

Case Study

Acute and Chronic Pain Challenges for Arthritis Patients in an Acute Care Setting

by Janet Bykowski, R.N.

Educational Objectives

1. Demonstrate the importance of chronic pain management in an acute care environment.
2. Discuss the special impact of co-morbidity of arthritis upon pain management intervention.
3. Provide education to clinicians, patients, and caregivers that would promote an interdisciplinary plan of care for acute and chronic concurrent pain management.

Background

In 1998, the American Geriatrics Society published clinical practice guidelines addressing chronic pain in older adults. The guidelines identified barriers and recommended practice improve-

ments to enhance routine assessment, pharmacological therapy, and non-pharmacological therapy. Recommended improvements focused on facilitating access to and delivery of optimal care for all older adults living with chronic pain. Nurses are encouraged to assess older adults routinely for the presence of chronic pain and to advocate for appropriate treatment when indicated (American Geriatrics Society, 2000). Eight years later, health-care organizations continue to struggle to implement interdisciplinary plans of care that provide comprehensive pain management for the patient suffering with chronic pain. Chronic pain is even more common than previously thought. Pain itself is rarely discussed as a condition in and of itself; it is mostly viewed as a symptom of another condition (CDC, 2006a).

Arthritis introduces a special set of conditions for pain management:

Centers for Disease Control and Prevention Background Information on Chronic Pain and Arthritis

- 10% of Americans struggle with chronic pain.
- Chronic pain is the leading cause of disability in the United States.
- 25% of adults suffered a day-long bout of pain in the past month.
- Three-fifths of adults ages 65 and older said their pain had lasted a year or more.
- Almost 1/3 of adults ages 18 and older and 1/2 of adults ages 65 years and over reported joint pain, aching, or stiffness during the past 30 days.
- More than 100 forms of arthritis exist, with rheumatoid arthritis and osteoarthritis the most prevalent forms.
- More than 33 million Americans have arthritis, 28 million of them being over the age of 45.
- By 2020, researchers project that 60 million people in the

Inside This Issue:

VCoA Editorial, 5
VGEN Editorial, 7
VDA Editorial, 8

Focus: Sung Hong, 9
ARDRAF Call for Proposals, 10
MCI Brochure, 11

Arthritis Summit, 13
New Elderhostel in Staunton, 13
Calendar of Events, 14

United States will be affected by arthritis.

- Osteoarthritis prevalence increases with age: as much as 80 percent of the population over 75 years old show radiologic signs of the condition.
- Each year, arthritis results in 750,000 hospitalizations and 36 million outpatient visits.
- Fibromyalgia is a debilitating pain syndrome that affects two to four percent of the population.

Rheumatoid arthritis (RA) is an inflammatory disease that causes pain, swelling, stiffness, and loss of function in the joints. It occurs when the body's white blood cells travel to the synovium, causing inflammation which thickens the synovium. The inflamed synovium invades and destroys the cartilage and bone within the joint. The surrounding muscles, ligaments, and tendons that support the joint become weak and unable to work properly. RA can also cause fatigue, occasional fevers, anemia, and depression (NIAMS, 2006).

Case Study

Jenny is a 52-year-old woman with severe rheumatoid arthritis and diabetes. She presented to her doctor's office with a severely infected finger from a paper cut. Jenny assumed that the nodule, swelling, redness, and pain of her finger were associated with her arthritis. As a result, she did not seek medical

attention until the finger became necrotic. After the initial hand examination, the physician immediately referred her to a surgeon for evaluation.

The hand surgeon recognized the possibility of an amputation if the infection had spread to the bone. He notified the hospital of her immediate admission and to prepare her for surgery that evening. As part of the patient intake process, a nursing assessment was conducted which included a complete medical history and listing of all medications, both prescription and non-prescription, including herbal products, vitamins, etc. As is standard of practice, all medications were discontinued prior to surgery and IV antibiotics were started thirty minutes prior to surgery.

Jenny has a history of autoimmune disease. At 18, she developed Hashimoto's thyroiditis and has taken replacement thyroid therapy for 27 years. Hashimoto's disease has been linked to many other autoimmune diseases, including rheumatoid arthritis, and diabetes mellitus (Slatosky et al., 2000). Jenny was diagnosed with rheumatoid arthritis (RA) at age 29. Her RA has been difficult to treat and she has been on many types of medications and treatments during the last 20 years in an attempt to alleviate pain and prevent disability from the disease. During the last two

years, the rheumatologist has used a multi-prescriptive approach, which has been very successful in managing her arthritis. Jenny was also diagnosed with diabetes mellitus at age 46 and is currently taking oral medications to manage this disease.

