administering this competitive program in 1982, awardees have taken the pilot findings they have obtained and parlayed their small awards (averaging about \$14,000) into sizable grants from NIH, foundations, and other non-Virginia sources. Impressively, ARDRAF's return on investment is over \$11 for every \$1 of GF appropriation. ARDRAF, however, would not work so well without the remarkable gift of time and expertise that our review panels have given. Scientists, clinicians, and other professionals from across Virginia give the thoughtful analyses of proposals that enable us to select the most promising applications. Partnering with these talented reviewers, many for several years, enables us to do our work. We thank them. We list both this year's reviewers and the new awardees elsewhere in this issue.

**AARP-Virginia internships.** We announce a brand new partnership. We are pleased to be among a handful of organizations nationally that have been chosen by AARP in Washington, D.C. to

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## Editorials

### From the **Executive Director, Virginia Geriatric Education Center**

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J. James Cotter, Ph.D.

Despite a year that looked to be the worst of times for geriatric education in Virginia, we are now buoyed by reports that funds may be available from the Virginia General Assembly. You are aware that the Geriatric Education Centers across the country were de-funded by the US Congress last year. With the able leadership of Dr. Ed Ansello, Director of the Virginia Center on Aging, a budget amendment was introduced in the Virginia General Assembly to counter the loss of Federal funds with new state funds for geriatric education. The budget passed by members of the Virginia General Assembly in late June indicates success. Funding is again available for the Virginia Geriatric Education Center (VGEC) of VCU's Department of Gerontology. Our thanks go to Delegate Jack Reid and Senator Benjamin Lambert for their sponsorship of this budget amendment. I also want to thank all of you who took the time to contact your members of the General Assembly and inform them about the importance of geriatric education.

There is also good news at the Federal level. Moderate voices have reasserted themselves and funding for the Geriatric Education Centers has been reinserted in the budget bill for 2007-2008. As of this writing, the full House of Representatives has still to vote on the bill

and the Senate has not yet weighed in nor has the President promised to sign the bill. Please contact your Congressperson and advocate for full funding of the Geriatric Education Centers under Title VII of the Public Health Act. It will be a long struggle. We hope for success. And take note – the Virginia Geriatric Education Center (VGEC) of VCU's Department of Gerontology will continue to function. Our partners – Eastern Virginia Medical School and the University of Virginia – have committed to a continuing collaboration to improve geriatric education in Virginia to the best of our abilities, money or no money. And our geriatric education does continue. We co-sponsored a successful annual conference of the Virginia Geriatric Society where some 200 physicians, nurse practitioners, pharmacists and other health professionals learned about hot topics in geriatric care. We were pleased that our own Dr. Kimberly Brill of VCU's Department of Gerontology spoke about how to assess whether an older person has metabolic syndrome and the diet and lifestyle changes needed to address that syndrome. The VGEC project was also able to help support The Annual Spring Symposium of the Department of Gerontology, a joint event of VCU's Department of Gerontology and VCU's School of Social Work. This event featured the always interesting Dr. Richard Lindsay, former head of Geriatrics at UVA, as the speaker, and 60 social workers and gerontologists received training at this event.

In September 2006, a collaboration of 14 of the Geriatric Education

Centers in the US, led by the VGEC, along with the Employee Education System of the Veterans Affairs health system, will sponsor a video-conference on "The Elderly Driver." Stay tuned for more information about this training on such an important and sensitive issue. This video-conference will be free of charge, and sites will be available across Virginia and the continental US!

Other related activities that continue in geriatric education include the Department of Gerontology's ECAT (Enhanced Care Assistant Training) project to train direct care workers using an enhanced curriculum (a project funded by the Virginia Department of Medical Assistance Services) and the Department of Gerontology's training of adult day care and assisted living facilities (funded by the Virginia Department of Social Services). We want to acknowledge that the leadership of Jason Rachel, Ph.D. candidate, in both projects has led to more training throughout the Commonwealth for direct care staff of these important areas of our LTC system.

Again, thanks to Delegate Reid and Senator Lambert, our advocates in the General Assembly. The existence of funds to continue geriatric education in Virginia has renewed our enthusiasm, and it brings hope to older persons who seek well-qualified health professionals trained in aging issues.

## Editorials

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

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Julie Christopher

#### *An Integrated Roadmap for Aging in Virginia*

Virginia has a collection of agencies, organizations, and providers who offer services and supports to the aging population. But even a cursory glance at our service delivery system would reveal a tremendously underfunded, loosely connected network, offering a variable menu of services from one community to the next. Over the years, numerous studies conducted by both state government and advocates have shown that just to meet the current need, we need: more money, more providers, and more services in more communities—of course we do. The real challenge that faces leaders today is to shape realistic, but meaningful expectations for the development and funding of coordinated services and supports for a “booming” population.

If we look at the aging services network as a roadmap or infrastructure of services and supports; then it is easier to understand the role of each organization and how an integrated system can assist older individuals and their families. Let’s look at governmental agencies as the interstates; non-profit

agencies as the US Routes; faith-based organizations as the state routes, for-profit organizations as the expressways; and families as the local roads.

