Volume 26 Number 1 Winter 2011

age in action

Activities in geriatrics and gerontology education and research
Virginia Center on Aging
and
Virginia Department for the Aging

Case Study

The Impact of Providing Rehab Mobility Equipment to Those in Need

by Bruce Stelmack, DO, MSc
& Brian Leitten, JD, MBA, MEng

Educational Objectives

1. Discuss the need to provide rehabilitation mobility equipment at no cost to those who have no other means to obtain it.
2. Assess the impact on a community when mobility equipment for underinsured impaired persons ("at risk") cannot be secured.
3. Describe a successful recycling program that provides free rehabilitation mobility equipment.
4. Explain the importance of a community-based model to provide rehabilitation equipment.

Background: The Need

Throughout the United States, a growing number of individuals and families are uninsured or underinsured. In Virginia alone, over one million citizens are uninsured, including over 820,000 adults (Cook, Kenney, & Lawton, 2010). As the economy continues to worsen, the problem grows. In this population, many individuals are attempting to recover from serious illnesses or injuries. The lack of adequate insurance presents serious challenges. Not the least of these challenges is the attempt to secure rehabilitation equipment that they need to become mobile again and get back to active roles in their communities and recover from their setbacks. Mobility equipment can make the difference between a person being disabled or being impaired, a difference in quality of life that is priceless.

An informal survey by FREE (Foundation for Rehabilitation Equipment & Endowment) of social workers, therapists, and case managers in the Roanoke, Virginia, area revealed that one in three individuals returns home after hospitalization without a prescription for needed rehabilitation equipment, due to limited resources or insurance limitations. Many fail to reach their maximum rehabilitation potential because of difficulties in acquiring needed mobility equipment. Often, they are forced to choose among competing needs, such as medications, rent, utilities or other life necessities, and the mobility equipment.

Historically, the mechanisms in place to address this problem have been haphazard at best. Often, churches will set up "equipment closets" to store small amounts of rehabilitation equipment that is donated by members of the congregation. The programs are typically known only to the particular congregation and only partly serve the needs of those in the congregation. Equipment is likely not well sanitized and repairs are minimal. When a specific piece of equipment needs to be fitted to the user, the closest piece is typically deployed. Some volunteer groups have attempted similar "equipment" projects, but organized, community-wide programs run by medical professionals are not the norm.
In the past few years, more extensive programs have cropped up in several states. In 2006, the U.S. Department of Education sponsored a "National Pass It On Conference on the Reutilization of Assistive Technology" in Atlanta, GA (Pass It On Center, 2010). For the first time

Inside This Issue:

on a national level, participants came together to discuss issues related to reuse programs, including liability, training, cleaning, repair, transportation, marketing, evaluation, and program sustainability. Programs from several states were showcased. FREE was invited to be the first presenter at the Conference. As a result of the conference, the Department of Education awarded several state-level equipment reuse grants, including o to a Virginia consortium led by The FREE Foundation (Virginia Assistive Technology System, 2010). FREE partnered with the Virginia Department of Rehabilitative Services and the Virginia Assistive Technology System to build a statewide network to provide rehabilitation equipment to persons in need.

The Impact

When at-risk citizens cannot secure the rehabilitation mobility equipment they need to fully recover from injury or illness, the impacts on the community in which they live are significant. At the individual level, people who cannot completely recover cannot live the full lives that they are entitled to. They lose a level of personal independence; they need to depend on family, friends, and others in the community for their well-being; and they risk not being able to return to their earlier employment. Spouses, parents, and other family members may have to cut back or completely quit their jobs, in order to stay at home and provide care. If this kind of support is not available, those at risk may have to leave their homes and move to a facility that can provide a higher level of ongoing care, (e.g., a skilled nursing facility or nursing home). The psychological, social, and financial impacts on both those at risk and their families can be immense.

In addition, the community at large often bears the financial burden of this failure. At-risk individuals who do not have the proper equipment are much more likely to suffer falls, need emergency room services, and require hospitalization. Since the at-risk population, by definition, does not have adequate insurance, these costs are shifted to the healthcare providers, the government, and the community. Available data from 2005-2007 showed the following costs, which, of course, are now greater:

The average daily cost of a hospital stay was $1,149 (American Hospital Association, 2006)

The average cost of an emergency room visit was $2,153 (Agency for Health Care Information, 2009)

The average annual cost of a stay in an assisted living facility was $35,616 (MetLife, 2006)

The average annual cost of a stay in a skilled nursing facility was $74,095 (MetLife, 2005)

Falls that result in emergency room (ER) visits and extended hospital stays quickly add up to substantial dollars. The need to move someone to an assisted living facility (ALF) or a skilled nursing facility (SNF) simply because they do not have the appropriate equipment to stay at home, results in enormous incremental and unnecessary costs. Often, the system ignores the logic of spending a small amount of money for equipment, to avoid a huge cost in care.

FREE's Successful Reuse Program

With the support and hard work of a group of therapists and healthcare professionals, FREE was launched in 1998 to help individuals meet and overcome these challenges by providing them with the rehabilitative equipment that would enable independent and productive living. FREE's mission is to help provide mobility related rehabilitation equipment to maximize functional independence and improve quality of life. Two thirds of the recipients who receive equipment gifts from FREE are 55 years of age or older. All devices that FREE donates are repaired, cleaned, and sanitized and gifted to those in need; devices include wheelchairs, walkers, power chairs, bathroom assistive devices, canes, lift chairs, hospital beds, crutches, shower chairs, transfer benches, and more . Trained professional volunteers insure that the correct piece of equipment is gifted and that devices requiring it are properly fitted. Volunteer members of FREE also raise funds, receive and process applications, promote the service to the community, and oversee the operations of several chapters throughout Virginia.

Recycling lightly used equipment is one of the keys to the success of FREE. Originally, FREE purchased and distributed new equipment. However, the cost of new equipment was simply too prohibitive and the foundation could not leverage the funds available to it

sufficiently to meet the needs of those at risk. We reached out to the community and found a wealth of equipment that was no longer being used that people were willing to donate. We forged a strong partnership with Goodwill Industries International, Inc. Their donation centers became drop off points for equipment. They gave us space at one of their locations to sort, store, and process the donations. Versions of this model have now been deployed in several Virginia communities.

To confirm the impact and effectiveness of its program, FREE measures outcomes. The ability to show outcomes quantitatively has been a valuable asset to the foundation, drawing volunteer and financial support and providing an easy means to demonstrate to a community the impact that FREE will have on its at-risk population. FREE has tracked since 2002 the consequences of the donated equipment on the lives of the recipients. The results are powerful, as demonstrated by the 2009 follow up:
83% of clients served reported decrease in falls; 90% of clients served reported decrease in hospitalizations; 94% of clients served reported decrease in emergency room visits; 85% of clients served reported greater independence; and 100% of clients served reported that they were able to stay in current home environment.

The FREE Foundation recently received a national award called the "Pioneer Award" from the National AT Reuse Conference in September, 2009 (Pass It On Center, 2010), sponsored by the Pass It On Center and National Assistive Technology Technical Assistance Partnership (NATTAP); a number of programs and individuals were recognized for significant contributions to the field of Assistive Technology reuse. This award recognized FREE as a national leader in the initial efforts and ongoing success of creating and operating an assistive technology reuse program and for continued leadership in assistive technology reuse efforts on a national level. FREE opened a new chapter to serve the Richmond, Virginia, area on December 16, 2010, supported by a grant from the VCU Occupational Therapy Department and the support of Goodwill of Central Virginia. Virginia Deputy Secretary of Health and Human Services Keith Hare, Virginia Department of Rehabilitative Services Commissioner Jim Rothrock, and former Virginia Lieutenant Governor John Hager were the guests of honor. Another new chapter serving South Hampton roads is scheduled to open in Spring 2011, supported by grants from the Hampton Roads Community Foundation and the Sentara Foundation. Information can be found at www.free-foundation.org.