The following medications were discontinued upon admission to the hospital.

- Nabumetone, an NSAID (Non-Steroidal Anti-Inflammatory Drug) for treatment of RA. Used for pain and to reduce inflammation.
- Methotrexate, a DMARD (Disease Modifying Anti-Rheumatic Drug) for treatment of RA. Relieves painful, swollen joints and slows joint damage.
- Remicade, for treatment of RA. Slows joint damage.
- Metformin HCL, for treatment of diabetes. Helps regulate glucose levels.
- Synthroid, for treatment of thyroid disease.

The surgeon performed an incision and drainage of her finger. The finger did not have to be amputated, since the infection had not spread to the bone. The acute pain was managed through a patient-controlled analgesia (PCA) pump, which allowed pain medication to be safely administered by preprogramming of the narcotic. Post-surgery insulin was ordered to control her diabetes, since

infection increases glucose levels. Synthroid medication was resumed to control the Hashimoto's Disease. Nabumetone (an NSAID), which Jenny took twice a day, was not reordered, since NSAIDs can cause bleeding, nausea, and vomiting. Jenny usually took methotrexate once a week; on that schedule it would have been due on the night of surgery; but methotrexate, due to immunosuppressive qualities, can increase risk for infection. Therefore, Jenny did not take this medication while in the hospital or during the time she recovered at home receiving antibiotics. Remicade, another scheduled medication for her RA treatment regime is an infusion that Jenny received every eight weeks. This was due within two weeks post-surgery. Remicade is also an immuno-suppressive medication and can increase the risk for infection. Therefore, this too was counter-indicated while receiving antibiotic therapy.

During Jenny's five days of hospitalization, **acute** pain was routinely assessed with safe and appropriate interventions. However, **chronic** pain, not acute pain, was the limiting factor in mobility of her hands, knees, feet and back. She was unable to change position in bed without assistance and getting out of bed to go to the bathroom and other walking activities were difficult and painful due to joint stiffness. Limited mobility due

to stiffness, the chronic pain, and the possible long term effects of missing rheumatoid arthritis medications and treatments were contributing factors. Significantly, the interdisciplinary plan of care focused on the acute pain and recovery from surgery and infection. As part of the medication reconciliation process, the physician determined that Jenny would be discharged with pain medication, antibiotics, Metformin for her diabetes, Synthroid, and NSAIDs. Antibiotic therapy was to continue for eight weeks; consequently, methotrexate or remicade were on hold.

As a result of the disruption to her usual treatment regimen, Jenny's RA flared. Aggressive treatment, managed by her rheumatologist, required nine months to gain control and alleviate the chronic pain. Subsequently, Jenny experienced frequent absences and decreased productivity when she was able to return to work. This led to increased stress levels, which accelerated the rheumatoid inflammatory response. Additional negative outcomes included depression, financial burden, guilt from decreased productivity at work and home, ankle trauma due to unstable mobility, and falls.

It is important to remember that Jenny received standard of care for the surgery, the diabetes, and acute pain control during the

five days she was hospitalized. Review of her case identified several issues:

- 1) Though a well-educated individual, at no time did Jenny advocate for her own chronic disease management;
- 2) A rheumatology consult was omitted;
- 3) There was clearly identified a need to provide both acute and chronic pain management in an acute care environment.

Next Steps

There is an opportunity to improve pain management of hospitalized patients with a history of arthritis. Reviewing our discharge coding data at Mary Washington Hospital for one year, we found that over 5% (1300) of our patients had a comorbidity diagnosis of arthritis. Their average age was 69; there was a 2:1 ratio of women to men; and the length of stay was 4.34 days. We are developing a nurse-initiated research study that will involve a retrospective review of patients with a comorbidity of arthritis, and development of a chronic pain protocol. The hypothesis is that patients with a comorbidity of arthritis have increased levels of pain and lengths of stay as a result of inadequate treatment of chronic pain.

The *Retrospective Review* will encompass these measures:

1. Check for a completed

medication reconciliation form that would identify medications used in the treatment of symptoms of arthritis. (In January, 2006 the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) announced the implementation of the *National Patient Safety Goal #8, Medication Reconciliation across the Continuum of Care*. Medication reconciliation applies to all care settings, including ambulatory, emergency and urgent care, long-term care, home care, as well as inpatient services. A complete list of the patient's medications is communicated to the next provider of service, when the patient is referred or transferred to another setting, service, practitioner, or level of care within or outside the organization. Medications in these references include prescription, over-the-counter, vitamins, herbals and nutraceuticals, and others (Rogers, 2006).