Government, as the interstate of aging services (or the skeleton shaping the network), should broadly cover and connect major aging services. The non-profits, US Routes, while converging on major aging services, also provide connection to population-specific or disease-specific services. Faith-based organizations add community specific services and help meet individual and localized needs. The for-profit expressways, the fastest and most flexible organizations, exist to meet the needs defined by the market. The range of aging services available from for-profit organizations is limited only by the funding to pay for them. And finally, but most importantly, are the family local roads that connect everything.

As the leader of the state’s aging agency, I am committed to meeting the challenge mentioned earlier: shaping realistic, but meaningful expectations for the development and funding of coordinated services and supports for the aging through a two-pronged approach. One prong is to define a core set of major services that are critical to the aging population, our aging interstate, then we work together to get adequate funding for those services. Yes, all of us agree with

numerous recommendations for more money and more services; but I suggest that we must prioritize what government will do. Second, I suggest that it is also critical that families are supported and incentivized to serve as primary providers of aging services. Historically families have provided the majority of support for the aging population; and most people agree that care or services provided by family members is preferable. Why not work together to develop ways and funding to support families in caring for the aging population without infringing on family and individual rights and responsibility?

You may agree completely with what I have said, you may disagree completely, or more likely, you’re somewhere in the middle. I think that it is essential that Virginia engage in this dialogue, and then move forward to advocate for and secure more funding for the development of aging services. I invite local government, non-profits, for-profits, families, individuals, and organizations of all types to let me know what you think is the priority for aging services. This fall, the Virginia Department for the Aging will be holding “community conversations on aging” around the state to gather input for Virginia’s state plan for aging services. Please participate. Come out and let me know what you think Virginia’s aging priorities should be.

## Focus on Contributing Agency Staff Members/Volunteers/Projects

### Focus on the Virginia Center on Aging

Kenneth J. Newell



Ken Newell is a long-term member of the VCoA Advisory Committee and its

current Vice-Chairman. He believes that one should enjoy the benefits earned from years of hard work, but, that once success is realized, it is important to share the rewards of the experience. In other words, it's important to "give a little back" to your school, to your community, to your profession, and to those who helped you attain your success.

Newell is the owner and senior officer of Manorhouse Management, Inc., which owns and operates full service assisted living communities for the frail elderly. His communities support aging in place as they deliver comprehensive assisted living services, including specially designed and operated programs for those residents suffering from Alzheimer's disease and other cognitive impairments. His company is a successor to Manorhouse Retirement Centers, Inc., a company that he co-founded in the mid-90's that developed, owned, and operated assisted living communities throughout the mid-Atlantic region.

Newell notes, "At Manorhouse, we recognize the importance of delivering assisted living in an

upscale, hospitality setting. However, we also recognize that we are in the health care business, and, to be successful, we must also provide our residents comprehensive assistance with their changing health care needs." Manorhouse emphasizes its health care focus in residential, home-like environments. "It's our goal to be the assisted living community of choice in each of our targeted markets. Together with personal dedication and a genuine respect for our residents, our staff consistently addresses our Company mission ... to exceed customer expectations in a unique and outstanding way," states Newell.

His management and development experience spans nearly 30 years in the health care and senior living industries, including President of Manorhouse Management & Development, Inc., assistant administrator of a United States Air Force hospital, assistant administrator of a community-owned hospital where he also oversaw the operation of a 125-bed nursing home, and administrator/CEO of a 180-bed acute care hospital. Newell credits much of his current success to the experienced management team and other dedicated professionals with whom he has had the privilege to work, for it taught him to surround himself with quality people who share values and a commitment to making a positive difference in the lives of customers and families.

Newell thanks his own family for their support and values the solid education he received from Penn State and the University of Arkansas where he obtained his undergraduate and masters degrees, respectively. As a result, Newell is committed to giving something back. He has served on the Penn State College of Health and Human Development Alumni Board and currently serves on its Development Council. He was recently recognized by Penn State with its Alumni Fellow Award, which is the highest acknowledgement given by the University to alumni. When given the opportunity, he enjoys spending time in the classroom with students, teaching or sharing his professional experiences, and serving as a mentor for students seeking a career in the health care and service industries.

Ken is married with two children and resides in Manakin Sabot. He and his wife are soon to become empty nesters. When asked about his future plans, Ken suggests that he will attempt to continue a balance between his professional efforts, his commitment to his family, and his personal hobbies and interests like golfing, boating, fishing, and riding his motorcycle. But, he adds, a part of his time will always be committed to working with students and "giving a little back" to his community and to those that might benefit from his experiences.

## Focus on Contributing Agency Staff Members/Volunteers/Projects

### New Course: The Business of Geriatric Care Management

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Care management has been part of many community programs working to help people to access services and to age with dignity and independence. A growing and diverse older population and the increasing needs of family caregivers have spurred the development of a new national business known as Geriatric Care Management.