Brian Leitten, FREE; Jim Rothrock, Comm. DRS; Bruce Stelmack, FREE; John Hager, Former Atty. Gen.; Keith Hare, Dep. Sec. of Health, at December ribbon-cutting.

The Importance of a Community-Based Model

In 2002, FREE sought and received a grant from the Christopher & Dana Reeve Foundation, to develop and document a replicable, community-based model for a medical equipment reuse program (Christopher & Dana Reeve Foundation, 2010). Along with the funds, FREE received the personal encouragement of Dana Reeve, who recorded a Public Service Announcement (PSA) for radio for the foundation. The FREE model was developed and documented and is made available to communities interested in implementing similar programs or chapters.

The involvement of the local community is a key element of the success of the FREE model. Local volunteers make sure that the right equipment gets to the gift recipients. A physician's prescription is required to determine the appropriate equipment needed. This, and the use of local volunteers, is critically important for items like wheelchairs, power chairs, and walkers, where the wrong fit can lead to more injury. Local volunteers are familiar with the specific needs of their community and can tailor the chapter's operating model to meet those specific needs. A good mix of volunteers from the healthcare community and the general popula-

tion insures that the entire community becomes aware of the program and brings a full set of volunteer skills to the chapter, from legal, finance, public relations, and advertising, to equipment repair and delivery. FREE solicits equipment donations and financial and volunteer support from across the community.

Case Study #1

Gary M., a 59-year-old salesman, was hospitalized with spinal stenosis, a constriction or narrowing of the spinal column through which nerves travel. Arthritis of the spine was affecting his spinal cord to the point that he lost function and movement in his limbs. After surgery, Gary had weeks of rehabilitation to learn to regain use of his body and to walk again, with a long road to recovery ahead of him. At discharge from the rehabilitation center, Gary could safely walk 15-20 feet in his home. He needed a special walker with a seat that would enable him to safely ambulate, but also safely and quickly sit down if he became suddenly too tired to make it to a chair. Without this device, he would have to be admitted to a nursing facility. Now unable to work and uninsured, Gary could not afford the walker he needed. A request for the special walker was made to FREE. The foundation was able to gift a properly sized walker with a seat to him. Importantly, FREE learned that Gary lived at home with his mother. Physically, she did well; but they lived together so that Gary could make certain that she received her daily medicine and food. Without Gary at home, his mother also would have to be admitted to a nursing facility, prematurely. With the gift of this walker, FREE was able to keep a family safely together. Now Gary leads a more independent life and has recovered well. He is back to his role of a primary caregiver, driving, shopping, and doing much more. This one piece of rehabilitative equipment has meant the difference between two family members living independent, productive lives and the need to place both of them in separate care facilities at tremendous costs to the family and the community.

Case Study #2

It has been an uphill battle for Nicole C. since suffering a traumatic brain injury in a motor vehicle accident at age 13. Nicole C. had been in desperate need of a power wheelchair, but neither she nor her family had the financial means to procure one. Due to injuries sustained in the accident, Nicole is unable to self-propel a manual wheelchair and thus constantly needs to rely on assistance for mobility. Nicole lives in a group home. Because she has required 1:1 assistance for mobility, and since staffing was not always able to provide this, she has been limited in the number of outings in which she could participate. As a teenager, she sees going out and about and participating in group activities as an important part of her quality of life. In 2009, when Nicole C. was 19 and a senior in high school, her special education teacher and other high school staff searched for weeks, for a way to provide Nicole with a much-needed power wheelchair. After numerous internet searches, they discovered the FREE Foundation and completed an application with her. The FREE Foundation was able to fulfill Nicole's lifelong dream of having a power wheelchair fitted to her specific needs. Nicole's special education teacher said, "This power wheelchair is providing genuine happiness and independence and creating a whole new world." When referring to Nicole's future career endeavors, this teacher added, "Perhaps her mobility will enable her to get a better position. She is ready for her next adventure."

The supervisor of the group home that Nicole lives in stated that with this power wheelchair, Nicole can go everywhere in the community and lead a more normal life as a teenager. She also noted that this newfound independence has given Nicole a much greater quality of life, with her newfound ability to maneuver in the community independently, as well as to transfer in and out of the wheelchair. Nicole now plans to attend a technical school to study horticulture, for her power wheelchair will enable her to navigate campus without physical assistance.

Conclusion

Throughout Virginia and across the country, an increasing number of at-risk adults attempting to recover from serious illnesses or injuries are in need of rehabilitation mobility equipment provided at no cost. Without this equipment, many will fail to become mobile again, unable to resume active roles in their communities and fully recover from their setbacks. The absence of such no-cost equipment affects the individual, the family, and the greater community, for the person without

the equipment must rely upon others and this dependence affects their daily lives physically, socially, emotionally, and financially. Community-based, volunteer-led equipment gifting programs like The FREE Foundation in Virginia can provide solutions to this dilemma. By collecting, repairing, sanitizing and recycling gently used rehabilitation mobility equipment, FREE leverages financial and volunteer resources to get the right equipment to those in need.

Study Questions

1. What are some social and financial for individuals and communities when at-risk citizens cannot secure needed rehabilitation mobility equipment?
2. What is the value of recycling and reusing medical equipment in a gifting program?
3. How does measuring outcomes contribute to a successful equipment gifting program?
4. Why is a community-based model importance to success?

References

Agency for Health Care Information (2009). Florida Center for Health Information and Policy Analysis, Table 7, November 2009. https://floridahealthfinderstore.blob.core.windows.net/documents/researchers/documents/Emergency%20Department%202007%20Utilization%20Report.pdf

American Hospital Association (2006). "2006 AHA Annual Survey," Health Forum LLC, an affiliate of the American Hospital Association, 2006. www.conseco.com/wsc/health/hospitalinsurance.shtml

Christopher & Dana Reeve Foundation (2010). Quality of Life Grants. www.christopherreeve.org/site/apps/kb/cs/contactdisplay.asp?c=ddJFKRNoFiG&b=4423813&sid=dpISKVMxFiIMLZMzHmH&r=1

Cook, A., Kenney, G. & Lawton, E. (2010). Number of uninsured Virginians and percent adults. Profile of Virginia's Uninsured and Trends in Health Insurance Coverage, 2000-2008, prepared for The Virginia Health Care Foundation, The Urban Institute 2010. www.vhcf.org/uninsured/documents/ProfileofUninsuredinVA_1_29_final.pdf

MetLife (2006). MetLife Market Survey of Assisted Living Costs, October 2006. www.investmentnews.com/assets/docs/CI16665412.PDF

MetLife (2005). MetLife Market Survey of Nursing Homes & Homecare Costs, September 2005. www.geckosystems.com/downloads/NHHCcosts.pdf

Pass It On Center (2010). www.passitoncenter.org/NationalTaskForce.aspx

Pass It On Center (2010). National AT Reuse Conference. www.passitoncenter.org/Home/Events/ATReuseAwards.aspx

Virginia Assistive Technology System (2010). www.vats.org/atrecycling.htm

About the Authors

Bruce Stelmack, D.O., is the founding President of The FREE Foundation. A Diplomate in the American Board of Physical Medicine & Rehabilitation and a Fellow in the American College of Physicians, he is an Assistant Professor at the University of Virginia, Department of Physical Medicine & Rehabilitation. Dr. Stelmack is a rehabilitation and neurology consultant to Centra in Lynchburg, VA and maintains a private practice in rehabilitation and neurology at Rehabilitation & Neurology Consultants PC in Roanoke, VA.