2. Check for reference to arthritis management in the patient's medical history prior to hospitalization.

3. Check for evidence of chronic pain assessment at the time of admission.

4. Check for evidence that both acute and chronic pain management education were provided to the patient.

5. Ascertain if unmanaged chronic pain contributed to increased length of stay.

The *Chronic Pain Protocol* will include the following:

1. Staff and patient education for protocol implementation.
2. Criteria and tools to identify chronic pain upon admission.
3. Chronic pain management addressed in the Inter-disciplinary Plan of Care (IPOC).
4. Holistic approach to discharge instructions.
5. Patient and family education at discharge.

People with arthritis can become a partner in chronic pain management in an acute care setting. The goal for pain management is to meet physical, emotional, spiritual, and social needs while the person with arthritis is hospitalized. People should be aware that health care providers in an acute care setting are focused primarily on assessing and treating acute pain. Most providers ask the person to rate pain using a 0–10 subjective pain scale. However, a behavioral scale is used for patients who cannot verbalize their pain rating. Assisting the providers in differentiating between one's chronic and acute pain is essential to safe, effective treatment outcomes.

You can become a care partner by doing the following:

1. Obtain a current universal medication form, update it regularly, and give it to your clinicians.
 - a. This form is available

from the Institute for Safe Medication Practices at www.ismp.org.

b. Read the instructions for use, including the importance of keeping the form with you.

c. Include non-pharmacological interventions which have been effective in the management of chronic pain, such as relaxation techniques (i.e., deep breathing, visualization); massage; yoga or other Eastern meditation exercises; walking, swimming, other exercises, according to your body's abilities and needs; music therapy; nutrition; etc.

2. Develop a chronic pain log that includes the following:

a. The pain log should be a 0–10 scale, with 0 as the lowest pain and 10 as the worst pain. This is consistent with the pain scale used in hospitals.

b. Note how chronic pain affects your daily functions: Physical Effects: Is it difficult for you to do what you want when in pain? Are you taking pain medications even if they provide little relief? Does it take you longer to complete daily tasks such as dressing or personal grooming? Do you accept that fatigue is a limiting factor? Emotional Effects: Are you depressed, angry, or frustrated due to pain and your limitations? Do you think that other people do not believe how bad you feel? Do you feel guilty when you have to rest? Do you experience feelings of helplessness or inadequacy?

Social Effects: Are you taking more time off from work? Are you unable to plan activities that would be fun? Do you become isolated from friends and family?

3. Create your own chronic pain scale.

a. An example that includes a printable form can be downloaded from www2.rpa.net/~lrandall/print.html. Patient instructions can be downloaded from the Randall Chronic Pain Scale web page at www2.rpa.net/~lrandall/scale.html.

Study Questions

1. Do patients, professionals and employers recognize and understand the negative outcomes of untreated chronic pain?
2. What are some of the system barriers that compromise chronic pain management in an acute care setting?
3. What steps can adults with arthritis and family caregivers take to become partners in pain management?

About the Author



For the past six years, Janet M. Bykowski, R.N., has been the Pain Management Clinical Manager for the Department of Nursing at Mary Washington Hospital (Medicorp Health System), Fredericksburg. Prior to this, Janet managed the

Oncology Unit for 12 years and helped launch the first Palliative Care Unit in a community hospital. Actively nursing for 45 years, Janet has received certifications, honors, and awards, including the Virginia Nurses Association Research Poster Award for "Pain Management Evidence Based Research." She is a member of the editorial board of the *American Journal of Hospice and Palliative Medicine*.

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Editorials

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

Edward F. Ansello, Ph.D.

The Good Got Better in 2006

This past year was significant for several breakthroughs, including great progress in our work on **Domestic and Sexual Violence in Later Life**. This fall VCoA was awarded a three-year \$429,000 federal grant from the Department of Justice to train law enforcement officers, prosecutors, and judges around metro Richmond to better recognize, investigate, and prosecute cases of elder abuse, neglect, and exploitation, including domestic violence and sexual assault against older persons. This initiative activates an extensive formal collaboration with VCU Police

Editorials

and over a dozen organizations. VCoA's existing grant-funded initiative on domestic violence and sexual assault in later life, called V-STOP (Virginia Services, Training, Officers, Prosecution), was refunded and has expanded statewide due to grant support from the Virginia Domestic Violence Victim Fund. Dr. Paula Kupstas directs these projects and we are pleased to have hired Lisa Furr, formerly a community educator at Safe Harbor in Henrico, to staff them.

