

Case Study

We Are Family: When Elder Abuse, Neglect, and Financial Exploitation Hit Home

by Jeannie Jennings Beidler

Educational Objectives

1. To describe a case, from discovery to prosecution, of familial abuse, neglect, and financial exploitation.
2. To demonstrate gaps in elder care policy.
3. To share my experience in order to help protect the vulnerable older adults.

Background

Research and popular press report alarming instances of familial elder abuse, neglect, and financial exploitation. The House of Representatives Select Committee on Aging found that older adults are at the greatest risk for abuse, and that, in more than two-thirds of substantiated cases, the perpetrator is a family member in a caregiving role, usually an adult child (H.R. 973, 2009). Contributing factors include

substance abuse, on the part of the abuser and or the victim, and diminished capacity of the elder due to conditions such as dementia (Spencer et al., 2000). Focused research, preventative programs, reforming policies and practices, and increased social awareness of what constitutes elder abuse, neglect, and exploitation can help to protect the elderly, and ultimately, eradicate the problem.

My Family's Case Study

In October 2005, police were dispatched to the home of my grandparents following a dispute between my parents and my uncle. My uncle, my grandparents' unemployed adult son who was living in the home, became infuriated when my parents presented for an unscheduled visit with my grandparents. He aggressively demanded that they depart and refused them access to the home. Hearing the commotion, my grandmother appeared and insisted that my parents stay, which further exacerbated my uncle's angst. As my parents attempted to leave, the situation worsened. In an effort to keep my grandmother inside, several glass

panes of a door were broken, cutting my grandmother and my mother. It was evident during this brief visit that my grandmother and the home were in poor condition. Thus, my parents called the police.

The Call to 911

Law enforcement arrived at the home following the complaint. My uncle appeared agitated, inebriated, and unclean. My grandparents were reportedly uncooperative and defensive, expressed no feelings of endangerment, and declined to press charges. Both elders appeared unclean and disoriented. From the outside, their single family home displayed shattered windows, overgrown landscaping, a boat filled with trash, and busted fencing. Inside, the home was filthy and littered with trash. Mounds of papers and mail were found piled high on the countertops and tables. There was little food available, but an abundance of alcohol. The police officers insisted this was a case of self-neglect; not of criminal action or intent. They did not create a case, and there was no further investigation. The only record of the incident was the 911 call. Upon

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learning that law enforcement would not intervene, my parents, though terrified of retribution by my uncle, reported their concerns to Adult Protective Services (APS).

Soon thereafter, an APS worker made a home visit. Again, my grandparents denied any concerns for their welfare and refused any offers for assistance. While there, the APS worker noted the same observations as the authorities. The couple was clearly oblivious to the dangers of their environment and required immediate medical attention. The APS worker obtained Emergency Custody Orders from the magistrate and the couple was involuntarily removed from their home and transported to local hospitals. My grandfather was treated for various non-life threatening conditions and was discharged within a few days, while my grandmother remained hospitalized for nearly three weeks. Upon learning of the situation, I became involved in her treatment and discharge plan. Though living two hours away, I visited often and regularly communicated with the hospital staff about her care. Later, I, along with my parents, uncle, and grandfather, attended a “family meeting” in preparation for my grandmother's discharge. During the meeting, it became apparent that my grandfather was confused about his wife's conditions and the level of care she would require; he was beginning to evidence dementia. During the meeting, my uncle agreed to tend to such tasks as transporting his parents to medical appointments, ensuring that prescriptions would be filled in a timely manner, and providing adequate food and water. He also admitted that he had been

unemployed for a long time and was working on his sobriety, a glaring “red flag” to me. Unable to suppress my concerns, I requested a competency evaluation for my grandmother and strongly recommended that she not return home but rather be assessed for placement in an assisted living facility. I vocalized concerns regarding the unlikelihood that my grandparents would receive the care they required should they return home with their son responsible for their welfare. Nonetheless, the medical staff and case management team determined that my grandmother would be discharged home.

In the following weeks, I called their home frequently to check on them. Though initially my grandmother would answer the phone and participate in conversations with some degree of awareness, this slowly faded. More often than not, calls placed would go unanswered. Within months, ensuring my grandparents' welfare could only be accomplished by contacting authorities to request a welfare check. Ultimately, my family was forced to place our confidence in the APS worker who had fervently promised to monitor the situation closely.

The Situation Worsens

From 2006 to 2010, the walls of my grandparents' home deteriorated, as did their lives. Countless times, concerned neighbors reported suspicious observations to the authorities and APS. My uncle continued to live in the home despite his claim that the arrangement was temporary while he regained employment. In reality, he was unemployable, due to uncontrolled substance abuse,

untreated anxiety, and uncontrollable aggression.

On Saturday, July 24, 2010, my great-uncle and husband made an unscheduled visit to my grandparents' home. Despite repeated calls into the house, there was no response. The house appeared to be in deplorable condition, inside and out. They drove to the end of the block and called 911.

Moments later, the city police arrived and confirmed the presence of three adults inside, my grandparents and their son. The officers warned my great-uncle and husband that, should they go inside, they “won't last long” because of the stench. The police made no attempt to rescue the elderly couple or confront my uncle. As the police were leaving, my great-uncle and husband questioned the officers' lack of action. One officer responded by suggesting that they contact APS once again to report their concerns. Stunned, my great-uncle and husband left the home, but returned moments later, fearing that the next time they saw my grandparents would be upon their deaths. It was obvious to them that there was no way anyone could survive such extreme conditions. My uncle was irate to see them reappear and an explosive dispute ensued. Despite my uncle's unyielding hostility, my great-uncle insisted on seeing my grandparents. He found my grandfather scantily dressed in nothing more than a torn undergarment, emaciated, weak, filthy, and lying in his own waste. Just down the hall, my grandmother was dressed in soiled men's clothing, immobile, and confined to a tattered mattress with no linens. My grandparents

were oblivious to their poor circumstances and responded pleasantly to my great-uncle.

My uncle continued to spiral out of control, his behavior becoming increasingly violent. Fearful of my uncle, my great-uncle and husband departed. They knew something had to be done, but what and how? If the police wouldn't take action, who would? That afternoon, the two shared the dire situation with me. Without hesitation, I shifted into "task mode" and began to make continuous phone calls for two days to the police, APS, and the crisis hotline. Finally, a crisis worker agreed to visit my grandparents. I was convinced that my grandparents would finally receive the help they so desperately deserved. To my disappointment, the crisis worker did nothing, stating that in her professional opinion, my grandparents were not in acute danger. Shocked and frustrated, I asked the crisis worker, to no avail, to define acute danger, if not their circumstance of no food, no running water, no heat or cooling, lack of medical attention, unstable shelter, obvious neglect, absolute filth, and financial exploitation. I concluded that the three organizations thought to be the top defenders of the defenseless were simply my top sources of disappointment.