Brian Leitten is the immediate Past President of The FREE Foundation and is a business and growth consultant to non-profit businesses in Port Orange, FL. He is an experienced healthcare executive and attorney, and former Vice President of Corporate Development and Technology with Hillenbrand Industries. He has led several businesses in southwest Virginia. Questions regarding this case study may be directed to Brian at http://consulting.leitten.com.

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

Edward F. Ansello, Ph.D.

The most terrible poverty

Maybe it's the darkness of the days of this season, the never-fully-robust sunshine that we've had for some weeks, that's prompting these reflections. Whatever the cause, I'm seeing the cold in some lives. The Great Recession has awakened in many of us some awareness of poverty, our own or a neighbor's. Jobs lost, houses foreclosed, plans curtailed. With unemployment levels being at their highest in years, it's natural to feel that present times are bleak. Austerity has been named the Word of the Year by Merriam-Webster. Yet the perspective of age shows that these circumstances will pass, that the high tide of economic difficulties covering the sand of our times will recede. When it does, it will uncover rocks of poverty that have been with us since before this tide and will likely remain long after. Mother Teresa described this poverty: "The most terrible poverty is loneliness and the feeling of being unloved."

The wintry beginning of a new year seems an appropriate time to recognize both lives in such poverty and our peers working to connect with these lives and end the loneliness. It seems almost facile to note that money, either its absence or its abundance, may have little to do with the poverty of loneliness. Surely we all know people with the economic ability to camouflage their loneliness with possessions, just as we know others whose lean finances seem unrelated to their rich engagement with life and others. The causes of these realities have always eluded clear delineation or generalization. Therapists, preachers, musicians, merchants, and others have long explored, and sometimes exploited, our need to connect, offering explanations, pronouncements, and remedies from their varying perspectives.

It seems to me that Mother Teresa effectively reduced the poverty of loneliness to its most basic working part, the feeling of being unloved. How does one redress this feeling? My brief time in India, the locus of Mother Teresa's life's work, exposed me to deeply meaningful actions by individuals to help those in need, including the relentless effort over decades by a determined Brahmin woman in Andhra Pradesh to establish a compound for people with intellectual disabilities, a home in which to live and work safely with others. The actions of many individuals and groups here in Virginia and elsewhere give us similar examples, although I'd wager that some I'll cite do not think of their actions as works of love. Caring, private individuals and agency employees and volunteers in "direct" or "human" services, sometimes called service providers, regularly deliver what can be called love, the antidote to the poverty of loneliness. Let us recognize them and their actions.

Friendly visitor and telephone reassurance programs offered by many area agencies on aging, communities of faith, and local organizations reach out, through face-to-face visits or by phone calls, to people who may be alone; the outreach may be the only "touch" by another in a day or week of being alone. Some 30% of all older Americans live alone physically, and unknown numbers of others are emotionally or socially alone. Therapeutic recreation programs of parks and recreation departments offer the chance for group fun and activities to individuals whose disabilities have limited their connections to others. Respite initiatives, such as relieving a family caregiver of his or her unceasing oversight of a loved one with dementia, may take an hour of the giver's time but help reestablish the recipient's connection to the outside world; clubs, congregations, health care organizations, and others often maintain lists of individuals in need of some respite or relief, and people step up unheralded to take on the role. Visitation organizations, such as ElderFriends, operated by Family Lifeline, screen, train, and pair volunteers with isolated older adults, in the hope of establishing a bond of relationship between them.

CARITAS in Richmond is a coalition of communities of faith that offers shelter and assistance to families and individuals in crisis; it began as an all-volunteer effort called "Winter Cots" in the early 1980s when that period's economic downturn and the wholesale discharge of mental health patients because of deinstitutionalization produced waves of homelessness; today some 15,000 volunteers and 150 congregations carry out the mission of CARITAS to touch others in crisis. Even purely informational efforts directed to people who may feel isolated and alone because of brain injury, domestic

violence, geographic distance, joblessness, loss of a long-term relationship, or some other reason, can serve to lessen the feelings of loneliness and being unloved. We just have to recognize the depth of value of so many underappreciated actions by those around us, here in the tide of the Great Recession.

The act of helping another to feel loved rewards the giver as well. But let's acknowledge the essential importance of people in various forms of human services, whether volunteer or paid, individual or group, who reach out to others who are alone. Trite as it sounds, the connection to another is probably what being human is all about. At the risk of sounding like a character out of Charles Dickens, we each can benefit during this tough economy from reexamining our definitions of poverty.

Invitation to Switch to E-Mail Delivery of *Age in Action*

Age in Action will be transitioning over time to an electronic version only. While we currently publish the same issue in identical print and PDF versions, we plan to move to an exclusively electronic format. If you now receive *Age in Action* as a hard copy by postal mail, please consider switching to e-mail distribution. Just send an e-mail listing your present postal address and best e-mail address for future deliveries, to Ed Ansello at eansello@vcu.edu.

From the
Interim Commissioner, Virginia Department for the Aging

Jim Rothrock
Commissioner, Virginia Dept. of Rehabilitative Services (DRS)

Promise and Work in the New Year

I would like to continue to focus, as in my last editorial, on some of the lessons I am learning in my role as Interim Commissioner of our Virginia Department for the Aging.

In this new role, I have been honored to serve as a board member of the Older Dominion Partnership (ODP). This vibrant organization is leading our efforts in the most important accumulation of data on how our Commonwealth responds to the needs and talents of Virginians who comprise a substantial part of our Age Wave. At the last meeting of the Board, John Martin, CEO of the Southeastern Institute of Research, a key partner within ODP responsible for the surveying to gather and interpret core data, made a statement that resonated with me. He noted that too often "we" are focused on the *problems* of aging and lose sight on the *promise* of aging. I and others too often fail to appreciate the richness we can realize as the natural processes of aging occur, particularly when communities are aware of the talents of older adults and assure that barriers do not limit them.

Many of you, both Boomers and seniors, will soon be asked by ODP to offer your *two cents worth* in an important survey that will offer guidance regarding how our agency, our partners, and the Commonwealth build communities without barriers and with the supports that foster independence for those in the Age Wave. I cannot overemphasize the importance of your making the time to respond to this survey which will put our state ahead of others in planning. The survey is about ready to be released and the spring should offer an initial report on the findings. Thanks to ODP for taking this important initiative and moving it along, and thanks to John for his sage wisdom.

I was also recently in DC at a Roundtable event hosted by the Department of Labor on issues faced by older workers and workers with disabilities. The Roundtable, in which I will continue to be engaged, is identifying:

- Critical gaps in research on aging and disability;
- Important and priority federal policy and legislative changes (short term and long term) that would improve employment prospects for older workers with disabilities; and
- Immediate and longer term technical assistance that could be provided to employers, state and local policy makers and practitioners, and others.

At the end of the day, all members of the Roundtable agreed that too much is expended on keeping this growing group of Americans out of the workforce and not enough on keeping their talents in our nation's workforce. In this New Year, I am resolving to:

- Increase collaboration between VDA and DRS and other HHR agencies in order to provide older

workers and workers with disabilities more workplace supports;
• Promote assistive technology measures that make the workplace more accessible and ergonomically friendly to this growing population; and
• Support our Commonwealth's *Medicaid Works* effort to make it easier to work and receive critical Medicaid supports.