Workplace Partners for Eldercare. VCoA is partnering in this project, funded by Richmond Memorial Health Foundation, and directed by Senior Connections: The Capital Area Agency on Aging, to develop successful local methods of offering assistance and support to employers who want to help their caregiving employees. We have 14 companies engaged, including E.I. Du Pont, Bon Secours, Troutman Sanders, Chesterfield County Government, and VCUHS, these employers representing in sum more than 21,000 employees. VCoA is conducting project evaluation; Dr. Connie Coogle and Bert Waters are central to this project.

The Alzheimer's and Related Diseases Research Award Fund (ARDRAF). VCoA administers for the Commonwealth this nationally-cited seed grant program for innovative

lines of inquiry into causes, consequences, and treatment of dementing illnesses. ARDRAF continues to spur practical applications, insights in basic science, further research, and an influx of grant monies into Virginia from federal and foundation sources. Because of increases in appropriations by the General Assembly last year, we received 20 full applications and awarded six \$30,000 grants for 2006-2007 after the third party review process in June. (See www.vcu.edu/vcoa/ardraf.htm for a list of 2006-2007 awardees and past project summaries).

VCoA's VCU Elderhostel. With lifelong learning program locations at Richmond, Natural Bridge, and Hampton, we are part of the Elderhostel, Inc., network of program providers in North America and more than 100 other countries in the world. Our program is in the top 20 in enrollments among some 900 across the nation. In 2006, we conducted 24 programs at Natural Bridge, 14 in Richmond, and one in Hampton Roads, with a total of over 1100 older learners coming to Virginia. Dr. Jane Stephan and Catherine Dodson direct our lifelong learning initiatives.

The Lifelong Learning Institute (LLI) of Chesterfield County. This public-private community engagement partnership of VCoA and Chesterfield

County grew substantially in 2006, as we welcomed additional members coming from the Senior Center of Richmond at Chesterfield, which ceased operations unexpectedly this summer. Over three terms this calendar year, we offered more than 120 courses, plus special lectures and events, for some 330 LLI members. Debbie Leidheiser is Director.

Geriatric Training and Education (GTE). The General Assembly appropriated \$375,000 annually to help develop geriatric expertise among practitioners, from direct care workers in long-term care to clinical geriatricians; this support allows continuation of important work by the Virginia Geriatric Education Center (VGEC) consortium and the Geriatric Academic Career Advancement (GACA) programs; the former involves colleagues at VCU, UVA, and EVMS, while the latter provides sustained support over years to develop geriatric research and teaching capacities among physicians. VCoA administers this appropriation.

Ageing with Lifelong Disabilities. Our multi-agency coalition, the *Area Planning and Services Committee*, constructed a health screening protocol for establishing baseline and progressive status with age for adults with lifelong disabilities, relative newcomers to the

Editorials

experience of later life. This year's collective focus will be on maintaining and improving health with lifelong disabilities; the APSC is currently developing a manual and a DVD on nutrition and meal-preparation for adults who live in group-homes or with aged caregiving parents and planning a regional conference on June 11th.

We wish you a productive 2007.

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

J. James Cotter, Ph.D.

In the past few issues I have talked about the dismal state of support for training of health professionals in the care of older persons. Finally, I have good news to share. The VGEC, with funds from the Virginia Center on Aging, is moving forward on a new initiative to improve geriatric care in nursing facilities.

Who is the most important staff person in a nursing home – the administrator, the nurse managers, the direct care staff, the medical director? We think all of them need to be involved in any effort to improve the quality of care. Our new project seeks to enhance skills at each level. The VGEC has these objectives:

1) To develop, implement, and refine training for direct care staff in nursing facilities in the areas of skills in professionalism and communication as part of a health care team; 2) To develop, implement, and refine training for nurse managers in nursing facilities in clinical areas such as cognition/dementia, end-of-life care, and nutrition, with an emphasis on how to inspire and manage a care team to achieve superb care; 3) To develop, implement, and refine training for nursing home administrators in culture change and its application to nursing facility operations and management; 4) To train community physicians, working with Peter Boling, MD and his staff at Virginia Commonwealth University, to improve their skill in dealing with geriatric clients; and 5) Working with community partners, such as the Virginia Geriatrics Society, the Virginia Association for Home Care, the Virginia Primary Care Association, and the Virginia Association of Free Clinics, to extend geriatric training to health professionals who are working in alternative and underserved settings.

Training will be held throughout Virginia, but we will work most intensively with seven nursing facilities in the Charlottesville area. At these facilities we will involve all levels of staffing and management in the same facility, thus capturing a synergy of

training effects on quality. The VGEC will rely upon Kathy Fletcher, MSN, and Jonathan Evans, MD, of the University of Virginia for this component. In Hampton Roads, meanwhile, Dan Bluestein, MD, of Eastern Virginia Medical School will lead efforts to improve cultural competency among geriatric services providers and to investigate the ability of older patients to work more proactively with their physicians to support their care.