Early Monday morning, I began a new round of calls to police, APS, the hotline, and miscellaneous elder advocacy groups. I ended each call with the statement, "My grandparents are going to die if they aren't helped. What is your name, so I can document that you knew and did nothing!" It was now well over 48 hours since the recent

911 call. With each passing moment, I feared that my worst nightmare would become a reality.

The Intervention

On Tuesday morning, an APS worker called me to say that an intervention was planned for that afternoon. She explained that she would be accompanied by the APS supervisor, medical professionals, and the police. The worker asked if I would accompany them to the home and, if so, how soon could I be there. Despite living 100 miles away, I arrived within two hours, to find an array of ambulances, police cruisers, and official government cars at the bottom of my grandparents' driveway.

When my great-uncle and husband described the conditions they had found days earlier, I suspected they had spared me some of the details. They had. Luxury sedans in the driveway that had once glistened were unlicensed, uninsured, and worthless. Inside the house, black mold covered the walls and ceilings. It was difficult to breathe with the intense stench of feces, urine, and rotting trash. Cupboards once chock full were bare; the refrigerator inoperative. There was no running water for drinking, bathing, or cleaning. With no operable HVAC system, the cold winter months and the sweltering summer months had to be unbearable. The exterior doors lacked doorknobs, having been busted off and never replaced. Windows were cracked and shattered. The once beautiful, brick home had become nothing more than an eyesore.

I found my grandparents just as my

great-uncle had described four days earlier. My grandfather was wearing the same undergarment and was sitting in the same urine saturated chair in the same position. He was removed from the home by paramedics, against his will, within minutes and transported to the ER. An ECO (Emergency Custody Order) was not necessary since his condition was deemed to be life threatening. In fact, his blood pressure was so high, he was unable to maintain consciousness. My grandmother was also wearing the same clothing as before. Her frail body was curled up in a fetal position in the middle of a rotting mattress with no linens. Maggots were swarming the waste that she was forced to lie upon. Oblivious to the horror of her home, my grandmother greeted me with enthusiasm.

The intervention team and I tried to persuade my grandmother to go to the hospital. Negotiations continued for hours. She was adamant against seeking medical treatment, stating there was absolutely nothing wrong with her. When the APS worker informed her she could not live in such conditions, my grandmother was grossly offended. She immediately told the worker that she had a beautiful home and scolded her for being so critical. Then, at exactly 5:00 p.m., the APS worker and supervisor left my grandmother's side and made their way to their car. Panicked, I asked how they could leave, knowing she was wasting away in her bed. They said that it was 5:00 p.m. and their day was over. They left. The only glimmer of hope that remained was with the behavioral health authority, the organization that handled after-hours emergencies. I called.

The after hours crisis worker arrived soon thereafter. She was familiar with the case because of my many calls over the past four days. She expressed frustration that APS had not attempted to get an ECO and simply passed the case to her unit. The crisis worker quickly surveyed the home and my grandmother before rushing out of the house. She looked into my weary eyes and promised me that she would end this nonsense and my grandmother would be saved. She left in order to request an ECO from the city magistrate. Less than an hour later, she returned with an ECO and instructed the paramedics to involuntarily remove my grandmother from the home. Though my grandmother was hysterical, I was relieved that both of my grandparents would soon be safe.

The Courts Become Involved

In the days that followed, I made myself known to the hospital staff. This allowed me to monitor their conditions closely and to ensure that they were not further exploited by my uncle. On the second day, a nurse informed me that my uncle had visited and it appeared that my grandmother had been signing checks for him. While my grandparents were fighting for their lives, my uncle was concerned with how their hospitalization was affecting his ability to access their funds. Realizing that another battle was brewing, I researched local elder advocacy groups hoping to find someone that could help me protect my grandparents. Meanwhile, TDOs (Temporary Detaining Order) were obtained to ensure that my grandparents remained hospitalized, while I raced against time to

make a plan for their discharge and institute a measure of protection from my uncle. I felt like a sitting duck, appearing calm and cool on the surface, but paddling like mad underneath.

Despite making phone calls for the remainder of the day, it seemed nothing had been accomplished. During my last call at 4:45 p.m., I received the tip that would prove to be a lifesaver. I was referred to an Assistant Commonwealth's Attorneys (ACA) who was known as a staunch elder advocate. Since it was so late in the day, I expected to reach her voicemail. I was elated when she actually answered the call. I introduced myself and begged for five minutes of her time. She listened intently, as I recounted the situation and detailed my concerns. At the end of the call, she instructed me to come to the courthouse the next morning, bringing any photos and any documentation, for she would arrange for me to go before a judge. At this point, I wasn't sure what I was going to ask the judge for, but she clearly had a plan. I thanked her profusely and began preparing for the unconventional court appearance.

Thankfully, while at my grandparents' home five days prior, I carried my cell phone with me and casually took photographs and video recordings. Though of poor quality, they were evidence nevertheless. I prepared a succinct presentation of the dire circumstances for the judge. The next morning, I met briefly with the ACA who explained that we would be asking for a protective order on behalf of my grandparents, against my uncle. Terrified of going before the judge, I mustered the

courage to state my case, knowing this was my one chance.

The judge seemed bewildered by my request, stating that I could not ask for a protective order against my uncle for my grandparents. He explained that a protective order could only be granted to the person in need of protection, the next of kin if the person is unable to make such a petition, or the legal guardian of the person. I met none of these requirements. I acknowledged the regulation but stated none was feasible and my grandparents were in grave danger. After a few moments of deliberation, the judge, with apparent hesitation, granted a temporary protective order for my grandparents and explained that I would have to return to court in two weeks for another hearing to determine if a permanent protective order was necessary.

Just as the judge prepared to move onto his actual docket of cases, he asked about my uncle's whereabouts and questioned why he had not been arrested. The ACA intervened to explain that the family had been making reports for years, that APS was involved, and that the police had yet to create a case. Expressing dissatisfaction, the judge directed the ACA to call police to initiate a report and to obtain a warrant for my uncle's arrest. He then advised that I take the necessary steps to become the legal guardian and conservator for my grandparents. This would cost me thousands in attorney fees and require proving their legal incapacity. Doing so would give me the authority to represent my grandparents' best interests. The judge added that, in order to represent my grand-

parents at the permanent protective order hearing in two weeks, I would have to confirm, at a minimum, that I had initiated this complex legal process.

By mid-afternoon, I had been interviewed by several officers, a warrant against my uncle was obtained, and he was arrested. The Sergeant apologized that his unit had failed both me and my grandparents. He assured me that from this moment forward he and his officers would do whatever necessary to be of assistance. Though saddened by the measures that were taken that day, I felt victorious. Exhausted, yet encouraged, I knew this undertaking would be all-consuming. On my return trip home, I contacted my employer to request an extended leave of absence, which later resulted in my resignation because of the continued demands of the situation.

In the days that followed, my mission was caring and planning for my grandparents. Although I lacked the legal authority to act on their behalf, by default my wishes were respected, for no one else was similarly involved. I communicated regularly with the discharge planners at the hospital and decided to relocate my grandparents to a nursing home near me in order to oversee their care. I hired legal representation for the guardian/conservatorship proceedings, while working closely with the ACA and investigators to prosecute my uncle for abusing and neglecting my grandparents. My uncle remained incarcerated, his requests for bond denied three times.