These measures, though small in some regards, may be of aid to more Virginians who wish to stay engaged as contributors to our common wealth as workers in our Commonwealth's workforce. It is also interesting to see that at the Department of Rehabilitative Services (DRS), where I am also Commissioner, there has been a solid upward trend in applications for vocational rehabilitation services. In 2001, DRS had just over 700 applicants involved in some DRS program. But a current review of the DRS rolls found more than 1,200 older Virginians with disabilities receiving vocational rehabilitation services in hopes of finding successful employment. Surely, this trend will continue and older clients will look to DRS for employment services.

In closing, we all need to resolve to be more focused on the promise of aging, contribute to the accumulation of important data to help us in responding to the Age Wave, and, finally, underscore the importance of work for all Virginians.

AAAG Issues Call For Membership

The Alcohol and Aging Awareness Group (AAAG), in partnership with the Virginia Department of Alcoholic Beverage Control (ABC), is committed to expanding its reach across the state and strengthening its mission to provide education, training, and resources on alcohol misuse among older adults. It is encouraging others to join in this mission and to become involved in helping Virginians to age successfully, safe from alcohol and medication misuse.

While alcohol misuse affects all people, statistics have shown it is a growing problem facing older adults, particularly when they mix alcohol with medications. Eighty-three percent of people over 65 take some form of medication, and almost one in five adults misuse alcohol and/or prescription drugs, according to Dr. Patricia W. Slattum, of VCU's School of Pharmacy.

In addition, age-related factors such as retirement, physical health changes, isolation, loneliness, depression and other mental health challenges make older adults more susceptible to increased alcohol consumption than other age groups.

The AAAG was founded in 2007 by the Virginia ABC to address the growing problems of alcohol misuse among older adults. This statewide coalition has also been the proud recipient of state and national level awards, including the 2008 Recognition Award for Innovative Prevention Projects from The Virginia Department of Health, and the 2008 Best Practices Award from the National Conference of State Liquor Administrators (NCSLA).

If you or your organization is interested in becoming an active member of the AAAG, please contact Regina Whitsett, AAAG Chair/ ABC Education Coordinator, at (804) 213-4445 or regina.whitsett@abc.virginia.gov.

Aging Well: New Initiative on SeniorNavigator

SeniorNavigator has launched its newest initiative, the **Aging Well: Healthy Choices Solution Center (AWHCSC)**, to address the growing need for health promotion among older adults, caregivers, baby boomers, and adults with disabilities. The goal of AWHCSC is to offer relevant educational materials and an interactive virtual toolkit to empower users to increase their physical activity, improve nutrition, and stop smoking. Lifestyle choices and the incidence of disease-related disability are inextricably linked. The AWHCSC will encourage users of all ages and fitness levels to make lifestyle changes to lower the risk of disease and disability due to inactivity, poor nutrition, smoking, obesity, type 2 Diabetes, and poor cardiovascular health. The Aging Well: Healthy Choices Solution Center was created and developed by SeniorNavigator, with grant funding from The Anthem Blue Cross and Blue Shield Foundation. Go to SeniorNavigator's opening page to try it: www.seniornavigator.org.

Focus on the Virginia Center on Aging

Chris McCarthy

Chris McCarthy, a member of VCoA's Advisory Committee, is a Partner at White & McCarthy, LLP, in Midlothian. He has been practicing in the field of Elder Law since 1999, focusing his practice in the following areas: estate planning; estate and trust administration; disability and special needs planning; Medicaid and long-term care planning; guardianships and conservatorships for incapacitated adults; and fiduciary services, including serving as agent, executor, trustee, and conservator.

Chris received his undergraduate degree from Georgetown University in 1992 and his law degree from the University of Richmond, T.C. Williams School of Law, in 1999. Prior to law school, he served as an Armor officer in the United States Army. His first active duty assignment was as a tank platoon leader with the 11th Armored Cavalry Regiment in Bad Hersfeld, Germany, in 1993. He notes, "I was assigned there just in time to receive notification that the Regiment was being deactivated, and spent the next several months getting the vehicles ready for long-term storage, and the soldiers reassigned throughout Germany. My second assignment in Germany was with the 3rd Brigade, 1st Armored Division, in Mannheim, and across the river from picturesque Heidelberg. As luck would have it, I arrived there in time to receive notification that the Brigade was moving 'lock, stock & barrel' (which is pretty impressive when you include hundreds of vehicles, and thousands of soldiers and their family members) to Fort Lewis, Washington. My two years at Fort Lewis were fairly uneventful by comparison."

Chris was the first attorney in Central Virginia to become a Certified Elder Law Attorney. He was certified through the National Elder Law Foundation, the only organization accredited by the American Bar Association to offer certification in the area of elder law. In addition to being a member of the Advisory Committee of the Virginia Center on Aging, Chris is President-Elect of the Virginia Academy of Elder Law Attorneys, a Past Chairman of the Elder Law Section of the Virginia Bar Association, a member of the Academy of Special Needs Planners, and an accredited attorney for the preparation, presentation, and prosecution of claims for veterans benefits before the Department of Veterans Affairs.

Chris's interest and involvement in organizations devoted to serving the elderly developed at an early age. "My parents were always active in various ministries at St. Nicholas Catholic Church in Virginia Beach, and I particularly remember visiting some of the older parishioners at the hospital. I also had the extreme good fortune of growing up about a mile from MaryEllen Cox, another St. Nicholas parishioner. My first real interaction with MaryEllen was during the last few weeks of her husband's life, and I was struck by how MaryEllen made sure that his final days were meaningful and dignified. He was surrounded by family and friends, everyone was sharing their fondest memories, and his passing was peaceful and filled with grace. Those are the same gifts and blessings that I witnessed MaryEllen sharing with countless people and organizations over the years, and if my contribution to services for the elderly in Virginia is even a portion of what hers was, I will count myself fortunate."

Chris continues, "My specialization in the field of elder law was a natural offshoot of my interest in serving the elderly. Another family friend provided me an introduction to the Tidewater elder law firm of Oast & Hook when I was studying for the bar exam. I joined Oast & Hook a few weeks later, and I've been practicing elder law ever since….Over the past 11 years, I've been able to concentrate my legal practice on some key areas that allow me to really help elderly clients. I make sure that they appoint appropriate agents to make financial and medical decisions in the event of incapacity. I help them plan to pay for the high cost of long-term care, including Medicaid planning, and a little-known disability pension benefit available to wartime veterans and their surviving spouses. It has been incredibly gratifying to be able to provide clients with solutions to their problems and with options that they didn't know they had."

Chris and his wife Jennifer have a young son, Aidan. But being a partner in a small elder law firm,

- continued on page 13

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: Prospective applicants are asked to submit by March 4, 2011 a letter of intent that includes a descriptive project title, contact information for the PI, the identities of other personnel and participating institutions, a non-technical abstract and 4-5 sentence description of the project in common, everyday language for press release purposes. Although the letter of intent is not required and is not binding, it is highly encouraged. Letters on letterhead with signature affixed will be accepted electronically. Applications (hard copy required; with an additional electronic copy e-mailed subsequently) will be accepted through the close of business April 1, 2011, and applicants will be notified by June 24, 2011. The funding period begins July 1, 2011 and projects must be completed by June 30, 2012.