The project also includes an extensive and rich evaluation that will help us determine the type of training that works best in the Virginia long-term care environment.

So I'm happy that I can finally share a positive outlook on our ability to enhance geriatric education for providers who serve older Virginians. I want to end with a thanks to Dr. Ansello and Dr. Coogle of the Virginia Center on Aging who worked extensively with the VGEC to craft a proposal that will result in real improvement in long-term care in Virginia.

Correction

Some copies of the fall 2006 issue of *Age in Action* contained a typographical error in the box on page 6 showing how to calculate one's BMI. The example's math should have read: 157 divided by 65x65 = 0.037.

Editorials

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

Julie Christopher

Community Conversations on Aging: The Virginia Department for the Aging is “Taking the Pulse” of Local Concerns

I have begun visiting various local communities as part of this Department’s statewide “Community Conversations on Aging” information exchange initiative to solicit feedback from the public. The initiative provides opportunities for older Virginians and their families, as well as local business, education, and legislative leaders, to address the needs of today’s aging population while sharing their vision for the growing aging baby boomer population. The information gathered in these meetings will be used by the Department as part of its overall plan to identify, fund, coordinate, and advocate for the delivery of services and programs for older Virginians. Information received during these events will also become a component of Virginia’s State Plan for Aging Services covering the next four years.

It is essential that the Department engage in this dialogue so that it can move forward to

advocate for the development of aging services. I am inviting local governments, non-profits, families, individuals, and organizations of all types to share their local priorities for aging services. This will allow me to take the “aging pulse” of the Commonwealth. The Department is committed to meeting the challenge of shaping realistic, but meaningful, expectations for the development and funding of coordinated services and supports for Virginia’s aging baby boomer population; and these Community Conversations will help identify needs at the grassroots level.

We have already held three Conversations this fall, and will soon schedule an additional six or seven for the spring of 2007. Conversations will be held in Southwestern Virginia, Northern Virginia, Southside Virginia, and Tidewater Virginia.

Each Conversation will feature remarks from three community leaders: a member of the General Assembly or local Board of Supervisors, a business person, and an educator. These leaders will spend a few minutes sharing their concerns about the impact of the aging population on their communities and on Virginia and will include their suggestions for how the Commonwealth should begin to prepare for this impact. Partici-

pants will be divided into small discussion groups to list their concerns and their suggestions for how Virginia can prepare for growth in the older population.

I have already held Community Conversations in Norfolk at the Norfolk Senior Center, in Newport News at the First Baptist Church, and in Northern Virginia at the Cascades Senior Center in Sterling. More than 250 persons participated in these sessions and have identified the following overarching issues:

- The need for additional federal, state, and local funding for programs and services to assist older Virginians to remain independent in their own homes and avoid more costly nursing home care;
- The high cost of long-term care services that keep individuals and families from seeking the support that they need; and
- The need to plan for the aging of the Baby Boomers.

I will soon announce the dates for the Spring Conversations and encourage you to plan on participating in the Conversation nearest you. It is critical that I understand your concerns and issues so that we can work together to plan for the aging of the Commonwealth’s population. For more details contact Bill Peterson at 804-662-9325 or via email at bill.peterson@vda.virginia.gov.

Focus on Contributing Agency Staff Members/Volunteers/Projects

Focus on the Virginia Center on Aging

Sung C. Hong, Ph.D.



Dr. Sung Hong joined the VCoA as a social researcher last spring.

In his most recent assignment, he and Dr. Coogle are mining the National Gambling Impact and Behavior Study for data on the older adult population. They are examining potential connections between at-risk gambling, alcohol abuse, and depression among older adults; as well as comparing younger respondents with those 50 years of age and older to uncover differences among those who are non-gamblers, gamblers not at-risk, and at-risk gamblers, in terms of the characteristics that constitute risk factors. Their analyses so far indicate that, although older adults are generally less likely to be problem gamblers, there are mitigating factors (e.g., depression, poor self-perceived health status) that contribute to more serious gambling among particular groups of older adults.

Sung worked at VCoA previously, with Drs. Coogle and Osgood on the *More Life to Live* project funded by the State of Delaware to develop and

implement a model education program aimed at helping elders to substitute healthful behaviors for such harmful behaviors as gambling and substance abuse. At that time, he was pursuing his Ph.D. in the School of Education at VCU, yet he compiled information on the health promotion aspects of nutrition and exercise for the project booklets and helped with the project's video/DVD. He also volunteered at ElderHomes Corp., a non-profit organization that provides housing upkeep and rehabilitation assistance for elderly, disabled, and low-income residents in the Richmond area. He became aware, first-hand, of the living conditions faced by elders in dire need of public care and help.

