

## Case Study

### Medications as a Risk Factor in Falls by Older Adults with and without Intellectual Disabilities

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#### Educational Objectives

1. Review common intrinsic and extrinsic risk factors for falls by older adults.
2. Compare risk factors for older adults with and without intellectual disabilities.
3. Focus on medications as a risk factor among a complexity of risk factors.
4. Suggest steps to improve appropriateness of medication regimens, as a step to help reduce risk for falls.

#### Background

Falls are a too common and much feared aspect of life for many older adults. The consensus from research is that about 30-40% of community-dwelling adults ages 65+ have fallen in the past year,

increasing to about half of those age 80 and above. A new study (Hsieh et al, 2012) using retrospective data of 1,515 adults with intellectual disabilities found a similar percentage among those 65+, with no further sub-analysis among those 80 and above. Importantly, Hsieh and colleagues found rates of falls among younger ages that were comparable to rates of older adults without intellectual disabilities. Our Virginia Geriatric Education Center team found well over a dozen definitions of what constitutes a fall, and this muddles generalizations from studies employing a variety of criteria. Our team chose as most useful: "A fall is an unplanned descent to the floor (or an extension of the floor) with or without injury." So, feeling dizzy and choosing to sit would not be considered a fall but other unintentional losses of balance that "plopped" one onto a chair or bed rather than onto the floor would be.

Research suggests that interventions to reduce risk for falls tend to be most successful when the intervention is multi-faceted and targets those with the most critical risk factors. This case study will review

various risk factors briefly but cannot be comprehensive. It will concentrate its focus more on medications, which, in fact, are associated with several of the most critical risk factors. Even there, the appraisal is limited by space.

#### Falls as a Signal

"Causes" of falls are often indefinite and complex, so health care researchers and practitioners have identified a number of risk factors that are associated with falling. These risk factors are clinically identified as either intrinsic or extrinsic. Intrinsic factors refer to characteristics or conditions of the individual, such as vision, gait, and health history. Extrinsic factors refer to conditions outside the individual, such as environmental hazards but also medications taken by the individual, brought into the body, that others may have prescribed.

As might be seen, falls may be a signal of other geriatric syndromes, such as falling when rushing to the bathroom because of incontinence or falling because of worsening sensory input from poor vision or

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hearing. Falls may be the cause or the effect of frailty. Falls may precipitate a downward cascade in quality of life. And so on. Clearly, reducing one's risk of falls deserves great attention from older adults, family caregivers, health care providers, agency staff, and others who are concerned.

### **Fall Risk Factors**

Intrinsic and extrinsic risk factors tend not to exist separately, in isolation, for they are frequently inter-related, as when balance disorders lead to medications being prescribed and vice versa. There is an interaction and probable synergism among multiple risk factors. They can relate and multiply. The risk of falling increases as the number of risk factors increases. There is not a direct and linear cause and effect. But identifying and addressing risk factors for falling does help to reduce its likelihood.

#### Intrinsic Risk Factors

Some of the common intrinsic risks include: lower extremity weakness; previous falls; gait and balance disorders; impaired vision; depression; functional and cognitive impairment; dizziness; low body weight; urinary incontinence; orthostatic/postural hypotension (a notable drop in blood pressure from sitting to rising); female gender; and being over age 80. Some intrinsic risk factors are simply not modifiable; some are.

#### Extrinsic Risk Factors

The more important extrinsic risk factors include: medications, especially polypharmacy (taking four or

more prescription medications); psychotropic medications (medications that affect the mind and behavior); and environmental hazards, such as poor lighting; loose rugs or carpets; lack of bathroom safety equipment, and improper foot wear, like slippers that provide no support. Generally, extrinsic factors are modifiable.

#### The Most Critical Risk Factors

For more than 20 years, geriatrician Mary Tinetti and colleagues have focused on risks for falling and interventions to reduce those risks. Her landmark randomized controlled intervention trials with community-dwelling elders in Connecticut (Tinetti et al., 1994) and subsequent work (e.g., Tinetti & Kumar, 2010) have identified the most critical risk factors for intervention. Pragmatically, she argues that health care practitioners should target the risks that they can fix most readily, through screening and interventions (Tinetti & Kumar, 2010). Tinetti and Kumar's updated fall risk factors suggest that screening and intervention should target older adults with: previous falls; balance impairment; muscle weakness; dizziness/orthostasis; female sex; low body weight; diabetes; gait impairment; vision impairment; and/or cognitive impairment. Notably, several of these factors may precipitate or be the result of medications. Hsieh et al. (2012) identified similar significant risk factors among adults with intellectual disabilities: female sex, having arthritis, having a seizure disorder, polypharmacy, using walking aids, and having difficulty lifting or carrying over 10 pounds. Specifically, among those without a seizure dis-

order, Hsieh and colleagues found statistically significant risk factors for falls were having a higher level of intellectual disability, having arthritis, back pain, a heart condition, urinary incontinence, using a walking aid, and having difficulty walking three blocks.