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 internet (www.vcu.edu/vcoa/ardraf.htm) or by contacting:

Constance L. Coogle, Ph.D.
Virginia Center on Aging
P. O. Box 980229
Richmond, Virginia 23298-0229
Phone: (804) 828-1525
Voice Mail: (804) 828-2243
FAX: (804) 828-7905
E-Mail: ccoogle@vcu.edu

Searching for a free resource to increase your knowledge about alcohol and aging?

Free online courses available!

The Alcohol and Aging Awareness Group (AAAG), in partnership with the Virginia Association of Community Service Boards, is pleased to launch free online training courses for service providers that address alcohol, medications, and aging.

The three web-based training sessions were originally presented during the 2008 and 2009 AAAG conferences, *The Hidden Epidemic: Alcohol, Medication and the Older Adult*, supported through Virginia's Geriatric Training and Education initiative administered by the Virginia Center on Aging at Virginia Commonwealth University.

To access, go to http://vacsb.elearning.networkofcare.org. Click on Course Providers (or Catalogs/Categories) and select Alcohol and Aging Awareness Group. Users then must log in to complete the courses that include pre/post tests, videos, power points, and **certificates of completion**. Note: Internet Explorer 6 or higher must be used to access this web site.

The three highlighted sessions include:

Paul F. Aravich, Ph.D., Department of Pathology and Anatomy; Division of Geriatrics, Department of Internal Medicine, Eastern Virginia Medical School. In *Alcohol and Aging: The Good, the Bad & the Ugly*, Dr. Aravich draws from his vast neuroscience expertise and teaching experiences to dynamically relate the physiological basis for alcohol's good, bad and catastrophic effects in older adults. Learners also are informed of the relations between alcohol and dementia, as well as traumatic brain injury. (Run time: 44 minutes)

Dr. Frederic C. Blow, Ph.D., Professor of Psychiatry and Director, Mental Health Services Outcomes & Translation Section, University of Michigan Medical School; Director, VA National Serious Mental Illness Treatment Research and Evaluation Center (SMITREC). *Screening and Brief Intervention for Older At-Risk Drinkers* outlines the history and what is currently known about the effectiveness of brief interventions. The presentation lays out the FRAMES approach to motivational enhancement and the rationale for each of the brief interventions steps. (Run time: 69 minutes)

Debra Jay, nationally known speaker, author, and interventionist specializing in older adults. *Aging and Addiction: Helping Older Adults Overcome Alcohol and Medication Dependence* provides a step-by-step guide to working with addicted older adults and offers insightful recommendations for understanding the responses of families. (Run time: 63 minutes)

For questions please contact Regina Whitsett at regina.whitsett@abc.virgina.gov or (804) 213-4445.

Lest We Forget: The Cognitive Aging Study at UVA

by Amy Martin Wilson

Dr. Timothy A. Salthouse, one of the world's leading authorities on the way aging affects memory and other mental processes, doesn't have a crystal ball, but he has a clear vision for the future of the Virginia Cognitive Aging Project at the University of Virginia. He is the Project Director at the Cognitive Lab located on Millmont Street in Charlottesville, Virginia. The broad goal of this project, made possible by two grants from the National Institute on Aging, under the umbrella of the National Institutes of Health, is to conduct research on the nature and ultimately the causes of age-related differences and changes in cognitive functioning.

Cognitive: the ability to think, reason, and remember; the part of mental functions that deals with logic and problem solving, analyzing, awareness, perception, reasoning, and judgment.

Most recently, Dr. Salthouse received a $2.7 million Merit Award from the National Institute on Aging for a ten-year study to measure how cognitive abilities vary from day to day and year to year.

The Virginia Cognitive Aging Project is currently one of the largest longitudinal studies focusing on age differences in cognitive functioning in the world.

Since 2001, staff at the Cognitive Lab, part of the Institute on Aging at UVA, have tested over 3,500 volunteers ranging in age from 18 to 98 to try to determine the relationship between age and memory. Participants are different people and different ages, and the same people at different ages and different times. Studies of currently available data suggest that on average, there is a slight decrease in memory from about 25 to 55, and a steeper decline beyond 60 years of age. No big surprise here.

"By following individual people over time, we will gain insight to changes in cognition, and possibly discover ways to alleviate or slow the rate of decline," said Tim Salthouse, Ph.D, UVA Professor of Psychology and the lead investigator. "We will also better understand the processes of cognitive impairment, the declines that may predict eventual Alzheimer's disease or other dementias."

The term "senior moments" is sometimes used to refer to periods of low alertness or memory lapses, a characteristic of many older adults. Most of us have experienced them. The Institute is trying to develop procedures that will help evaluate whether changes in memory performance are a function of aging.

My husband and I were tested in 2006 and again in 2009. At least 1,300 people from the 2006 study were also in the 2009 study, with approximately 35% of these being over age 60. The oldest in 2009 were a male, age 98 and a female, age 96.

In the lab, we were asked to perform a variety of different cognitive tests designed to assess memory, reasoning and spatial visualization, perceptual speed, and vocabulary.

We attended three two-hour sessions with a questionnaire requiring about two hours to be filled out at home between sessions one and two. Some tasks were completed on a computer in the lab with others conducted by an "examiner." In addition to Dr. Salthouse, there were two full-time coordinators and 20 full-time research assistants. Labs are conducted May through August.

On one test, Word Recall and Logical Memory, the task was to remember lists of unrelated words, such as coffee/roof.. Several working memory tasks were performed, all of which required simultaneous storage and processing. Dr. Salthouse reports people who were good at remembering one type of information also tended to be better than average at remembering the other types of information.

Males and females scored very similarly until about age 40, and after that females tended to do better. However, males tended to do better than females at tests that required spatial visualization abilities. I personally found the tests on spatial relations much harder than the word tests, but my husband was the exact opposite.

Does personality affect cognition? Based on questionnaires, people with self-rated "openness" scored higher on vocabulary. People who self-reported being depressed or anxious rated their level of memory

lower. These results suggest that one's *beliefs* about their own memory functioning may be dependent on mood to a degree.

The results of this year's tests are compared with results of previously tested participants. No individual results are revealed, but a composite report is sent after the data is collected, analyzed, and compiled according to different age groups. Eventually, the results will be published in a professional journal.

One practical implication of the resulting data from this research may be that continuing to be active could help resist cognitive decline. There is also some evidence that people who pursue mentally stimulating activities could possibly slow age-related cognitive decline. We are also hearing this from many other sources as well.

According to their brochure, The University of Virginia Institute on Aging "seeks to understand and enhance the aging process throughout the human lifespan...."

Over the next several years, the Virginia Cognitive Aging Project plans to extend these observations by asking more participants to return for additional research sessions in order to make comparisons with previously gathered data. Meanwhile, the project will continue to educate the community through lectures and service.

But now the most exciting news: Dr. Salthouse is hoping to learn enough from the studies to determine the feasibility of applying for a substantial federal grant to do brain imaging at UVA using their state-of-the-art Magnetic Resonance Imaging (MRI) technology. The possibilities are enormous. More can be found at www.virginia.edu/aginginstitute.

In the words of a song (1977) by Jimmy Buffet -- who seems somehow to remain perpetually young: "Just...try and recall the whole year, all of the faces and all of the places, wonderin' where they all disappeared. [Don't] ponder the question too long...."

VCU's Department of Gerontology to Celebrate its 35th Anniversary

The Department of Gerontology will be celebrating its 35th Anniversary this spring. In honor of the occasion, it will be hosting an anniversary event on **April 9th** at The Virginia Historical Society from 5:30 p.m. - 8:30 p.m.
Dr. Baxter Perkinson will give the keynote address, speaking on Creativity and Aging.