Sung was born and educated in South Korea, earning professional credentials in architecture. After college, he practiced architectural design, before moving to the Seoul Municipal Government and later to the National Construction Ministry to participate in city and regional planning. After a decade of practice in Korea, he came to the U.S. to pursue advanced studies in planning. Upon completing his Master degree, Sung joined architectural/planning firms in the D.C. area. He subsequently returned to Korea to teach and apply his arduously-acquired

knowledge to numerous projects. After a time, he came back to the U.S. He is a member of the both the American Institute of Architects and the American Institute of Certified Planners.

He has committed himself to new career goals in adult education and the application to older adults of his expertise in the physical environment. These days a new breed of psychologists (environmental) and design professionals (architects and interior designers) work together to redefine and formulate environments beneficial for not only persons with physical impairments but also those with cognitive impairments. These professionals believe that the environment itself can be an effective treatment.

Sung lives in Northern Virginia with his wife Chung (music director at a Catholic church in Fairfax County). They are very proud of their three grown children: Theresa (consultant to the Smithsonian, educated at Dartmouth/Yale), Andrew (software consultant, MIT/MIT), and John (architect, UVA/Harvard).

COMMONWEALTH OF VIRGINIA

Alzheimer's and Related Diseases Research Award Fund

THE VIRGINIA CENTER ON AGING VIRGINIA COMMONWEALTH UNIVERSITY

- Purpose:** The Commonwealth of Virginia established the Award Fund in 1982 to promote research into Alzheimer's and related diseases. Because of a commitment to program balance, the Fund encourages scientifically rigorous applications from a broad spectrum of disciplines. Studies may involve:
- (1) the underlying causes, epidemiology, diagnosis, or treatment of Alzheimer's and related diseases;
 - (2) policies, programs, and financing for care and support of those affected by Alzheimer's and related diseases; or
 - (3) the social and psychological impacts of Alzheimer's and related diseases upon the individual, family, and community.
- Funding:** The size of awards varies, but is limited to \$40,000 each. Number of awards is contingent upon available funds.
- Eligibility:** Applicants must be affiliated with colleges or universities, research institutes, or other not-for-profit organizations located in Virginia. The Fund encourages partnerships between community-based agencies/facilities and academic institutions.
- Schedule:** We request a non-binding letter of intent with tentative title, non-technical abstract, and a four - five sentence description of the project in common, everyday language for press release purposes by March 2, 2007. Applications will be accepted through April 2, 2007, and applicants will be notified by June 21, 2007. The funding period begins July 1, 2007 and projects must be completed by June 30, 2008.
- Review:** Three qualified technical reviewers, one of whom is identified by the applicant, will review proposals for scientific merit. The Awards Committee will make the final funding decision.
- Application:** Application forms, guidelines, and further information may be obtained on the World Wide Web (www.vcu.edu/vcoa/ardraf.htm) or by contacting:

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Additional 2006-2007 ARDRAF Recipient Awarded

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.

An additional ARDRAF Award has been made for the 2006-2007 cycle, bringing the total number awards for this round of competition to seven.

ODU Sheri R. Colberg, Ph.D., FACSM, and colleagues (Department of Exercise Science) "The Relationship among Alzheimer's Disease, Dementia, Diabetes, and Physical Activity Status"

Diabetes increases an individual's risk of developing AD and other forms of dementia (e.g., vascular), while regular physical activity has been shown to lower this risk. The purpose

of this study, therefore, is to examine the relationship among cognitive status, exercise status, and type 2 diabetes or impaired fasting glucose. The investigators will study 150 people, ages 50-85, half with and the other half without diabetes, using a battery of tests, including two cognitive tests (Mini-Mental Status Exam and the St. Louis University Mental Status exam), a depression scale (the Even Briefer Assessment Scale for Depression), physical activity (Harvard Alumni Physical Activity Questionnaire) and activities of daily living (the Modified Barthel Index) questionnaires, and various metabolic tests (fasting insulin, glucose, glycated hemoglobin, C-peptide, cholesterol, tumor necrosis factor-alpha, and more). The primary goal is to determine whether regular exercisers have a better cognitive status compared with non-exercisers, and, more importantly, if subjects with diabetes who are regular exercisers have better cognitive function than sedentary diabetic (and even possibly non-diabetic) subjects. These findings would indicate that the enhanced risk of developing AD or dementia due to diabetes or impaired glucose metabolism can be, at least partially if not fully, offset by the AD risk reduction conferred by regular physical activity. *(Dr. Colberg can be reached at 757/683-3356 or 4995)*

Mild Cognitive Impairment (MCI): What do we do now?