Trying to put together the pieces of my grandparents' lives was no easy

feat. Neither could reveal information regarding their financial matters, for both were diagnosed with Alzheimer's type dementia. My investigations exposed dozens of delinquent accounts in collections equating to tens of thousands of dollars in debts. I learned that each morning my uncle would persuade my grandmother to write him a check under the guise that the money was for household bills. He would cash the check at the same convenience store and purchase a case of beer that he would finish sitting in the driveway. In addition, he abused a sundry of prescription drugs filled by various clinics and pharmacies.

Further investigation revealed that the city's building inspector had also been involved and was keenly aware of the situation. The inspector had made multiple visits to the property over the past year and had left numerous citations for the hazardous environmental conditions. Unfortunately, no further action was taken to report these findings to the authorities, despite the fact that the inspector knew an elderly couple resided in the home under the care of their son. Within two weeks of the intervention, the property was officially deemed uninhabitable and condemned. The home, once valued at \$175,000, was reappraised and reassessed to reflect its dilapidated condition. With the permission of the Commissioner of Accounts, I sold the house to an investor for its true value of \$32,000 in order to pay the debts in collections and mounting medical expenses.

Through numerous court appearances and continuances over an

eight month period, my uncle avoided going to trial. With an overwhelming amount of evidence, he eventually pleaded guilty to two felony charges of the abuse and neglect of an incapacitated adult. He was sentenced to 10 years on each charge and mandated to serve three years incarcerated and 17 on probation.

My grandfather passed away four months after the intervention and my grandmother joined him 11 months later. While this case study is one of great tragedy, it certainly did have a happy ending. I find great peace in knowing that they were well cared for and happy during their final months alive. Moreover, I hope that their story proves instructive in improving the circumstances of other vulnerable older adults.

Conclusion

This case all too vividly illustrates some of the warning signs that contributed to my grandparents' torment, warning signs that should have been addressed. Looking back, there were ample opportunities for the appropriate agencies to respond. However, assigning blame neither changes the past nor improves the future. Carefully appraising the facts of this case may help to improve the protection of vulnerable populations. Better inter-agency communication, more personal responsibility by agency staff members, increased community awareness and response, collaboration between well-trained professionals, and policy reformation are key ingredients in eradicating elder abuse and neglect.

Editorials

Study Questions

1. What clues should have alerted authorities and the community of the couple's need for help?
2. How and when could professionals have intervened?
3. Did the system fail this couple and, if so, how?
4. What changes in policy are necessary in order to prevent cases such as this in the future?

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About the Author



Jeannie Jennings Beidler earned a degree in Social Work from George Mason University and has 15 years of related work experience. She resigned from her position with DePaul Community Resources to intervene and advocate on her grandparents behalf. She is currently the Marketing and Outreach Specialist for a local Area Agency on Aging. You can learn more about this case through her blog, "My Journal; Their Journey" at www.jennings411.weebly.com. Her e-mail address is jeannieb2@gmail.com.

From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

Is Aging a Disability?

A recent essay, in the *Richmond Times-Dispatch*, by the chairman of the Commission on Government Reform and Restructuring was headlined "Building smaller, smarter government."

The Commission recommended abolishing or combining elements of state government. The proposed changes in state agency and committee structure, at least as related to aging, pose both opportunities and concerns. The Commission has recommended folding the Virginia Department for the Aging, the Department of Rehabilitative Services, and the Department for the Deaf and Hard of Hearing into one agency, and collapsing three gubernatorially appointed bodies (a Council, a Board, and a Commission) into one. Knowing many involved in developing the proposed changes and, prospectively, in implementing them, I do not doubt their best intentions. But the devil is in the details.

Aging Does Not Equal Disability

I spent the first decade or more of my life as a gerontologist trying to disabuse people of equating aging with disability. Later life is the most varied, least homogeneous part of the life course. Growing older, we taught then (and now), is not predictable decline, and we used plentiful data to impart that the over-

whelming majority of us age without acquiring disabilities. We may acquire conditions or even impairments but these are not necessarily disabilities.

Citations that reportedly show large percentages of older Americans with disabilities often fail to distinguish among impairments, disabilities, chronic conditions, and handicaps, and conflate the terminology, showing instead the simple presence of an impairment and not a disabling consequence. Working in the area of aging with lifelong disabilities for the past 25 years, I know that definitions of "disability" are many and, at times, contradictory. The World Health Organization (WHO) notes that "Disabilities is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations." Using the WHO terms, relatively few older adults have activity limitations and participation restrictions, and aging does not equal disability. Pointedly, the Centers for Disease Control and Prevention (CDC) currently reports data for 2003-2007 showing that the percentage of adults ages 75+ without limitations in their activities of daily living is 91%.

For these reasons the Four-Year Plan of the Virginia Department for the Aging, sent to the General Assembly and the Governor in 2009-2010, incorporated an enlightened perspective acknowledging

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this reality and proposing to focus on the whole spectrum of older Virginians. The Introduction, which spoke of older Virginians as "us" rather than "them," spelled it out:

One of the most significant breakthroughs in our understanding is that, as we grow older, we tend to grow less alike.....On virtually every important dimension, from health to income to acquired skills and experience, aging increases the variety within each generation. Simply put, there is greater variability in characteristics and function among 75 year olds than among 45 year olds.....Viewing later life on a continuum, the vast majority of us will be healthy, active contributors to our communities. Most of us will need information; some will need intermittent services; fewer still will need coordinated long term services to delay or prevent institutionalization; and a smaller number will require facility-based care.....Often government reports focus almost exclusively on older adults in need, an understandable priority, yet ignoring us also as resources, as volunteers, as experienced employees, as caregivers, as grandparents raising grandchildren, and as citizens actively engaged in the civic structure.

Collapsing Committees

The Commission recommended collapsing not only the three agencies mentioned above but also three advisory bodies housed within VDA: the Commonwealth Council on Aging, the Virginia Public Guardian and Conservator Advisory Board, and the Alzheimer's Disease and Related Disorders Commission.

For ease of communication, I will call these "committees." The proposed collapse of the three into one committee poses both philosophical and practical challenges to maintaining Virginia's commitment to all older Virginians.

The purposes and operations of the three committees are quite different. The focus of the Commonwealth Council on Aging is broad, reflecting aging's breadth. Recent quarterly agendas illustrate this. The committee's 19 members, volunteers from across sectors and geographies, dealt with issues as diverse as housing, healthcare, elder rights, and best practices in community services. The 15 members of the Public Guardian committee focus on indigent, vulnerable Virginians, especially those with mental illnesses, cognitive impairments like intellectual disabilities and autism, and other conditions that restrict their ability to execute judgment. The work of the Alzheimer's Commission embraces research, on-line training, shared data bases, public awareness, and a state plan related to dementia; it maintains the "Alz's possible" website (www.alzpossible.org) offering resources and webinars for family caregivers and service providers. The three bodies have little overlap in focus. They do have in common that they are comprised of citizens who are concerned community leaders and professionals in related fields who are donating their time and expertise.