The course, The Business of Geriatric Care Management, is for those individuals who want to learn about Geriatric Care Management as a career path or how Geriatric Care Management can enhance service delivery in existing disciplines and programs. Suitable for professional and community caregivers, this course provides an overview of the field, as well as the issues involved in establishing a business and providing services. The course will include guest lectures from a variety of health professionals who specialize in Geriatric Care Management.

#### Schedule of Topics

The Business of Geriatric Care Management is offered by the Department of Gerontology at VCU as a five-week series held on consecutive Thursdays from 4:00-6:40 p.m., beginning August 24th and ending

September 21st, 2006.

- **August 24, 2006, 4:00– 6:40 p.m.** Overview and history of Geriatric Care Management
- **August 31, 2006, 4:00– 6:40 p.m.** Conducting the Geriatric Assessment
- **September 7, 2006, 4:00– 6:40 p.m.** Ethics and Geriatric Care Management
- **September 14, 2006, 4:00– 6:40 p.m.** Geriatric Care Management with Families
- **September 21, 2006, 4:00– 6:40 p.m.** Geriatric Care Management Models of Business

#### Class Location

Senior Connections  
24 East Cary Street  
Richmond, VA 23219  
804-343-3000

#### Registration Information

Continuing Education Credit: The Business of Geriatric Care Management is 1.25 CE credits (12.5 contact hours) for the \$250, five-session series.

Deadline: August 18, 2006

Contact Katie Young, Education Coordinator, Department of Gerontology, Virginia Commonwealth University, at (804) 828-1565 or [youngka@vcu.edu](mailto:youngka@vcu.edu) to register or with any questions.

### Transitions

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We congratulate VCoA's **Connie Coogle** who is now president of the Southern Gerontological Society. She has set *Improving Elders' Lives: A Collaborative Enterprise* as the theme for the 2007 SGS annual meeting to be held in Greensboro, NC next April. We wish Connie well in her presidency.

VCoA's **Aly Cooper** is leaving us later this summer, accompanying her husband to northern Virginia where he has assumed a new job. Aly has been the day-to-day spirit of our projects on combating domestic violence, bringing seemingly inexhaustible energy to this work. Her enthusiasm and good humor have enlivened our activities and helped to strengthen our partnerships. Aly and her husband are expecting their first child this December. We wish them all the very best.

VCU's **Allison Wilder** has taken a faculty position at the Metropolitan State College in Denver and will begin teaching this Fall. She has been a vital part of the Area Planning and Services Committee on Aging with Life-long Disabilities, conducting outreach, promoting, and evaluating its work. She will finish her dissertation here on social and recreational programs for older adults with developmental disabilities. We wish her well in her life's new chapter.

## COMMONWEALTH OF VIRGINIA

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

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#### **2006-2007 ALZHEIMER'S RESEARCH AWARD FUND RECIPIENTS 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 in Richmond. The six grant awards for 2006-2007 are as follows:

**VCU Dusan Bratko, D.Sc. (Dept. of Chemistry) "Computer Screening of Amyloidogenic Protein Variants"**

Because of its ability to provide microscopic insights not accessible by experiment, computational chemistry is becoming an important tool in biophysical and biomedical research. This study addresses, through computer simulation, the molecular properties of pathological intra- or extracellular agglomerations of misfolded proteins associated with Alzheimer's and related diseases. The role of mutations that affect peptide aggregation will be inspected as well. If successful, the proposed work will represent a significant step toward the development of high-throughput computational methods to screen amyloidogenic protein variants. This understanding will assist in identifying systems conditions and protein mutations relevant for prediction, treatment, and prevention of debilitating processes involved in neurodegenerative diseases. New insights into these association mechanisms will contribute toward elucidating fundamental biophysical principles of multi-protein assembly, a key element for successful control of disease-related aggregation processes. *(Dr. Bratko can be reached at 804/828-1865)*

**EVMS Frank J. Castora, Ph.D. (Department of Physiological Sciences) "Effect of T9861C mtDNA Mutation on Cytochrome Oxidase Structure and Function"**

Mitochondria, the "powerhouses" of cells, play an important role in the development of Alzheimer's Disease (AD), and researchers are examining the mitochondrial DNA molecule for mutations that may be associated with AD. This investigator has identified a mutation (T9861C) that dramatically reduces the activity of cytochrome oxidase, one of the essential components of the respiratory chain. The current project is designed to extend this preliminary observation by evaluating the activity of cytochrome oxidase in more AD samples that also possess the same mutation. This research will also use a combination of separation techniques to determine if the mutation is changing the structure or assembly of the cytochrome oxidase complex. Evaluating the effect of this mutation on the structure and function of cytochrome oxidase may help identify how disrupting normal mitochondrial function could lead to or accelerate the development of AD. This, in turn, could provide a potential target for slowing down that inevitable progression. *(Dr. Castora can be reached at 757/ 624-2270)*