### **Medications as a Risk Factor**

Older adults may be at greater risk of falling because they may have multiple chronic conditions like high blood pressure, arthritis, sleep problems, etc., for which medications are prescribed; moreover, there are likely multiple prescribers involved who may or may not know what others are prescribing for the older adult. The older adult may be taking multiple medications, both prescribed and over-the-counter, and there may be a significant mix of medications being taken. This mix may lead to unintended consequences, including lessened or heightened therapeutic results or adverse drug events. Note that these situations apply across the board to older adults with or without lifelong disabilities. Many medications go to market having few adults ages 75 and above in the clinical trials that tested the drug.

Surprisingly, there have been few randomized controlled trials to study the effect of a specific medication on risk of falling. And, as noted earlier, interpretation of the studies has been complicated by variations in fall definitions. However, psychotropic medications are strongly related to risk for falls; the use of sedatives and hypnotics, antidepressants, and benzodiazepines (prescribed for anxiety, insomnia, muscle spasms) demon-

strates a significant association with falls in older adults (Wolcott et al., 2009; AGS/BGS, 2010, 2011).

Importantly, several of the most frequent manifestations of adverse drug events are risk factors themselves for falling; these adverse drug effects include orthostatic/postural hypotension (a precipitous drop in blood pressure when rising), bradycardia (heart rate that is too slow), cognitive changes, and dizziness. Falling may represent the final common pathway of cumulative adverse drug events (Agostini & Tinetti, 2002). So, it is prudent to take steps to ensure that medications are both appropriate and taken correctly.

### Case Study #1

Anthony, age 43, has mild to moderate intellectual disability due to difficulties at birth during delivery. He is the youngest of four children and is doted upon by his three sisters. He lives with his parents and participates in a sheltered workshop where he helps assemble materials for promotions and marketing contracts that the agency obtains. He's active in his church and accompanies his father to monthly meetings and outings of his Knights of Columbus chapter. Only slightly overweight, he nonetheless has high blood pressure, which his physician is treating aggressively. Recently, he began experiencing dizziness and mood changes and he has communicated his apprehension about leaving the safety of his home. He sits in his room. For his high blood pressure, Anthony takes hydrochlorothiazide 25 mg/metoprolol succinate 200 mg (Dutoprol®) daily. He was recently prescribed lorazepam 0.5 mg (Ativan®) daily

for symptoms of anxiety. His dose of Dutoprol® was recently increased to the maximum recommended dose. Metoprolol causes dizziness in 3-10% of adults and bradycardia in 5% of patients. The higher the dose, the greater the risk of experiencing these adverse drug events. It is important to ask about symptoms of dizziness and to monitor Anthony's pulse and blood pressure (sitting and standing) to be sure that he is not experiencing side effects that may increase his risk of falling. His symptoms of dizziness may be related to his blood pressure medication, considering that the dose of his blood pressure medications was increased just before the dizziness started. Fortunately, there are many different medications available to manage high blood pressure and an alternative may not result in the same side effects. Lorazepam also increases Anthony's risk of falling. This medication should be used temporarily at the lowest possible dose. Long term treatment with benzodiazepines should be avoided whenever possible. Non-medication therapy can be helpful in both hypertension (exercise and a healthy diet) and anxiety (cognitive behavioral therapy or relaxation techniques).

### Case Study #2

Ethel is a 72-year-old widow who lives alone in the home where she and her husband raised their two children. They each live nearby. While she has always considered herself to be healthy, she has recently been plagued by painful arthritis, troubling problems with her vision, joint pain, and cardiovascular problems. Her appoint-

ment book is filled with names of physicians. Last weekend, she fell and bruised herself badly when leaving her house. Ethel is taking one acetaminophen 500 mg (Tylenol Extra Strength®) three times per day for arthritis. For pain unrelieved by acetaminophen, she takes tramadol 100 mg (Ultram®) three times per day as needed. Recently she has been taking tramadol two-three times a day. Ethel also takes zolpidem 10 mg (Ambien®) occasionally when her arthritis pain makes it difficult for her to fall asleep. For her cardiovascular problems, Ethel takes atorvastatin 20 mg (Lipitor®) daily to lower her LDL cholesterol and hydrochlorothiazide 25 mg daily for high blood pressure. Ethel's most significant medication-related risk for falling is her use of psychotropic medications, particularly as needed tramadol and zolpidem. To reduce her use of tramadol, Ethel can try increasing her scheduled acetaminophen dose to 1000 mg two-three times per day. Topical analgesics may also help. Management of chronic pain is important for quality of life, so it is necessary to balance the risks and benefits of drug treatments. Zolpidem should only be used for the short-term treatment of insomnia and at the lowest effective dose. Older adults and women are at higher risk for adverse events (impaired balance and cognition, falls) from zolpidem, and a lower dose of 5 mg daily as needed is recommended. Taking tramadol and zolpidem simultaneously is particularly troublesome, as the adverse events are exaggerated. Blood pressure lowering medications can also increase the risk of falling, so periodic monitoring to be sure that the blood pressure does