Challenges to Effective Functioning

How would a combined super-committee work? Three options come immediately to mind: 1) there

would be one omnibus committee representing the pooling of the three formerly separate committees; it would be one having dozens of members with little overlapping interests. As well, this would be logistically unwieldy: when and where might their very large membership meet? 2) the omnibus committee would have three separate subcommittees, operating as before the restructuring. In this case, what is the gain other than changing a digit on a government organizational chart from a "3" to a "1"? 3) the combined committee's size would be greatly reduced by eliminating appointments to each of the three committees that constitute the new whole. This would mean jettisoning great amounts of donated time and expertise; what would be the gain to the Commonwealth? Members of each of the three committees are volunteers, and I know from my terms on the Alzheimer's Commission (appointed by Governors Gilmore and Warner) that state appropriations for its operation were calculated in modest hundreds of dollars.

Smaller, smarter government? The logic seems elusive. Philosophically, practically, and economically, questions arise about collapsing these aging-related entities. Collaboration among the three agencies would seem more productive than integration. Parenthetically, by adopting the Restructuring Commission's recommendations, the estimated total savings potentially realized across all Secretariats of state government, not just those that are aging-related, would be 2.2 million dollars in an 82 billion

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Editorials

From the Interim Commissioner, Virginia Department for the Aging

Jim Rothrock
Commissioner, Virginia Dept. of
Rehabilitative Services (DRS)
and
Tim Catherman, Director of
Administrative Services (VDA)

Governor McDonnell vowed to make Virginia a Commonwealth of Opportunity. Immediately after he was sworn into office Governor McDonnell created the *Commission on Government Reform and Restructuring*. This body, composed of leaders from both the private and public sectors, met for more than a year and recently offered an array of recommendations for consideration.

Governor McDonnell reviewed these recommendations and recently reported that he accepted measures to:

- eliminate two state agencies;
- merge seven state agencies into others, and, of interest for the readers of this document, create a new one);
- eliminate 19 boards and commissions;
- merge 23 boards and commissions to form 11 boards and commissions;
- move four offices and initiatives; and
- de-regulate three professions.

One of these measures, close to all of our readers, is the measure to create a new agency which will include all of the functions currently within the Department of Reha-

bilitative Services, Department for the Aging, and the Department for the Deaf and Hard of Hearing, and, in July of 2013, move Adult Services and Adult Protective Services into this new agency.

Some factors lending credence to this measure are as follows:

- Individuals over the age of 85 are the fastest growing segment of population.
- A recent report from the US Bureau of Census says that 81% of the population 90 or older has a disability.
- There is a national trend to blend the aging and disability networks. In 2003 the Administration on Aging and the Centers for Medicare and Medicaid Services launched a collaborative effort of Aging and Disability Resource Centers (ADRCs) and in 2010 the National Association of State Units on Aging formally changed its name to National Association of States United for Aging and Disabilities (NASUAD).
- Last year 27% of the individuals served in Virginia's Centers for Independent Living (CILs) were age 60 or older. One third of the CILs reported over 40% of their individuals were age 60 or older.
- Virginia needs to prepare for the Age Wave that will affect all three agencies and thousands of Virginians.
- Several states have blended agencies or blended departments within health and human services: Delaware, Nevada, Oregon, Tennessee, Texas, Vermont, and Washington State.
- Creating a combined agency will be made easier because of existing shared service arrangements for administrative service.

- Frail elders and adults with disabilities are vulnerable populations in Virginia. The coordination of services, resources and protective functions such as Adult Protective Services and the Long-Term Care Ombudsman will improve coordinated response and action.

Driving this initiative is the desire to help Virginians improve their quality of life, develop and maintain self-sufficiency, and remain contributing members of their communities. Long-term services and supports will be based on the unique strengths and needs of each individual and the menu of choices afforded them will be expanded.

Eventual success will be measured through support provided to individuals, families, and caregivers; expanding service options; and continuously improving quality of care and support in all settings. Strategic planning will be facilitated to decrease duplication of efforts and make bureaucracy more responsive to Virginians with disabilities and Vintage Virginians.

Impact

The combined efforts at the state level will help guide a coordinated system of services that is quality driven, responsive to individual needs and preferences, and cost effective. The system will provide seamless support services, rehabilitation and employment in the person's own community, and offer new technologies that should foster increased independence and safety. Overall costs will be contained by promoting prevention, wellness, disease management and self-reliance, reducing unnecessary use

of more expensive services, and preventing or reducing the need for future services or resources. Program integrity will be assured through the distinctive funding streams.

Citizens who need services will have a more complete menu of programs to meet their individual needs. Vintage Virginians needing communication assistance will also be able to learn about services that will help support them in the community. Caregivers will have expanded service options, all available under one umbrella.

The Commonwealth hopes to improve its response to adults in abusive or vulnerable living arrangements through the coordination of Adult Protective Services and the Long-Term Care Ombudsman, as anticipated by the 2013 enactment of programs currently found under the Department of Social Services portfolio.

It should also be noted that local integrity of programming will be sustained; AAAs will still be locally directed; CILs will still be directed by their boards, which are unique due to the requirement that they have a majority of members who have disabling conditions; and the local social service units will still be offering day-to-day supervision of staff engaged in serving adults within local DSS offices.

Conclusion

The citizens of Virginia will be better served by a new integrated agency. Each individual is unique. Each person has his or her own needs. Every individual needs to be

heard. Only the individual or their caregiver can best identify their needs for wellness, prevention, support services, care, and abuse investigation. It is only when the disparate services of state government can be coordinated to better serve its citizens that we can create a Commonwealth of Opportunities for All.

The Dementia State Plan and Improving the Coordination of Services

by Patricia W. Slattum, Ph.D.,
Commission Chairman

The Alzheimer's Disease and Related Disorders Commission is pleased to present the Commonwealth's plan for meeting the needs of persons with dementia and their caregivers. With the number affected expected to triple by 2050, the five goals of the plan provide a comprehensive vision to:

1. Coordinate quality dementia services to ensure dementia capability
2. Use dementia related data to improve public health
3. Increase awareness and create dementia specific training
4. Provide access to quality coordinated care in the most integrated setting
5. Expand resources for translational research and evidence-based practices

As a first step, the Commission is advocating for improved coordination of state services through creation of a "dementia services coordinator"

to facilitate policy and research efforts linking services and activities of state agencies, service providers, and advocacy groups. A coordinator would help the state be better positioned to ensure efficient and effective coordination.

The work of the Commission and, potentially, the coordinator will be most successful with the input and efforts from other individuals and organizations already involved in collaboration and innovation to meet the needs of persons with dementia and their caregivers. The Commission hosted a webinar through AlzPossible in December to introduce the plan and begin receiving input on the priorities for implementation. Workgroups have been formed to address the five goals, and these workgroups are ready for your input and ideas.