**UVA Paul Freedman, Ph.D., Richard J. Bonnie, LL. B., and Thomas M. Guterbock, Ph.D. (Department of Politics; Government & Foreign Affairs) "Voting and Dementia in Virginia Long-Term Care Facilities"**

This group of investigators will study the policies and practices that affect voting by senior citizens in long-term care settings such as nursing homes and assisted living facilities, particularly as they bear on the enfranchisement (or disenfranchisement) of residents with dementia and other cognitive impairments. The first component of the study is a multi-mode survey of staff informants from a representative sample of long-term care facilities in the Commonwealth of Virginia. The survey will be designed to collect data on registration and voting practices, with an emphasis on the measures taken (if any) to assess voting capacity of individuals with diagnoses of dementia, to promote and facilitate voting by those who are capable of doing so, and to prevent fraudulent exploitation of those who lack the capacity to vote. The second component is a vote-validation study, designed to ascertain from public records the registration status and rate of electoral participation of a sample of residents from a sub-sample of the surveyed long-term care facilities. The results will indicate which policies and practices are most effective in

facilitating voting by those residents capable of doing so, and provide the foundation for a national study. (*Dr. Freedman can be reached at 434/924-1372; Professor Bonnie can be reached at 434/ 924-3209*)

**UVA Ian G. Macara, Ph.D. and Huaye Zhang, Ph.D. (Center for Cell Signaling, School of Medicine)**  
**“The Role of Septins in Alzheimer’s Disease”**

One of the pathological hallmarks of Alzheimer’s disease (AD) is the formation of neurofibrillary tangles (NFTs), twisted tangles inside the brain’s nerve cells, which contain hyperphosphorylated tau proteins. In healthy cells, tau is attached to long strands called microtubules, which act as the cell’s “skeleton.” However, in the brain cells of AD patients, tau falls off of the microtubules and sticks together to form tangles. In addition to tau, a family of guanosine triphosphate (GTP)-binding proteins, known as septins, is also found in the NFTs. These investigators have found that septins bind with a homologue of tau that is distributed mainly in non-neuronal tissues, microtubule-associated protein 4 (MAP4), and induces dissociation of MAP4 from microtubules. The major goal of this research is to elucidate the role that septins play in regulating tau-microtubule interactions in hippocampal neurons. In addition, the study will test the hypothesis that septins facilitate NFT formation, first in cultured cells, and then eventually in vivo. These results will provide new insights into the function of septins in neuronal cells and their role in Alzheimer’s disease. (*Dr. Macara can be reached at 434/924-1236*)

**GMU Jeanne Sorrell, Ph.D., R.N. (College of Nursing & Health) and Catherine J. Tompkins, Ph.D. (Dept. of Social Work)**  
**“Ethics of Respect for Spirituality in Persons Living with Alzheimer’s Disease”**

This study seeks to answer the question, “How do members of a faith community describe experiences of spiritual connections to Alzheimer’s disease (AD)?” The investigators will implement a grounded theory methodology to explore the concepts that comprise spiritual pathways and identify categories of spiritual connections within the social context of persons with AD and their families living in a faith community. Unstructured interviews with persons diagnosed with AD, family caregivers, and members of five faith communities will elicit in-depth descriptions of participants’ experiences in three primary focus areas: 1) spiritual beliefs related to coping with AD for both persons with AD and caregivers, both in the early and late stages of the disease, 2) ways in which spirituality contributes to the overall concept of quality of life within a faith community, and 3) ways in which members of faith communities facilitate or hinder the development of spiritual connects for persons with AD and their families. Qualitative data will be analyzed to identify codes, concepts, and categories relevant to the spiritual dimensions that characterize participants’ experiences. Implications of an ethics of respect for spirituality in persons living with AD will be discussed in terms of their implications for health care practice, education, research, and policy. (*Dr. Sorrell can be reached at 703/993-1944; Dr. Tompkins can be reached at 703/ 993-2838*)

**VCU Jeffrey L. Dupree, Ph.D. (Department of Anatomy and Neurobiology)**  
**“Understanding the Role of Sulfatide in Maintaining Viable Neurons in Alzheimer’s Disease”**

Since neuronal death is the most prevalent pathology in AD, most research has focused on understanding intra-neuronal processes that regulate survival. This project, however, will investigate a class of cells whose role in maintaining viable adult neurons has been grossly ignored, i.e., the supporting glial cells known as oligodendrocytes (OLGs), best known for their role in the formation of myelin, the insulating wrap that ensures rapid nerve impulse transmission. In addition, they are almost exclusively responsible for the production of a prominent brain lipid, known as sulfatide, which is significantly reduced in the earliest stages of dementia. The investigator has recently used a mouse that is unable to synthesize sulfatide to show that this lipid is required for the maintenance of oligodendrocyte-neuron interactions. The loss of proper OLG-neuron communication induces abnormal tau phosphorylation as seen in AD. In the aged sulfatide null mice, the accumulation of phosphorylated tau results in a collapse of the microtubular network and the formation of neurofibrillary tangles, one of the hallmark features of AD. This investigator is primarily interested in the initial events that alter tau phosphorylation, and hypothesizes that the loss of OLG-neuronal interactions is one of the unknown external insults that activates tau-directed kinases and contributes to AD pathogenesis. The funded study will test this hypothesis by analyzing the accumulation of hyperphosphorylated tau and determining changes in the expression and distribution of specific tau kinases implicated in AD. (*Dr. Dupree can be reached at 804/828-9536*)