A research-based brochure based on interviews with 99 families across Virginia.

Prepared by the Center for Gerontology at Virginia Tech.

- What is MCI?
- Recognizing signs and symptoms
- How to cope with the challenges
- Strategies to compensate for memory loss
- Reactions to having MCI
- Strategies for family and friends
- Strategies for care partners

Limited quantities of the brochure are available free of charge and may be obtained by contacting the Center for Gerontology at gero@vt.edu.

An electronic copy of the brochure is available on the Center website at www.gerontology.vt.edu/resources/index.htm

This project was supported by a grant from the Alzheimer's Association (IIRG-03-05926)

DaVinci Conference in Okinawa



A select international group of about 80 academicians, health practitioners, elected

officials, business leaders, and elders will meet in conference in Okinawa, March 1-4, 2007, to continue their work on redefining and “re-imagining” the field of gerontology, with the aim of introducing the study of aging into several Southeast Asian nations. VCoA’s Ed Ansello has been invited to attend. Participants in the DaVinci Kigatsuku Conference have set for themselves the formidable tasks of improving “ways of knowing” human aging and constructing an educational curriculum to communicate this reformulation. Conference Director, Dr. Ryo Takahashi of Nippon Care-Fit Services Association, explained that participants will begin developing a multidisciplinary curriculum with broad, international applications at this conference in Okinawa, home of some of the world’s oldest humans, people who have aged in a style or manner that is exceptional.

The curriculum redefines gerontology (the study of aging), by adding to the five senses (seeing, hearing, touching,

smelling, and tasting) a sixth sense that’s roughly the spiritual sense. Dr. Takahashi states, “We redefine gerontology through education of the heart, changing the concept and experience of aging, what it means to be old or to interact with others who are old. Kigatsuku, in Japanese, refers to the emotional-heart centered way of knowing, a kind of emotional intelligence.”

The conference will begin with an explanation and exploration of how to think like Leonardo DaVinci, an extraordinary artist and inventor; how to become open to receive, to reflect, to go beyond a single discipline or perspective. After the plenary opening session, the conference sessions are organized along a 4x3 matrix of four Focal Points and three Universal Vectors, the latter operationally defined as elements of influence that exist in most every contemporary nation. The Focal Points are: Person, Family, Community, Society. The Vectors are: Education, Business, Communication/Information Technology. Each of 12 sessions in the conference addresses how a vector affects a focal point with respect to achieving the potential in aging.

Dr. Takahashi expects to hold subsequent conferences in India and elsewhere in this revolutionary approach to better understanding of human aging.

Hold This Date: June 11th

The Area Planning and Services Committee (APSC) on aging with lifelong disabilities is hosting another annual conference. These have been excellent forums for creative thinking, best practices, and insights into the problems and potential solutions associated with the new experience of growing old with lifelong disabilities. The APSC brings to the table diverse expertise from over a dozen community organizations in health care, recreation and leisure, mental retardation, adult services, higher education, and more, all meaningfully complemented by members who are family caregivers.

This year’s conference at the Holiday Inn - Koger Center in Richmond on June 11, 2007 will focus on health and nutrition for older adults living in group homes or with their families. Dr. Dawna Mughal, Director of the Dietetics Program at Gannon University in Pennsylvania, will be the conference’s keynote speaker.

Details are still developing, but pencil in this conference as something not to miss!

Arthritis Summit May 2007

The Virginia Arthritis Action Coalition, a partnership of numerous community-based organizations across Virginia, is hosting its second statewide summit, **May 11, 2007** at the Marriott West Hotel, Innsbrook, in Richmond. This summit offers a forum for up-to-date information and practices about arthritis, the most common chronic condition in America among older adults. The summit will offer two tracks, health care professionals and lay health care, recognizing that much of chronic care is in the hands of the family and friends of people who have any of the more than 100 conditions that fall under the umbrella of “arthritis.”

Summit topics include Pharmacological Therapy, Dealing with Pain Management, Adapting Your Environment, Maintaining Healthy Joints, Managing Self-Healing through Water, Fibromyalgia: The Invisible Arthritis, Breakthroughs in Joint Replacement Surgery, and much more. There will be exhibit tables, opportunities for questions and answers, and interactions with expert panels.

For more information, please contact Mary Casebolt, Mary Washington Hospital, at (540) 741-1751 or mary.casebolt@medicorp.org.

VCoA Launches Elderhostel in Staunton

Why not treat yourself to a “spring break” that’s close to home but far enough away to feel like an escape?