We truly appreciate all of the effort that has already been put forth through the town hall meetings and public comment forums during the development of the plan, and we look forward to continued engagement as the plan is implemented to achieve the overall goal of improving the lives of persons with dementia and their caregivers in Virginia.

Read the plan, learn more about the Commission, listen to the webinar archive, and provide your input at www.AlzPossible.org.

Focus on the Virginia Center on Aging

Jeffrey Ruggles



Jeffrey Ruggles joined VCoA in February 2011 as the administrator for the VCU Road Scholar program. He wears several hats: educator, copywriter, and business manager. Given that his position calls upon different skills, it is fitting that his work career has been rather varied (let's not say "checkered").

For eight years, Jeffrey worked for the Virginia Historical Society as the curator for prints and photographs. He was a scholar and an educator, an expert on Virginia history and an advisor to researchers seeking images. As a "public historian," he prepared museum exhibitions, gave gallery tours and talks, and answered lots of questions. His book, *Photography in Virginia*, was published by the Virginia Historical Society in 2008.

Before this, Jeffrey operated Main Street Grill, a restaurant in downtown Richmond, from 1984-2001. He cooked, cleaned, cultivated customers, and kept the books. The Grill was an old-fashioned place with tin ceilings, wood booths, and barstools with shiny metal rims and leatherette seats. It was a diner in the daytime, went vegetarian in the evening, and for regulars was like a pub. The Grill's previous owner, Wally Bless, had run it until he was in his 70s and was something of a guru figure. Wally had been involved in Civil Rights during the

1960s and decided to open an integrated restaurant, something the city lacked in 1969. Thus, Main Street Grill came with a legacy: one of the first Richmond restaurants integrated not by law but by choice. Wally also set a tone with his interest in natural foods, tolerance for differences, and enthusiasm for world travel. Jeffrey improved the food and hung art on the walls. "There are probably enough stories and characters from those years," he says, "for a book full of inspiration, drama, and farce."

While working seven days a week, Jeffrey found time for a few side projects. In 1987, he prepared a set of historical markers for the Canal Walk in downtown Richmond. (About ten of the original 32 remain, including those at the big gears on Brown's Island, and a kiosk at Kanawha Plaza.) While slinging beans, he also wrote his first book, *The Unboxing of Henry Brown*, a biography published in 2003 by the Library of Virginia. The research took him as far as London and Oxford. Henry Brown was a Richmond slave who had himself shipped to freedom in Philadelphia in a box. Once in freedom, he became Henry Box Brown and went on to career as a performer on the show circuit in the United States and Great Britain.

Before the restaurant, Jeffrey worked in photography. He received a Master of Fine Art degree in Design/Photography from VCU in 1983.

Jeffrey's parents met in Hampton, where his father grew up. His dad's job as an engineer took them to Washington, D.C., where his moth-

er grew up, and where Jeffrey was born. After a few years in Maryland and a decade in Connecticut, the family moved to Richmond. His younger siblings now live in Boise, Tucson, and Raleigh. Jeffrey graduated from the University of Virginia and also spent an exchange year at Hampton Institute (now Hampton University), where his grandfather had taught many years before. Jeffrey and his wife, Sandra, have four children, ages 10 to 19. They reside in Woodland Heights, a streetcar suburb in south Richmond, in a 1912 house that, like most centenarians, requires a little attention.

Jeffrey enjoys working at the VCoA offices in the Theater Row building at 8th and Broad streets. "It's a place with interesting historical associations," he says. From the 1890s through World War II, the streetcar lines converged on Broad Street between 7th and 9th, and the area became the city's hotel and theater district. Among the young Richmonders who took in shows were Dots Toney, Bill Robinson, and Freeman Gosden, who later became, respectively, the Vaudeville headliner Eddie Leonard, the dancer Bojangles, and one-half of the original Amos & Andy. Before then, for much of the 1800s the tracks of the Richmond, Fredericksburg, and Potomac railroad ran down the median of Broad Street. Out front of the Theater Row building, the train to Washington was loaded in the middle of the street, including in 1849, a box addressed to Philadelphia and marked "This Side Up with Care" that contained Henry Brown. "It's good to be aware of what's come before," states Jeffrey, "and it makes things more fun, too."

Fall Intervention Effort Launched in Northern Virginia

by Anne Blackstone, MSPT
Inova Loudoun Hospital
NVFPC Member

With one of three adults over the age of 65 falling every year, and over 1,100 fall-related deaths in this population between 2004-2007 in Virginia alone, Tony and Becky Schaffer noticed a need. In 2008, these home-modification professionals organized the Northern Virginia Fall Prevention Coalition (NVFPC). The NVFPC is a grass roots effort comprised of local doctors, pharmacists, nurses, rehabilitation specialists, government representatives, business owners and professionals. This team of seasoned professionals has begun implementing the CDC's Preventing Falls program in the communities of Northern Virginia in an effort to reduce the incidence of fall-related injuries and the devastating financial and emotional impact they have on families and institutions.

On September 20, 2011, the members of the NVFPC, in collaboration with the Loudoun County Area Agency on Aging, launched the first Community Fall Risk Screening Event at the Cascades Senior Center in Sterling. The event was the first of its kind modeled after the CDC's Preventing Falls program. Forty five participants received a vision assessment by an optometrist, a medication review by area pharmacists, and a mobility/conditioning assessment by physical therapists. Participants then sat

down with a health professional who discussed the results and created a personalized fall prevention plan. (Participants were asked to discuss the recommendations with their primary care physician prior to implementing any of the recommendations.) Of the 45 individuals screened that day, 32 were found to be at risk for falls: about 71%.

The NVFPC held another screening event in November at the Carver Senior Center in Purcellville. Of the 34 participants screened that day, 28 were found to be at an increased risk for falls: about 82%. The next community screening event is scheduled for January 2012 in Leesburg. Participants in the screening events will be followed-up with every six months to monitor progress in their fall intervention plan, and to make further recommendations when indicated.

The locomotion research department at Virginia Tech has also joined this initiative. Dr. Thurmon Lockhart and his team are studying the relationship between gait, mobility, and falls in older adults. The team is present at the screening events to conduct voluntary data collection on community dwelling older adults in an effort to further identify fall risk patterns and prevention.

The NVFPC is working toward duplicating this Community Fall Screening and Intervention Plan throughout Virginia. **Falls are preventable and are not an inevitable part of aging.** If you would like more information on fall prevention initiatives, or if you would like to host a screening event in your area, visit www.nvfpc.org.

From the Virginia Center on Aging, *Continued from Page 7*

dollar budget, or less than 3 cents on \$100. The purported savings within the aging-related realm, of course, would be just a portion of this. Unanswered is how much the loss of donated expertise from any collapse of the committee membership would offset this savings.

One has to ask if these proposed aging-related collapses, as related to the three agencies, represent a diminishment of aging and, as related to the three committees, a loss of *government of and by the people*.