The Department will also present awards and scholarships, have a silent auction, and other fun celebratory activities.

During the day, there will be a continuing education event on the topic of Cultural Humility featuring three presenters: Tracey Gendron, Sonya Barsness, and recent graduate Shannon Marling.

For more information, contact Kimberly Williams or Sheri Shelton at (804) 828-1565.

VCoA Focus on McCarthy, *continued*

and the father of a 6-year old, Chris says that he doesn't have as much spare time as he'd like anymore, and most hobbies now revolve around the interests of his son. For the past year or so, that has meant Star Wars, Harry Potter and LEGOs (preferably LEGO Star Wars and LEGO Harry Potter). Chris is introducing Aidan to sports, namely, soccer and basketball, and is looking forward to his son's being old enough to go skiing and to take a trip to Europe. Chris says, "I'd love to be able to show him where I was stationed in Germany, and help him appreciate how much the world has changed in just 20 years."

Life Line Screenings

February 25, 2011

Senior Connections
24 E. Cary Street, Richmond

Senior Connections is offering screenings for:
- Carotid Artery
- Heart Rhythm
- Abdominal Aortic Aneurysm
- Peripheral Arterial Disease
- Osteoporosis Risk Assessment

The cost is $139. The Osteoporosis screening is an additional $10. This is a savings of $66. An appointment is necessary. Call (800) 679-5192 to register.

Arthritis, Agriculture and Rural Life: State of the Art Research, Practices, and Applications

Purdue University's Beck Agricultural Center, West Lafayette, IN

May 11-13, 2011

The AARL Conference will assist rural professionals in becoming more aware of evidence-based strategies to aid farmers and ranchers battling the many forms of arthritis.

- Keynote Speakers
- Ergonomic Workshops
- Farmer Panel
- Appropriate Assistive Technology
- Farm Worksite Tour

Registration, travel, and housing information available at www.arthritis-ag.org. Registration and housing reservations will open in February 2011.

Conference made possible by the National AgrAbility Project, the Arthritis Foundation, USDA, NIFA Special Project 2008-41590-04796.

17th Annual Conference of The Virginia Coalition for the Prevention of Elder Abuse (VCPEA)

Virginia Beach Resort & Conference Center

June 2-3, 2011
with pre-conference half-day workshops the afternoon of June 1st

The premier statewide conference on issues of elder abuse, neglect, and exploitation, with opening and closing plenary sessions and nine breakout sessions

Keynote Speaker: Candace Heisler, JD, on Domestic Violence in Later Life

Closing Plenary: Kathleen Quinn, President of NAPSA, on the Elder Justice Act

Scholarships are available for first time attendees. Please visit www.vcpea.org for more information about scholarships and to access the conference brochure. For more conference information, contact Lisa Furr at (804) 828-1525 or furrl@vcu.edu. Registration deadline is May 20, 2011. Conference scholarships are made possible in part by Geriatric Training and Education (GTE) funds appropriated by the General Assembly of Virginia and administered by the Virginia Center on Aging at Virginia Commonwealth University.

Growing Poverty

by Saul Friedman

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

Long before there was a war on terrorism and the war on drugs, the nation declared war on poverty. Specifically, Lyndon Johnson in his first State of the Union, in 1964, declared amid great cheers from the Congress, an "unconditional war on poverty in America" and he pledged not to rest "until that war is won."

In his last State of the Union in 1988, Ronald Reagan, who had been no fan of Johnson's agenda, declared to snickering lawmakers, that in the War on Poverty, "poverty won." He was right, of course, but at least part of the reason was the (political opposition's) hostility to the array of Johnson's civil rights and anti-poverty campaign.

Richard Nixon adopted the War on Poverty and gave us the Social Security cost-of-living protection, but he abolished the Office of Economic Opportunity and other key segments of the law. Jimmy Carter eroded part of Social Security, and Bill Clinton boasted that he "ended welfare as we know it" by destroying the Depression-era Aid to Families with Dependent Children. This bipartisan gnawing away at anti-poverty programs has had consequences for millions of poor American families. In 1964, 19 percent of Americans lived below the poverty line; the numbers of poor Americans was estimated at a shameful 50 million. That declined to 12.8 percent in 1968, and 11.1 percent as late as 1973.

But after that brief decline in the poverty rates, since Reagan's speech in 1988 and his emphasis on the "truly needy," poverty in the United States has made a slow climb upwards to the 2008 rate of 13.2 percent, nearly one percent higher than in 2007, the most significant increase since 1994. And that doesn't count the near-poor who live desperately just above the poverty line.

But the overall figures don't tell half of the ugly story of poverty in the richest nation on earth. The 2008 Census Bureau figures, bad as they were, do not take into account the effects of the Great Recession. It will doubtless show an alarming slide into poverty for millions of American families, especially children and young workers and minorities who, for the first time in their lives, need food stamps, Medicaid, extended unemployment insurance, and the poverty programs that have been decimated.

In these cynical times, with deep divisions between left and right, it's hard to believe there was a time when a book and a couple of articles struck a chord in the American conscience that made the plight of the poor a major issue.

University of Virginia historian Kent Germany recalled the works that caught the attention of President John Kennedy and his brother Robert. The *New York Times'* Homer Bigart wrote a series on poverty in Appalachia which is at Washington's door step. And the *New Yorker's* Dwight MacDonald wrote a glowing review of Michael Harrington's *The Other America*, a searing portrait of the 50 million poor.

John Kennedy had campaigned in the desolate areas of West Virginia. Later, Robert Kennedy made a tour of the most poverty-stricken areas and his report to his brother set in motion what became Johnson's War on Poverty. Part of the groundswell for action came from the moral imperatives of the civil rights movement which opened many wounds including the plight of the poor – rural whites as well as blacks who lived without basic amenities.

Thus the Johnson administration, in the wake of Kennedy's murder and his 1964 election sweep, pushed through the Congress the elements of his war on poverty, some parts of which still stand: the Office of Economic Opportunity (OEO), Volunteers In Service to America (VISTA), Upward Bound, Head Start, the Neighborhood Youth Corps, the Community Action Program, programs for rural areas, the urban poor, migrant workers, small businesses, and local health care centers.

And because the reasons for poverty had their roots in racism and segregation, the Great Society programs included an $11 billion tax cut, the Civil Rights acts, the Food Stamp Act, the Elementary and Secondary Education Act (which encouraged school desegregation), the Higher Education Act, the Voting Rights Act, and, of course, the monuments of Medicare and Medicaid. Those two years, 1964-5, were the greatest periods of the federal government's social activism since the Great Depression's New Deal. But Johnson's agenda and the latter years of his presidency were crippled by the Vietnam War and a Republican come-back in 1966.

Since then the turn away from government has been dramatic, epitomized by Democrat Clinton's declaration that the "era of big government is over." But what have we wrought in this time of the near-depression and the need for government? The poor and the newly poor have only a tattered safety net and official indifference.

According to the Census Bureau, there were nearly 40 million American men, women, and children struggling in poverty in 2008, before the full effects of the downturn were felt. Now the numbers surely reach past 50 million. The Pew Research Center estimates that 55 percent of adults in the workforce have become unemployed, taken a pay cut or had their hours reduced. The official unemployment figure is 9.5 percent, but many estimates say the real unemployment/underemployment rate is closer to 20 percent.

The long-term unemployment rate has not been seen since the Great Depression, with a quarter of the jobless without work for more than a year. High, long term unemployment has put a strain on pantries and other facilities providing food for the poor. And most shameful are the unemployment rates (more than 25 percent) among young workers and their families.