Dr. Jane Stephan, VCoA’s Assistant Director of Education, is pleased to announce an inaugural series of Elderhostel programs this spring in Staunton, the product of collaborations between VCoA, the American Shakespeare Center, and other organizations and businesses in the heart of the Shenandoah. Older learners from Virginia and across the country will be able experience something extraordinary by attending an Elderhostel in Staunton. Entitled **The American Shakespeare Center: Blackfriars and the Bard**, these programs revive the thrill of the Renaissance stage and recover the joy of language at the Blackfriars Playhouse, the world’s only re-creation of Shakespeare’s original indoor theatre.

Elderhostelers will study two of Shakespeare’s plays at the American Shakespeare Center and attend two full evening performances at the Blackfriars Theatre. They will engage in wordplay and swordplay, learn about staging and make-believe, and go behind the scenes with actors and scholars. Grounded in

an academic model of lifelong learning, Elderhostelers will delve deeper into the Bard’s life and work to examine enduring themes of love, hate, jealousy and madness in his classic plots of misadventure, treachery, secret trysts, satire, comedy and tragedy – and they will enrich their understanding of the original meanings of words and phrases that are now part of everyday vocabulary, as they discover the delights of “speaking Shakespeare.”

Elderhostelers will make full use of Staunton’s resources, lodging in a superb guest house hotel, dining in local restaurants, walking its historic streets, and absorbing its rich cultural heritage. VCoA has conducted Elderhostel programs at sites across Virginia since 1979 but this marks its first initiative entirely in Staunton.

The American Shakespeare Center: Blackfriars and the Bard – Elderhostel program #14828 – will be offered in 2007 on April 24-27, May 22-25, September 25-28, and TBA dates in October and November. To register or to learn more about these programs, including registration information and transfer/withdrawal schedules, please call Elderhostel toll free at (877) 426-8056 Monday through Friday, 9 a.m. to 6 p.m. (Eastern Time) or at www.elderhostel.org.

Calendar of Events

February 1-2, 2007

For the Common Good: What Role for Social Insurance? Conference on Social Security, Medicare, and retirement security, sponsored by the National Academy of Social Insurance, to be held at the National Press Club, 529 14th Street NW, Washington, DC. For information, call the National Academy at (202) 452-8097 or contact Johanna Gray at jgray@nasi.org.

March 1-4, 2007

Mentorship: The Dyad, Triad, and Beyond. 33rd Annual Meeting and Educational Leadership Conference of the Association for Gerontology in Higher Education to be held at the Hilton Hotel, Portland, OR. For information, call Jennifer Mendez at (313) 577-2297 or j.mendez@wayne.edu.

March 16-18, 2007

Care of Our Oldest Old. Virginia Geriatrics Society Conference to be held at the Williamsburg Lodge, Williamsburg. Conference contains 20 hours of physician Category 1 CME, nursing, and pharmacy CE credits. For information, visit www.virginiageriatrics.org.

March 19-20, 2007

Palliative Care Leadership Center (PCLC) Training. Focus on finance, design, marketing, and operation of palliative care program, sponsored by the

Center to Advance Palliative Care at Massey Cancer Center of VCUHS in Richmond and held at different sites. For information, call Carrie Cybulski at (804) 628-1918 or ccybulski@vcu.edu.

April 19-20, 2007

The Golden Years, Domestic Abuse and Displaced Homemakers. Conference sponsored by the Family Violence Program, Inc. of Pitt County to be held in Greenville, NC. For information, call (252) 758-4400 or smunzer@pittfvp.org.

April 23-24, 2007

Joint Conference on Guardianship, Elder Rights, and Disability Services. Conference sponsored by the Virginia Guardianship Association, the Virginia Elder Rights Coalition, and the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services, to be held at the Omni Hotel in Charlottesville. For information, call Joy Duke at (804) 261-4046 or joyduke@msn.com.

May 11, 2007

Living Well with Arthritis.... You Can. Arthritis Summit sponsored by the Virginia Arthritis Action Coalition at the Marriott West Hotel in Richmond. For information, call Mary Casebolt at (540) 741-1751 or mary.casebolt@medicorp.org.

May 31-June 1, 2007

13th Annual Conference of the Virginia Coalition for the Prevention of Elder Abuse to be held at the Virginia Beach Resort and Conference Center. For information, call Ed Ansello at (804) 828-1525 or eansello@vcu.edu.

June 11, 2007

Aging Well: Health and Nutrition with Lifelong Disabilities (tentative title). Conference sponsored by the Area Planning and Services Committee (APSC) to be held at the Holiday Inn – Koger Center, Richmond. For information, call Tara Livengood at (804) 828-1525 or tmliveng@vcu.edu.

Age in Action

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