Annual SGS Meeting

The 33rd Annual Meeting of the Southern Gerontological Society (SGS) will be held April 19-22, 2012 at the Sheraton Nashville Downtown Hotel. This year's theme is *Gerontology: A Legacy of Commitment*.

Conference tracks will include:

- Historical Perspectives and Innovations in Aging
- New Strategic Models in Service Delivery, Advocacy, Policy
- Intergenerational Programs- Linking the Past with the Future
- Educating Future Gerontologists

Early bird conference registration, before March 1st, is \$225 for members and \$255 for non-members.

For more information, visit: www.southerngerontologicalsociety.org.

COMMONWEALTH OF VIRGINIA

Alzheimer's and Related Diseases Research Award Fund

2010 – 2011 FINAL PROJECT REPORT SUMMARIES

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

Alzheimer's Association Southeastern Virginia

Patricia Lacey, MBA, Sonya Barsness, MSG, and Scott Sautter, PhD “The Impact of Early Alzheimer’s Support and Education Programs on Both Diagnosed Participants and Their Care Partners”

This study investigated the social and psychological impact of EASE (Early Alzheimer’s Support and Education), a program intended to empower diagnosed individuals and their partners to become active participants in their care. The study employed a quasi-experimental (switching replications) research design with validated measures and a wait-listed comparison group. It was hypothesized that, in comparison with those assigned to the delayed intervention group (n = 17), EASE participants (n = 20) would show improvements in personal self-efficacy, mental and physical health status, and the quality of life for those diagnosed with Alzheimer’s disease. No statistically significant group differences were documented between the intervention and wait list groups, but 2 X 2 factorial and repeated measure ANOVAs showed main effects for time of testing on all three outcome measures, and improvements in the intervention group were generally sustained three months after the program. Comparing scores for care-partners and those diagnosed revealed statistically significant interaction effects for several of the health status and quality of life indicators. Scores provided by those with the diagnosis decreased (worsened) from the time of pre-testing, while the scores for the care-partners increased (improved). However, both care-partners and those with the diagnosis indicated that the overall quality of life for the diagnosed person improved. Given the benefits of the EASE program documented in this study (e.g., lessened depression, improved quality of life, and perceived ability to handle unforeseen situations), it is surprising that the primary hypothesis was not supported. It appears that there was a positive anticipatory effect for the wait-list group in knowing that they would participate. Perhaps simply making the decision to participate in EASE improved their outlook and knowledge of future participation influenced both self-efficacy and quality of life. Although early stage programs have garnered some evidence-based support, additional research is needed to document new models of support and education, and determine the long-term effects of these as the disease progresses.

(Ms. Lacey may be contacted at (757) 459-2405; Ms. Barsness may be contacted at (757) 773-7841; Dr. Sautter may be contacted at (757) 498-9585.)

VCU Kate Lapane, PhD “Assessment of Factors which Influence Physician Decision-making Regarding Medication Use in Patients with Dementia at the End of Life”

Few studies relating to the importance of rationalization of medications in patients with advanced dementia nearing the end-of-life exist. Little is known about the impact of non-clinical factors on prescribing decisions. We evaluated the extent to which nursing home placement, family involvement, and advanced directives influence prescribing decision-making in patients with end-stage dementia. A multidisciplinary team developed four vignettes of patients with end-stage dementia with specific questions relating to discontinuation or initiation of specific medications. Using a modified Dillman approach, the investigator invited a sample of primary care physicians with an active Virginia medical license to participate via email. Of the 269 responders, 191 were eligible for the study. Physicians were emailed surveys and randomly assigned three factors: 1) Place of residence of the patient (community-dwelling, nursing home); 2) Presence / absence of an advance directive; and 3) Family desires active measures, family desires supportive measures, no family involvement. Chi-square analyses were performed as balance of potential confounders was achieved through randomization. Continuation of therapies not likely conferring benefits (e.g. statins) was commonplace, regardless of randomly assigned factors. Physicians were less likely to initiate antibiotic therapy for patients with advanced directives (e.g. treating pneumonia with fever: 38% with advanced directives vs. 53% without ($p < .05$)). Medication initiation was not influenced by family involvement or nursing home residence. Prescribing decisions for patients with end-stage dementia may be influenced by non-clinical factors. Guidance on strategies to discontinue medications may be warranted.

(Dr. Lapane may be contacted at (804) 628-2506.)

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 2, 2012 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 ensures the most informed review of applications and 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 2, 2012, and applicants will be notified by June 22, 2012. The funding period begins July 1, 2012 and projects must be completed by June 30, 2013.
- 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:

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Coping with a Life Changed by Alzheimer's Disease

by Frank Fuerst

My wife, June, was in her forties when Saeko, a holiday guest, described her as the perfect role model for a woman who wanted to have both a career and a family. Little did we realize that early-onset Alzheimer's disease was already slowly creeping into our lives. Three years later it showed itself.

For the two and one half years after June's uncharacteristic behavior became obvious, doctors attributed the dramatic change alternately to menopause or depression. With our inability to understand what was happening, I was the one who was becoming depressed. Only after a neuro-psychiatrist conducted an additional six months of tests did we get a diagnosis that was later confirmed by the National Institute on Aging.

June had always been the family nurse. She had great sympathy and empathy. She would have been the perfect caregiver. I lived in a business world of fast changing technology and felt ill-equipped to be a caregiver. Spirituality, creativity, initiative, determination, and devotion to June, however, became the foundation on which I began building caregiver skills. Based on everything that I had heard and read, caring for a family member full-time was a nearly impossible task that got harder every year. The path that I followed, however, got easier as time went on. So, what was different about my approach?

Cornerstones of Care

Early on, I revisited my spiritual roots and prayer became one of four cornerstones. Some things that I prayed for were wisdom, patience, and mental toughness. I needed all of those traits in abundance because I had more than my share of negative emotions and other challenges. Since the disease marched steadily onward, June was not going to change, which meant that I must. For example, to release anger, I vented it in a harmless way by writing on handy legal pads about everything, including the cause of my anger and a possible solution. By putting my thoughts in writing, I found that it was easier to overcome my inertia and act on a solution. Spirituality became my first cornerstone.

Another challenge, fatigue, affected me physically and mentally. One of my solutions was to use a day-care facility (and eventually home healthcare and a nursing home) to give me respite from continuous caregiving. Although I later used more than a week to vacation with my family, even a weekend of respite gave me much greater energy. Respite became my second cornerstone.

Dealing with many new things, I also isolated myself from people other than family members. I knew, however, that I needed to share thoughts and feelings with others, so I joined a support group. It provided the companionship that I had lost and became a third cornerstone.

Because I now had a plan to help myself, I could take time to think about better helping June. So I

prayed for empathy, lots of empathy. To gain it required me to visualize how June was feeling, especially how she wanted me to provide care. During her most content part of the day, as she watched song videos and had a favorite juice, I wrote her imagined caregiving 'wish list' in my journal. After several months, I had almost 40 ideas. I boiled these down to the 10 most important. These caregiving "rules" helped me to fulfill her imagined wishes. Giving "care with dignity" was the fourth and last cornerstone and affected me as well as June.