And no one is suffering more than children. Before the recession, the official poverty rate among persons under 18 was close to 20 percent. Poverty rates among children over the last 40 years ranged from 15 to 23 percent. We are at a new high. According to the Urban Institute, before the downturn, 37 percent of children lived in poverty for their first year, and ten percent spent half their childhoods (nine years) in poverty. Kids know what poverty is like. I remember the humiliation when my mother applied for what was called "relief" and inspectors came to the house to determine if we were really poor.

During the Depression, writers like James Agee, Sinclair Lewis, and T.S. Eliot and photographers like Dorothea Lange, Walker Evans, and Robert Capa helped Franklin Roosevelt's New Deal stir the American conscience to action as Homer Bigart, Michael Harrington, and the Kennedys did a generation later. Where are such voices now?

Federal Healthcare Changes in 2011

Medicare

Medicare Part B Premiums

For the majority of enrollees, in years when there is no cost-of-living increase to Social Security, Medicare Part B premiums are not allowed to increase. Medicare beneficiaries who have their Part B premium deducted from their monthly Social Security benefit and have incomes of $85,000 or less will continue to pay $96.40 through 2011. (Some pay $110.50.) For all others in that group, the monthly premium is $115.40. People with incomes greater than $85,000 (and couples filing joint IRS returns with incomes above $170,000) will see an increase of 4.4 percent and pay anywhere from $161.50 to $369.10 on a graduated income scale based on 2009 IRS income.

Physician Payments

Time Goes By readers have reported in the past that they have been "fired" by their physicians who stop seeing Medicare patients. In an effort to slow the outflow, primary care physicians, including nurses, nurse practitioners, and physician assistants with 60 percent or more of their services devoted to primary care will get a 10 percent increase in their payments from Medicare beginning now. Also, general surgeons will receive the increase if they practice in areas where there are shortages. It's not a lot to retain Medicare physicians, but it's a beginning. However, the benefit expires at the end of 2015.

Annual Wellness Examination

New Medicare rules now require a free annual wellness exam which includes a review of the patient's medical history along with a schedule of screenings for the coming decade and a personalized prevention plan. For those just joining Medicare, the 20 percent co-pay for the Welcome to Medicare physical exam has been eliminated.

Wellness and Preventative Services

As of January 2011, Medicare offers more wellness and prevention services without any co-pay or deductibles; these include vaccinations, screenings for high blood pressure, cancers, cholesterol abnormalities, and bone mass loss, and more that are Medicare-covered are free, so long as the U.S. Preventive Services Task Force has graded them "A" or "B." You can see the A/B list at: www. healthcare.gov/center/regulations/prevention/taskforce. html.

Prescription Drugs

On joining Medicare, under Medicare Part D, one may have to pay up to the first $310 of prescription costs annually; this is known as the deductible. After this, during the initial coverage phase, one's drug plan pays75% of covered drug costs and the enrollee pays the remainder until total drug costs (including the deductible) reach $2,830. After $2,830 an enrollee enters the so-called "doughnut hole," and must pay the full cost of prescription drugs until out-of-pocket costs reach $4,550. After spending more than $4,550 out-of-pocket, the coverage gap ends and the drug plan pays most of the costs of covered drugs for the remainder of the year; this is known as "catastrophic coverage." Now there is some small relief as drug companies are required to give Part D enrollees a 50 percent reduction on brand-name drugs while they are in the doughnut hole and generics will also be cheaper. Personal costs could be reduced by $700 for typical Medicare enrollees and the National Council on Aging estimates that savings could reach as much as $1800.

Advantage Plans

Medicare Advantage plans are health plan options that are approved by Medicare but are run by private companies. Someone in a Medicare Advantage Plan is still in Medicare. About 25 percent of Medicare beneficiaries subscribe to private Advantage plans that cover all the parts of traditional Medicare in one fell swoop. Because Medicare pays Advantage plan providers $1000 or more per person above the average cost of traditional Medicare patients, traditional Medicare enrollees subsidize these plans with higher premiums for their coverage than would be necessary if everyone were enrolled in traditional Medicare. This year, Medicare has frozen their payments to Advantage plan providers at 2010 levels and lower rates will be phased in beginning in 2012 until the payments are eventually eliminated. Current Advantage enrollees who wish to join or return to traditional Medicare have 45 days from 1 January to do so, i.e., until February 14th.

Medicaid

Fighting Hospital Infections

It is estimated that each year 1.7 million hospital patients suffer serous, sometimes life-threatening but preventable infections and some die, with estimates ranging from 20,000 or so to more than 100,000. Beginning in July, Medicaid will stop paying for treatment of some hospital-acquired, preventable infections, something Medicare and some private insurers already do.

General

Restaurant Food Labeling

It is shocking, sometimes, how many calories are in fast food, and it is difficult to get that information. That's about to change. Although it is unlikely to happen before next December, chain restaurants with more than 20 locations and owners of 20 or more vending machines will be required to post calorie information. Such restaurants will also be required to provide customers with a brochure listing more detailed nutritional information. You can see a Food and Drug Administration Q&A on the development of these new requirements at: www.fda.gov/food/guidance compliance regulatoryinformation/guidancedocuments/food labelingnutrition/ucm223266.htm.

(Age in Action thanks Ronni Bennett, developer and editor of the Time Goes By website (www.timegoesby.org) for permission to excerpt sections of her essay, and UnitedHealthcare Medicare Solutions for its briefing documents.)

Calendar of Events

January 26, 2011
Virginia Center on Aging's 25th Annual Legislative Breakfast. St. Paul's Episcopal Church, Richmond. 7:30 a.m. - 9:00 a.m. For information, call (804) 828-1525.

February 17, 2011
Social Workers Conference. Presented by the Alzheimer's Association Greater Richmond Chapter. Spring Arbor of Salisbury, Midlothian. 9:00 a.m. - 2:30 p.m. $20 per person. For information, call (804) 967-2580.

March 17-21, 2011
Living the Old Age We Imagine. 37th Annual Meeting and Educational Conference of the Association for Gerontology in Higher Education. Hilton Cincinnati Netherland Plaza. For information, call (202) 289-9806 or visit www.aghe.org.

March 18, 2011
Alzheimer's and Dementia Seminar. Sponsored by The Beard Center on Aging. Lynchburg College. 8:00 a.m. - 5:00 p.m. The class meets the requirements for certification as a dementia practitioner by the National Council of Certified Dementia Practitioners. Cost is $185/person. Discounts offered for multiple participants from the same organization . For information, call (434) 544-8456 or e-mail scruggs.dr@lynchburg.edu.

March 26, 2011
The Faith Community Speaks Out: Breaking the Silence About Dementia. Presented by the Alzheimer's Association Greater Richmond Chapter. Gillfield Baptist Church, Petersburg. 9:00 a.m. - 3:00 p.m. $20 per person. If registered by March 1, fee is $15 per person. For groups of five or more, fee is $10 per person. For information, call (804) 967-2580.

March 28, 2011
In-Home Caregivers: Providing Care for Persons with Dementia. Presented by the Alzheimer's Association Greater Richmond Chapter. Mt. Vernon Baptist Church, Henrico. 3:30 p.m. – 9:00 p.m. $20 per person. Box dinner included. For information, call (804) 967-2580.

March 31, 2011
Alzheimer's Based Activity Care. Presented by the Alzheimer's Association Greater Richmond Chapter. Chapter Office, 4600 Cox Road, Glen Allen. 8:30 a.m. - 5:00 p.m. $75 per person. For information, call (804) 967-2580.