# The Impact of Medicare Prescription Drug Coverage on Dual Eligibles

by Lingda Yang  
College of William & Mary

## Background

Dual eligibles are individuals qualified to receive assistance from both Medicare and Medicaid. There are approximately 7.5 million “duals” in the United States, who are generally characterized as being over the age of 65, below the poverty level, and/or disabled (Elam, 2006). This group is considered a vulnerable population due to their poor health status and low income. They are more likely to have greater health needs and thus, tend to rely more heavily on prescription drugs (“Dual Eligibles,” 2006).

The Medicare Modernization Act of 2003 created the Medicare Part D prescription drug plan, which took effect on January 1, 2006. It is a voluntary program in which participants may purchase drug coverage through privately administered prescription drug plans or Medicare Advantage plans (“Medicare Prescription Drug Improvement,” 2006). Duals have been randomly assigned and enrolled into Part D plans. Interestingly, unlike others, duals are afforded flexibility to switch plans every month to find a plan that meets each individual’s needs (Elam, 2006). Figures have yet to be reported on the numbers of duals who are utilizing this option to alter their plans.

Extensive cooperation between state and federal officials helped to assign and enroll dual eligibles automatically in drug plans. States were required to send Medicaid files of all individuals who were known to have Medicare coverage to the Federal Government. The Federal Government then automatically assigned those individuals into plans according to the state in which they reside. This process occurred every month for a number of months in advance of the May 15, 2006 enrollment deadline. (P. Sykes, personal communication, April 11, 2006).

## Challenges

Several issues have arisen during the transition process to Part D. Some dual eligibles were not detected in the auto-enrollment process while others were unaware of their auto-assigned plan (Elam, 2006). Computer malfunctions may have been to blame in situations when individuals were actively enrolled in two prescription drug plans at the same time, which resulted in being charged more than once (Pear, 2006). Mandatory co-payments also affect dual eligibles due to their poor financial status. Many were charged incorrect cost-sharing amounts and some were unable to obtain filled prescriptions when told that their drugs were not covered (Elam, 2006). Plans that were supposed to provide transitional supplies of non-formulary medications did not do so for drugs that were covered before Part D was instituted (Smith et al., 2006). The long-term burden that pharmacies incur from reduced reimbursements has resulted in financial troubles for them because

of the slow and low reimbursements from Part D (Guerrero, 2006). Also, states have been required to help offset federal costs for Part D by paying the “clawback fee,” which is an additional financial burden. This fee was to help the Federal Government fund Part D by having each state make a monthly payment that reflected a percentage of the amount of money each state would have previously spent for duals before the new prescription drug program was implemented (“An Update on the Clawback,” 2006).

## Implications

As of April 18, 2006, more than 30 million Medicare beneficiaries were receiving prescription drug coverage from a Part D plan (19.7 million) or a creditable employer plan (10.3 million). Virginia accounted for 2.3% of this total number, with more than 709,000 enrolled in a Part D plan (see Table 1). The Department of Health and Human Services has projected that by the end of 2006, 39.1 million Medicare beneficiaries will have creditable prescription drug coverage, with 29.3 million receiving coverage from Part D and the remaining 9.8 million receiving coverage through an employer plan that is deemed creditable (Medicare Prescription Drug, 2006).

States should closely monitor dual eligibles’ health status and circumstances, as these individuals are more fragile than other groups. Nationally, there were more than 5.8 million duals automatically assigned to a prescription drug program, with Virginia accounting for 1.8% of this number. It seems

that the technical aspects of this transition have proved to be more difficult than the actual plan. However, education and outreach programs such as the Medicare Learning Network, which offers a variety of ways to obtain information and training in order to promote national consistency of Medicare provider information, provided much needed assistance for both beneficiaries and health-care professionals during the crucial transition process (“Medicare Learning Network,” 2006). In theory, Part D should provide more choices, greater control and better benefits for all Americans. Perhaps this means that once this stage is successfully completed and the major issues are addressed and resolved, the positive aspects of the Medicare prescription drug plan will become more apparent, as the key objectives begin to take full effect.

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Medicare Prescription Drug, Improvement, and Modernization Act. (2006). Retrieved March 5, 2006, from [http://en.wikipedia.org/wiki/Medicare\\_Prescription\\_Drug%2C\\_Improvement%2C\\_and\\_Modernization\\_Act](http://en.wikipedia.org/wiki/Medicare_Prescription_Drug%2C_Improvement%2C_and_Modernization_Act)

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Table 1. Medicare Beneficiaries with Creditable Prescription Drug Coverage by Type, as of April 18, 2006.