Together, these four cornerstones of spirituality, respite, companionship, and giving care with dignity allowed me to become more compassionate. To quote Winston Churchill, these four cornerstones "did not mark the beginning of the end," but they did mark "the end of the beginning."

Caregiver Phases of Dementia

Other changes were also coming into my life. After realizing that my story was special, I converted my four file drawers of information into a manuscript, so others might benefit from my experience. As soon as my first chapter was finished, it won prizes in both contests I entered. After publication, *Alzheimer's Care with Dignity* won a number of prizes.

Knowing what to expect from this disease and how to prepare for them was something that I would have liked to have known up front when I began to provide care. In my book, I have introduced new definitions of the phases of the disease in terms that caregivers can

understand and that will help them pinpoint the start of each phase.

Independent Phase

This phase started with the first significant symptoms. June was 'independent' from the standpoint that I was still working. To provide for her if I died first, I took care of all the financial and legal issues. To help others, we worked with doctors to enroll June in research and drug studies at the National Institutes of Health.

Companionship Phase



This phase started when June could no longer be trusted to keep out of harm's way, and she became a risk to others. June stopped driving and I took an early retirement.

We did things that she loved most, such as dining out and travel. During this phase, I became the family chauffeur and began to assume tasks around the house like cooking and cleaning.

Dependent Phase



This phase started when June became incontinent. It was a period of rapid mental decline, with care responsibilities

increasing accordingly. June needed help with all activities of daily living, such as bathing, dressing, eating, and moving from place to place. (Picture taken in the middle of this phase)

Final Phase

The final phase was a period of rapid physical decline that included seizures, infections, and much time in a wheelchair.

Real, Perceptive, and Sensitive Persons

After I started speaking across the country, I began to hear from other caregivers. In my support group, I encountered what I first thought was a misconception about persons with dementia. One member consistently said, "That is not my wife." Then a person from a Bible study group asked me how I dealt with this opinion. I said that persons with dementia are as real, perceptive, and sensitive as they were before they became ill. To prove this point, I later extracted from my book and journal moments that led to this understanding for each of the four caregiver phases of Alzheimer's disease. Illustrations follow.

Independent Phase. Wandering was not a problem when we were at home. When we traveled, however, June disappeared once and my anxiety and blood pressure reached the upper limits. So at one bedtime, I wedged a chair under the hotel room doorknob and moved another piece of furniture into that area. I told her it was to keep us safe. She looked at me in a strange way and said, "I'm sorry. I don't know why I

act this way. My brain is short-circuiting."

Companionship Phase. As June's anxiety level peaked, she tossed and turned relentlessly every night. I arose each morning feeling exhausted. Reluctantly, I realized that I needed my own bedroom. On a month-long trip, however, we again shared a bed. When we returned home, we each went back to our separate bedrooms. June awoke the first morning and came rushing into my room sobbing. She said, "Thank God you're here. I thought I had lost you."

Dependent Phase. June was going to day care on a regular basis. A bus picked her up mid-morning and brought her home mid-afternoon. I walked her to the bus and made sure she was seated. The bus driver later reported that she said with a tear in her eye, "Poor fellow."

Final Phase. To keep up June's strength, one exercise we did was to climb stairs. After she reached the top of the stairs, I usually said, "Good job." I varied this once with, "I am very proud of you." After waiting a few moments, she said to herself, "Good job." Another day in her last month, I fed her some cole slaw and tea. She suddenly looked me in the eye and gave me an appreciative smile.

Faith and Hope

One's background may make a person ill prepared to be a caregiver. However, the personal qualities that one does have (e.g., spirituality, creativity, initiative, determination, or devotion to a family member) can compensate. As a family

member deteriorates, caregivers will sometimes think that they cannot possibly handle the next challenge. When the need arises, however, they do learn the required skills. Going through this experience, a caregiver can become a kinder, gentler, and more fully developed person.

Anyone who has been on a plane knows what they say at the start of every flight. "If you are traveling with a small child, please ensure that your mask is in place first. Then secure the mask for the child." The primary obstacle for me was in my mind. To help June, I had to first learn how to 'get my mask in place' for my own emotional and physical challenges. Because I was lost in an uncharted jungle, it took me 11 years to do it.

Thousands of other caregivers have taken the path of keeping their family member at home for the length of an illness. Unfortunately, there have been few markers laid out detailing which directions they should follow. Now, with a well-blazed trail, it need never again take anyone 11 years to find their way. In my journey, the last six years, theoretically, should have been the hardest. Instead, everything I learned along the way made those six years the easiest from mental and emotional points of view. So, a caregiver who is directly affected by a long-term illness, needs to have faith. He or she can become spiritually, mentally, and emotionally stronger as time goes on.

Life after Alzheimer's

Speaking around the country brought another meaningful

change. A minister from Kirkwood, Missouri heard me being interviewed by Don Marsh on St. Louis Public Radio. The minister said he liked my spiritual message and asked me to give the keynote talk at a conference for caregivers. He also asked if I would consider giving both Sunday sermons at his church. Since giving 'The Power of Prayer' that day, I have completed a 'lay speaking' course and look forward to giving my latest sermon, 'The Fifteenth Commandment.'

Find more information at www.dementiacaregiving.com.

Three Old Ladies on a Bench

Dementia Training for the Professional through the Eyes of the Person with Dementia

The Alzheimer's Association Greater Richmond Chapter will offer a new training program for professionals designed to provide basic dementia training in a format that recognizes the individual differences of those with dementia diseases. The training will be offered in Fredericksburg and Richmond.

This training will provide tools to care for those with dementia diseases as individuals. It will also provide tips on changing the culture of the care we provide to individuals in residential communities, adult day centers, and home care agencies. Topics will include: overview of dementia diseases, how relationships are an integral part of communication, tips that can create more effective communication, the

relationship between challenging behaviors and communication, and physical issues such as infections that can cause behavioral issues. Training will include role play by the presenters and interactive demonstrations with the attendees who will have the opportunity to experience the virtual reality of those with dementia diseases.

The targeted audiences are all long-term care professionals, including frontline staff, administrators, and nurses. National Association of Boards of Examiners of Long Term Care Administrators (NAB) for administrators and Continuing Education Units (CEU) credits will be made available. All attendees will receive a certificate of attendance.

This training is made possible by a grant from the Geriatric Training and Education (GTE) initiative at the Virginia Center on Aging. There is no cost for the training, but registration is required.

Richmond

March 9, 9:00 a.m. – 2:00 p.m.
Lunch included. Covenant Woods, 7090 Covenant Woods Drive, Mechanicsville. To register, contact Fran Foster at (804) 967-2580 or fran.foster@alz.org.

Fredericksburg

June 14, 9:00 a.m. – 2:00 p.m.
Lunch included. Salem Fields Community Church, 11120 Gordon Road. To register, contact Lori Myers at (540) 370-0835 or lori.myers@alz.org.

The Growing Younger Program

by Merie Brumfield



Arlene, a member of the YMCA's Growing Younger Program since April 2011 is growing younger every day at 86.