April 14-17, 2011
The New Aging Enterprise. 32nd Annual Meeting of the Southern Gerontological Society. Raleigh Marriott City Center, Raleigh, NC. For information, contact LGage4SGS@aol.com or visit www.southerngerontologicalsociety.org.

April 30, 2011
Keys to Caregiving: Unlocking the Mystery. Annual Caregiver Conference of the Prince William Area Agency on Aging. Westminster at Lake Ridge, Lake Ridge. 8:30 a.m. - 4:00 p.m. For information, call (703) 792-6374 or email leckhardt@pwcgov.org.

May 23-24, 2011
Virginia Association for Home Care and Hospice Leadership Conference. Wyndham Virginia Beach Oceanfront, Virginia Beach. For information, call (804) 285-8636 or visit www.vahc.org.

May 24, 2011
Aging Well in Mind, Body, & Spirit. Presented by the Beard Center on Aging at Lynchburg College in partnership with Centra Health. Lynchburg College, Lynchburg. 8:00 a.m. – 5:00 p.m. Now seeking sponsors and exhibitors. Cost is $75/person. Discounted price of $40/person offered for students and seniors. For information, call (434) 544-8456 or e-mail scruggs.dr@lynchburg.edu.

June 6, 2011
Liveable Communities and Lifelong Disabilities. Annual conference of the Area Planning and Services Committee (APSC). Holiday Inn Koger Center, Richmond. For information, contact Ed Ansello at (804) 828-1525 or eansello@vcu.edu.

Age in Action
Volume 26 Number 1
Winter 2011

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

James A. Rothrock
Interim Commissioner, VDA

Kimberly S. Ivey, M.S.
Editor

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

Spring 2011 Issue Deadline: March 15, 2011

Virginia Center on Aging

at Virginia Commonwealth University, Richmond, Virginia

www.vcu.edu/vcoa

Staff:

Director
Edward F. Ansello, PhD

Elderhostel Coordinators
Catherine Dodson, MS - Richmond
Jim Gray, MS - Natural Bridge
Barbara Wright - Staunton

Associate Director for Research
Constance L. Coogle, PhD

Assistant Director for Education
Jane F. Stephan, EdD

Research Specialist
Paula Knapp Kupstas, PhD

Lifelong Learning Institute
Monica Hughes

Law Enforcement Liaison
Barbara Walker

Program Manager
Bert Waters, MS

Project Coordinator
Lisa Furr, MA

Research Associate
Sung Hong, PhD

Research Assistant
Jessica Hellerstein

Administrative Assistant
Paige Ulvi

Editor, *Age in Action*
Kimberly S. Ivey, MS

Advisory Committee:

Frank Baskind, PhD
James Bennett, MD, PhD
Cecil Drain, PhD
William F. Egelhoff, Director Emeritus
Jonathan Evans, MD
Patricia Giesen
Hon. Franklin P. Hall
James Hinterlong, PhD
Robert D. Holsworth, PhD
Paul G. Izzo, JD
Richard W. Lindsay, MD
Christopher M. McCarthy, Esq
Kenneth J. Newell, MS, Vice Chairman
Mary C. Payne
Sheldon Retchin, MD, MPH
Saundra C. Rollins, MSSW
David Sadowski
Robert L. Schneider, PhD
Ralph E. Small, PharmD
Beverley Soble
Alexander Tartaglia, DMin
Marcia A. Tetterton, MS, Chairman
Gordon Walker
Thelma Bland Watson, PhD
E. Ayn Welleford, PhD
Victor Yanchick, PhD

Virginia Department for the Aging

www.vda.virginia.gov

Staff:

Interim Commissioner: Jim Rothrock
Faye Cates, MSSW, Program Coordinator
Tim Catherman, MHA, Director of Administration
Pat Cummins, MA, Program Coordinator
Leonard Eshmont, IT Director
Nick Gemelos, No Wrong Door IT Coordinator
Solomon Girmay, External Financial Auditor
April Holmes, Prevention Program Coordinator
Becky Hunley, Accountant
Janet James, JD, Public Guardianship & Legal Srvcs. Coord.
Georgie Lewis, Receptionist
Nancy Lo, MSW, GrandDriver Coordinator
Deb Loving, Info. Systems Specialist
Christy Miller, Bus. Analyst Cert., IT Business Systems Analyst
Kathy Miller, RN, MS, MSHA, Long-Term Care Director
Marica Monroe, CPA, Financial Manager
Ellen Nau, MA, Program Coordinator
Peggy Neider, Community Living Program Coordinator
Ann Petersen, Graduate Student Intern
Charlotte Peterson, Accountant Senior
Bill Peterson, MSW, PhD, Senior Policy Analyst
Elizabeth Pierce, MSW, VICAP Program Director
Katie Roeper, Assistant Commissioner
Cecily Slasor, Information Specialist
Elaine Smith, MS, RD, Program Coordinator
Pam Smith, VICAP Coordinator
Jane Snead, Contracts/Grants Coordinator
Jackie Taggart, Executive Secretary Senior
Kathleen Vaughan, No Wrong Door Program Coordinator

Commonwealth Council on Aging:

Members

Juanita Armstrong Bailey
Beth Barber
Robert B. Blancato, Chair
Gene Ecton Davis
Jeffrey C. Delafuente, MS, FCCP, Secretary
David M. Farnum
Karen L. Fortier
Pete Giesen
Richard W. Lindsay, MD
Susan McCammon
Brenda Kelly Nelum
Nancy A. New
Valerie Scott Price
Roberto Quinones
Stephen G. Reardon, Esq.
Joan Boyd Short
E. Harris Spindle, Jr.
Donald T. Thorne
Vernon Wildy

Ex Officio Members

The Hon. William A. Hazel, Jr., MD , *Secretary of Health and Human Resources*
Paul Lavigne, *President, VAAAA*
Gail S. Nardi, *VDSS*
Jim Rothrock, *VDA*
Terry Smith, *DMAS*

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

Return Service Requested

Nonprofit Organization
U.S. POSTAGE PAID
Permit No. 869
RICHMOND, VIRGINIA

Fourth Annual Community Conference on Senior Care

Charlottesville University Area Holiday Inn
1901 Emmet Street, Charlottesville

March 2-3, 2011

Don't miss the Fourth Annual Caregiver Conference with featured speaker Teepa Snow giving both Keynote addresses and teaching three of the Dementia Care Workshop sessions. The conference is hosted by the Community Partnership for Improved Long-Term Care, an initiative of the Legal Aid Justice Center, with co-sponsors the Alzheimer's Association Central and Western Virginia Chapter, Jefferson Area Board for Aging, and Blue Ridge Long-Term Care Associates. For more information, contact Claire Curry at (434) 977-0553 x105.

Join direct care providers from diverse settings (nursing home, assisted living, home health, hospital, family caregivers, ombudsmen, social workers, and consumer advocates) for a dynamic, interdisciplinary conference designed to build skills, enhance professionalism, and recognize and celebrate caregivers.

In addition to the focus on caring for those with Alzheimer's, the conference will feature sessions to:

- Improve teamwork, communication, and problem-solving
- Understand normal aging, and observe and report changes (including issues of medication management)
- Improve clinical skills in areas such as Fall Prevention and Pressure Ulcer Prevention
- Increase preparedness for emergencies and for dangerous or difficult situations
- Exchange information on best practices and celebrate successes

This program was made possible in part by Geriatric Training and Education (GTE) funds appropriated by the General Assembly of Virginia and administered by the Virginia Center on Aging at Virginia Commonwealth University.