	Total Medicare Beneficiaries	Beneficiaries with Creditable Drug Coverage	Beneficiaries with Stand-Alone PDPs	Beneficiaries in Medicare Advantage with Prescription Drugs	Dual Eligibles (Auto-Enrolled in PDPs)	Beneficiaries without an Identifiable Source of Creditable Drug Coverage
United States	43,404,884	30,040,451	8,071,294	5,772,767	5,826,789	13,364,433
Virginia	1,002,150	709,824	248,489	37,304	107,440	292,326

Source: <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicare&subcategory=Medicare+Drug+Benefit&topic=Medicare+Rx+Drug+Coverage>

## Avian Influenza

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by Charlene Peters, MSA  
Executive Director, Instructive  
Visiting Nurse Association

A growing concern over avian flu has led to much talk in the media and around the water cooler, but it seems few of the major questions have been answered in regard to what will actually happen when and if a pandemic occurs.

The strain causing concern is H5N1, a naturally occurring avian flu virus common in wild birds. While it does not usually make the birds sick, they are carriers of this highly contagious virus that can make domesticated birds such as chickens, ducks, and turkeys extremely ill. It is very hard for humans to catch H5N1 in its current form. So far, there have been 186 reported cases of humans contracting bird flu, and none of these has continued beyond one person (meaning there has been no person-to-person transmission of the virus).

Limited exposure has occurred in Europe and Asia as a result of persons coming into contact with infected birds or their droppings. No cases have been reported in the United States yet.

Those who have become sick from the avian flu have been seriously ill—50% have died. What concerns doctors and scientists is that

influenza viruses are adept at changing; and if H5N1 adapts and mutates to become ready to jump from human to human, a pandemic (worldwide outbreak) seems inevitable. The new virus would be devastating, since humans have no immunity to the strain and, therefore, no protection.

Many of us have experienced the human flu and can easily recall the discomfort. Contracting avian flu will likely bring many of the same symptoms, albeit intensified: intense chills, muscle aches, nausea, and high fevers. For those who survive, getting better will take longer. The lack of human immunity to avian flu presents an increased danger (compared to human flu) for pneumonia and delirium, if left untreated. Entities such as the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, the World Health Organization, and nearly all regional health departments are sounding the pandemic alarm because the timing and conditions seem to be right, and avian flu is an unknown for us so far. The usual drugs may not be effective, the symptoms and mortality rate appear to be more severe; and, if and when person to person transmission occurs, avian flu could spread quickly.

What would a pandemic look like? It is reasonable to think that hospitals would become full, the

general workforce would be greatly reduced (some estimates have job absenteeism as high as 40%), schools and businesses may close, and necessities could become scarce. The most concrete advice thus far has been to stay home if illness strikes and to have essential items set aside at home, such as bottled water (estimate a gallon per family member per day), batteries, flashlights, battery-powered radio, shelf-stable food like peanut butter and canned goods, water treatment tablets, over-the-counter remedies, first aid items, and any needed medications. Stockpiling Tamiflu or vaccines is discouraged, as it is unknown whether these will be effective and such actions could endanger the national supply.

No one can predict when or if a pandemic might occur. In keeping with recommendations from the CDC and the Virginia Department of Health (VDH), IVNA advocates personal research, preparedness, and protection. To enhance personal readiness efforts, IVNA has put together an Avian Flu Preparedness Starter Kit that contains a sampling of masks, gloves, goggles, gown, and antiseptic hand-cleansing gel. More importantly, there is a booklet of information and instruction to aid in the process of preparing for a pandemic and how to care for your loved ones. The cost is \$20 per kit and can be ordered by calling (804) 254-6624.

## ***VCoA Editorial, continued from page 5***

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administer graduate internships for the state chapter. Interns work in communications or in advocacy with the state staff. VCoA has solicited applications and awarded its first eight-week communications internship effective early June. We shall seek applications for a 12-week fall internship shortly.

**GACA and VGEC.** Our colleague Jim Cotter notes in his editorial the success of a new relationship in a long-standing partnership. Thanks to the insight and tenacity of Delegate Jack Reid in the General Assembly, there will be GF monies available to continue geriatric training and education across Virginia. After the Congress voted to eliminate support for both the Geriatric Academic Career Awards (GACA) that helps train physicians as geriatricians and the Geriatric Education Centers (GECs) across the country that train clinicians and other professionals in many disciplines for more appropriate geriatric care in communities and long-term care settings, Delegate Reid introduced a budget bill amendment for appropriations for the VCoA to administer these much-needed programs. We thank him, Sen. Benjamin Lambert as co-patron, and members of the General Assembly's conference

committee for this commitment to older Virginians. We look forward to working with long-time friends in the VGEC and GACA programs.