"It is amazing

what this program has done for me," she says. Arlene was living alone when she had a stroke and heart attack almost two years ago, which resulted in left sided weakness and, as she describes, "like a baby, I needed to relearn everything." She now lives with her daughter and son-in-law in Richmond and goes to the Innsbrook Senior Center Monday through Friday. Her daughter drops her off in the morning before work and picks her up on the way home. Arlene is so grateful that this allows her daughter to still have a career and a fulfilling life. As a mother of five, Arlene has always cared for others, but now realizes the importance of focusing on herself.

At the Innsbrook Senior Center, Arlene participates in the YMCA's Growing Younger Program three to four days a week. The Growing Younger Program, a partnership among the United Way, YMCA of Greater Richmond, Senior Connections, and Genworth Financial, provides wellness and arts activities that focus on a combination of physical, mental, and social well-being. The program includes a chair-based exercise class that works on each individual's flexibil-

ity, strength, and muscular endurance through fun and engaging exercises. Participants are evaluated through fitness testing and health screenings. Everyone is encouraged to gain knowledge and take ownership of their own health.

Like many, Arlene has benefited from the exercise program which has improved her daily life. Some skills most important to her on her long list of accomplishments include: being able to walk up and down a flight of stairs independently, dressing herself, getting in and out of the car and buckling her own seat belt, and holding a glass of water with her left hand. Also, as part of the exercise program, Arlene travels to the Shady Grove Family YMCA twice a month to take an exercise class in the fitness studio. She is constantly making new small goals to help her move forward in exercise class; currently she is trying to participate in more of the standing challenges. Her long term goal is to be able to walk around the small lake behind the center by summer 2012. We will all work together to help her meet that goal.

When Arlene's youngest son was a child and living with a brittle bone disease, she introduced him to art because she believed it was important for him to experience different activities and not be limited by his disease. This was something they both enjoyed, and she became quite skilled. After her stroke, she was not sure if art was something she would ever enjoy again, until she started participating in the arts component of the Growing Younger Program. Facilitated by Art on Wheels and the Visual Arts Center of Richmond, this program is

designed to encourage participants to express themselves, improve fine motor skills and stimulate cognitive growth. Arlene has created masterpieces, such as pastel drawings, silk scarves, and mosaics. She praises the art and exercise classes for helping her "grow in confidence" and gain many new friends. Previously too intimidated to go out in public, she has learned that there are others like her and she embraces the new opportunities.



Innsbrook Senior Center participants at Shady Grove Family YMCA.

The Growing Younger Program is free and offered at locations in partnership with Senior Connections' Friendship Café program, The Innsbrook Senior Center, and Chickahominy Family YMCA.

To learn more, visit www.seniorconnections-va.org.

The Growing Younger Program participants may also engage in some of the many active adult programs offered at branches of the YMCA of Greater Richmond (www.ymcarichmond.org).

Merie Brumfield is the Director of the Growing Younger Program at the YMCA of Greater Richmond.

VCU's Department of Gerontology Receives New Funding

The Department of Gerontology has had the great fortune to be the recipient of, or collaborator on, a number of new grants.

- *Oral Health Care Training of Direct Care Providers and Health Care Professionals.* Geriatric Training and Education Initiative (GTE) proposal submitted by Ph.D. in Health Related Sciences student Patricia Brown Bonwell. Funding from the Virginia Center on Aging. In-service training sessions and a seminar/webinar will be presented addressing oral health in older adults. This will increase education of direct care providers and health care professionals in nursing homes and in private practices.
- *A Community and Academic Partnership for Training on Depression and Dementia.* GTE proposal submitted by Tracey Gendron, Assistant Professor, and Megan Felton, MSG. The project partners with Memory Commons at the University of Virginia and the Beard Center at Lynchburg College to develop trainings for healthcare professionals on the differential diagnoses between dementia and depression.
- *Mental Health and Aging Training Initiative.* Funded in partnership with the Center for Excellence in Aging and Geriatric Health. The project will address training issues identified by the Geriatric Mental Health Partnership as important for developing a workforce prepared to address the behavioral health needs of the aging population.

Calendar of Events

January 25, 2012

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

February 23-26, 2012

Engaging Aging in Higher Education. The 38th Annual Meeting and Educational Leadership Conference of the Association for Gerontology in Higher Education. Renaissance Arlington Capital View Hotel, Arlington. For information, visit www.aghe.org.

March 28 - April 1, 2012

Aging in America. 2012 Annual Conference of The American Society on Aging. Washington, DC. For information, visit www.asaging.org/aia12.

April 16-17, 2012

National Association of Area Agencies on Aging's 18th Annual Aging Policy Briefing. Washington Court Hotel on Capitol Hill. For information, visit www.n4a.org.

May 3-5, 2012

2012 Annual Scientific Meeting of the American Geriatrics Society. Seattle, WA. For information, visit www.americangeriatrics.org.

May 22, 2012

Aging Well in Mind, Body, & Spirit. Annual Conference on Aging presented by the Beard Center on Aging at Lynchburg College and Centra Health. The event will feature free health screenings, poster sessions, and workshops on topics including effective advocacy, mental health, cultural diversity in aging and dementia. Lynchburg College. For information, contact

(434) 544-8456 or scruggs.dr@lynchburg.edu.

May 31- June 2, 2012

18th Annual Conference of the Virginia Coalition for the Prevention of Elder Abuse. Virginia Beach Resort & Conference Center. Pre-conference workshops May 31st. Keynote speaker is Mary Twomey, National Center on Elder Abuse, University of California at Irvine. Conference scholarships for first-time attendees are available. For information on the program or the scholarships, visit www.vcpea.org or call Lisa Furr at (804) 828-1525.

June 18-20, 2012

Virginia Association of Nonprofit Homes for the Aging's Annual Conference and Trade Show. The Cavalier Hotel, Virginia Beach. For information, visit www.vanha.org.

Age in Action

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

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March 15, 2012**



Virginia Center on Aging

at Virginia Commonwealth University, Richmond, Virginia

www.vcu.edu/vcoa

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Falls Risk Prevention and Protection of Older Adults: An Interdisciplinary Conference

March 29, 2012

Hotel Roanoke, Roanoke

9:00 a.m. - 5:00 p.m. (registration opens at 8:00 a.m.)

*Co-Sponsored by Radford University's School of Nursing (RUSON) and
the Virginia Geriatric Education Center (VGEC)*

Conference Goals and Objectives

- Participation in case scenarios identifying appropriate fall intervention.
- Engaging interdisciplinary professionals to discuss evidence-based protocols on fall risks and management.
- Identifying risk and assessment parameters in prevention of falls.

Cost

- \$90 fee includes the conference, the hotel's famous lunch buffet, and refreshments throughout the day!
- Student registration fee is \$80.
- An estimated seven CE's or CME's are provided for an additional \$15 at registration.
- The hotel is offering special rates on sleeping rooms.

For more information, contact Radford University Conference Services at
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