## **ARDRAF 2006-2007 Awards Committee**

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We gratefully acknowledge the invaluable help of the talented reviewers in this year's competition. They make the program the success that it is. We thank, as well, VCoA's Connie Coogle and Bert Waters, for their leadership and guidance. Our thanks to: Paul Aravich, Ph.D., Eastern Virginia Medical School; Jorge

Cortina, M.D., Hampton VA Medical Center; Melissa Burns Cusato, Ph.D., UVA Health System; Kathleen Fuchs, Ph.D., UVA Health System; Douglas M. Gross, Ph.D., College of William & Mary; John T. Hackett, Ph.D., UVA Health System; Christine J. Jensen, Ph.D., College of William & Mary; Peter Kennelly, Ph.D., Virginia Tech; Richard Lindsay, M.D., UVA Health System; Merle E. Mast, Ph.D., James Madison University; Patricia A. Trimmer, Ph.D., UVA Health System; Beverly A. Rzigalinski, Ph.D., Via College of Osteopathic Medicine; and Richard B. Westkaemper, Ph.D., VCU Medical Center.

## **In Memoriam**

We note with sadness the death of Herbert Chermiside, "Chuck" to his many friends. The linchpin and Director of VCU's Office of Sponsored Programs, Chuck was for some of us an inescapable presence on campus, an indispensable cog in the wheel of grant development. He helped me many times to understand, or at least negotiate, the intricacies of submitting a competitive grant proposal to this or that funding entity. Long a fixture of the first floor of Sanger Hall, he would pull on his suspenders as he leaned back in his swivel chair to discuss or to dispense the acquired expertise and idiosyncratic perspectives that made him so valuable. He was, in addition, a man of interests, including a lifelong involvement in the Boy Scouts of America. He only recently retired from VCU. We shall surely miss him. Donations in his memory may be made to Blue Ridge Mountains Council Reservation, Boy Scouts of America, P.O. Box 7606, Roanoke, VA 24019.

## The Graying of Transgender

Tarynn M. Witten, Ph.D.,  
MSW, FGSA

My friend John, a 64-year-old female-to-male transsexual, stared at a healthcare survey he had recently been asked to fill out. It asked his gender and then gave him the choices of male and female. John looked at me and said, “I think they mean sex, but even that wouldn’t work, and even then they didn’t include the options of intersex and transsexual as a choice. Moreover, if they meant gender, then the choices should have been masculine, feminine, and transgender, at least.” John’s resignatory comment illustrates the ongoing demographic invisibility challenge that transgender individuals undergo during the course of their journey (Witten & Eyler, 1999). Couple this with the typical marginalization suffered by the elderly in the U.S., and you are faced with an emerging population of persons (Witten, 2003) who suffer from significant degrees of healthcare (Witten & Eyler, 2004) and eco-socio-political disparity and inequity (Witten, 2004ab; Witten & Whittle, 2004).

Within the worldwide older adult population, transsexuals, transgenders, cross-dressers, and other persons whose gender expression or identification is other than the “traditional” male or female represent a substantial minority group. In an era in which forecasting the health of elder populations has become more important, and where issues of

healthcare inequity (Institute of Medicine, 2003) are being touted as critical to address, discussion of quality of life issues faced by mid-to-late life transsexuals and other gender minority persons should not be deferred. It is difficult, unfortunately, to provide data-based information about many of the healthcare and related issues faced by elder transsexuals, as this group is particularly “epidemiologically invisible” (Witten & Eyler, 1999), with many of its members preferring not to reveal their natal sex, due to perceived and real risks and stigma associated with being “out.”

Transgender elders face not only the normative problems of aging but also, due to their contragender hormone use and other possible gender realignment surgeries, problems evolving from the interplay of such alterations with the normative aging processes. Confounding these biomedical processes are a constellation of psychosocial and eco-legal-political factors that further exacerbate the biomedical condition because of elevated stress, loss of social network support, loss of income, and divorce/loss of children (Witten, 2004b; Witten & Whittle, 2004).

Biomedically, little is known about the long-term effects of contragender hormones and genital or other surgery or if there are changes in morbidity/mortality risks for osteoporosis, breast and prostate cancer, stroke, cardiovascular and cerebrovascular disease, and oral health. Additionally, it is important to exercise good clinical judgment when starting a transgender journey later in life because of the potential

consequences arising from the processes of growing older. For example, smoking cessation should be emphasized due to elevated risks associated with hormone use and smoking.

Psychosocial issues pervade the life of a transgender-identified individual. Normative aging dynamics may include decline of social responsibilities, end of child-rearing, reduced income due to retirement, deterioration of physical strength and health, and a decline in social networks. These factors are magnified for trans-identified individuals, as they risk loss of economic status, loss of access to qualified services such as healthcare, and a decrease in various social support networks such as friends, family, significant others, and access to religious and spiritual organizations. During later-life transitions, individuals may be dealing with issues of shame, lack of support, and a sense of loss of “lifetime experience.”

Transgender individuals are frequently concerned with financial stability, safety, independence, living environment changes and their consequences (Witten, 2004b). Elderly transgenders must face the usual processes of case management, government support services, utilization of home health and community health services, retirement, adult day care, assisted living, and continuum of long-term care all within the context of the actual and perceived stigma/marginalization of their transgender status. Moreover, being a transgender person of color, race, ethnicity, immigrant, and/or disability or having HIV/AIDS

status may exacerbate all of the negatives further. Caregivers should be aware that these factors may relate to increased depression, anxiety, suicidality, alcohol/drug/substance abuse, and other related mental health issues.

Questions of marriage, partnership, non-traditional family structures, sexual expression, and personal rights become more complex as legal actions begin to address such scenarios (Witten & Whittle, 2004). Family dynamics change as transgendered parents are taken care of by their children. Issues of elder maltreatment, abuse, neglect, and self-neglect may arise and must be carefully monitored.

As complex as these matters are, we can best attend the needs of the graying transgender and intersex communities through a considered and holistic approach, including family, provider, and community education and the development of appropriate professional and community networks. There need to be health and social policy development on behalf of both the transgendered and the intersex elders that includes the assurance of nondiscrimination with regard to quality healthcare services, privacy, confidentiality, respectful treatment and caregiving, and personal safety.

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All of the above papers are available as free pdf downloads at the TranScience Research Institute website <http://www.transcience.org> in the Research Archives section. The author can be contacted at [twitten@vcu.edu](mailto:twitten@vcu.edu). If you are interested in participating in the research effort in support of transgender aging (as either a study participant or collaborator) or know of someone who might be, please contact the author for further details.

## Did You Know?

The Virginia Center on Aging's website features a list of videos available at no cost from their extensive lending library, links to aging-related resource, staff profiles, annual reports, *Age in Action* current and back issues, ARDRAF archives, and much more.

[www.vcu.edu/vcoa](http://www.vcu.edu/vcoa)

## Calendar of Events

### August 24-25, 2006

*Responding to Elder Abuse and Domestic Violence in Later Life.* Co-sponsored by the Richmond Police Department and the Virginia Center on Aging. Doubletree Hotel Richmond Airport. For more information, call (804) 828-1525 or [tmliveng@vcu.edu](mailto:tmliveng@vcu.edu).

### October 30, 2006

*Greater Hampton Roads Coalition on Aging 10th Annual Legislative Event.* 8:00 a.m. - 10:00 a.m. Hilton Garden Inn at Constance Wharf, 100 East Constance Road, Suffolk. The growing needs of area seniors have brought seven task forces on aging (Chesapeake, Portsmouth, Suffolk, Norfolk, Virginia Beach, The Peninsula and, as of this year, Franklin/Southampton County) to join forces and form the Greater Hampton Roads Coalition on Aging. Since 1997, the Coalition has invited legislators annually to hear and discuss proposed legislative changes to improve the quality of life for older adults in the Hampton Roads area. For more information, call Mandy Jordan at 757-846-5541.

### November 16-20, 2006

*Education and the Gerontological Imagination.* The 59th Annual Scientific Meeting of the Gerontological Society of America to be held at the Adam's Mark Hotel-Dallas, Dallas, TX. For more information, call (202) 842-1275 or visit [www.geron.org](http://www.geron.org).

### January 24, 2007

*Virginia Center on Aging's Annual Legislative Breakfast.* St. Paul's Episcopal Church, Richmond. For more information, call (804) 828-1525 or [eansello@hsc.vcu.edu](mailto:eansello@hsc.vcu.edu).

#### **Age in Action**

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**Kimberly A. Spruill, M.S.**  
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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 [spruill\\_kimberly@yahoo.com](mailto:spruill_kimberly@yahoo.com).

**Fall 2006 Issue Deadline:  
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## **Responding to Elder Abuse and Domestic Violence in Later Life: Safety, Accountability, Services, and Collaboration**

**Thursday and Friday, August 24 and 25, 2006**  
**Doubletree Hotel Richmond Airport, Sandston**

**Target Audiences:** Law Enforcement, Prosecutors, Attorneys, Judges, Health Care Providers, Social Workers, the Aging Network, Adult Protective Services, Domestic Violence/Sexual Assault Programs

**Sponsors:** Richmond Police Department, Virginia Center on Aging, Virginia Coalition for the Prevention of Elder Abuse, Central Virginia Task Force on Older Battered Women

**Speakers** include Attorney General Bob McDonnell, Chief Rodney Monroe, Candace Heisler, Peter Boling, William Lightfoot, Susan Carson, Betty Bowden, Aly Cooper, Peggy O'Neill, and more.

**Topics** include Investigative techniques; Detecting elder abuse through home visits; Forensic nursing in cases of elder abuse; Elder financial abuse and undue influence; Adult protective services investigations; Elder homicides and what we have learned; Virginia TRIAD: Empowering elders; Promising practices; and more.

**Registration:** Advance registration of \$40/person ends on August 15th. For more information, call (804) 828-1525 or e-mail Tara Livengood at [tmliveng@vcu.edu](mailto:tmliveng@vcu.edu).

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