not drop too low when standing is also important. Tramadol can also enhance the orthostatic hypotensive effects of hydrochlorothiazide. Whenever multiple medications are being taken, their interactions with each other should be considered.

### **Interventions Related to Medications**

Tinetti and colleagues (1994, 2010) identified several interventions that reduced falls by older adults. (Notably, even the most comprehensive interventions do not eliminate the risk for falls.) When orthostatic/postural hypotension was present, with the individual experiencing a precipitous drop in blood pressure on rising, behavior modification and medication review/change proved helpful. For example, teaching the individual to rise from a chair more slowly and to use a chair with a higher and more firm seat lessened the risk, as did, of course, modifying medications that can cause the drop in blood pressure in the first place. Use of benzodiazepines (psychotropics for anxiety, insomnia, muscle spasms, etc) may be modifiable, with tapering off sometimes possible; if not, instruction in appropriate use helped. Multiple medications in one's drug regimen which prompted involvement of the person's primary care provider to conduct serious review of each medication's indication, dosage, adverse effects, interactions, and so on, resulted in changes in medications and improved communication among providers. While Hsieh et al. (2012) employed secondary analysis of data from the Longitudinal Health and Intellectual Disability Study and did not involve clinical inter-

ventions, it seems reasonable, given the similarities among risk factors for falls by older adults with and without intellectual disabilities, that a focus on medications is prudent. Notably, seizure disorders and other health conditions (arthritis, heart condition, back pain, and urinary incontinence) for which prescribed medications are the most common treatment modality emerged as the most important risk factors, as well as the risk factors for fall-related injuries requiring medical care (Hsieh et al., 2012).

Some more specific suggestions follow.

#### The Medication History

Older adults, family caregivers, and health care providers can help reduce the risk for falls by careful appraisal of the medications that the older adult is taking. An accurate medication history is important but can take some detective work to obtain. The medication history needs to be comprehensive. The current medication list should include: prescription medications, over the counter medications, dietary supplements or herbal products, alcohol and other recreational drugs (AGS/BGS, 2010, 2011). For each medication, it is necessary to record the dose, time(s) taken each day, frequency of use for "as needed" medications, and indication (why the person is taking the medication). In the latter case, there are occurrences where someone is still taking a drug long after it ceased being needed. Discrepancies between the patients' understanding of what they should be taking, what they actually are taking, and what healthcare providers record on their

medication lists are common.

#### Screening for Medication-Related Fall Risk

The "Brown Bag" review where all medications are literally or figuratively put together in a paper bag offers an opportunity to determine how the older adult patient is actually taking medications and to inquire about medication effectiveness and possible adverse events (Steinman & Hanlon, 2010). Significant questions to ask include:

1) Is the person taking more than four medications?

2) Is he or she taking psychotropic medications? These include sedatives, antipsychotics, antidepressants, antiepileptic medications, benzodiazepines, and anticholinergic medications (which block receptor sites of the neurotransmitter acetylcholine). Many of these medications appear on the Beers list of potentially inappropriate medications older adults ([www.americangeriatrics.org/health\\_care\\_professionals/clinical\\_practice/clinical\\_guidelines\\_recommendations/2012](http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/2012)). Psychotropic medications are among the most frequently prescribed for individuals with developmental disabilities, because of anxieties, spasms, etc. Also, as persons with Down's syndrome age, they are more likely to be taking antiepileptic medications (Sipes et al., 2011).

3) Is the person taking medications that cause bradycardia (slowing of heart beat)? Such drugs include digoxin,  $\beta$  blockers (metoprolol, atenolol®), non-dihydropyridine

calcium channel blockers (diltiazem, verapamil), and amiodarone. Note that here and in the following we name just some of the drugs within each type.

4) Is the person taking medications that can cause orthostatic/postural hypotension? These drugs include the very large number of antihypertensives, anti-emetic phenothiazines (promethazine, prochlorperazine), tricyclic antidepressants (amitriptyline, nortriptyline), anti-Parkinsonian drugs, diuretics, and any phosphodiesterase-5 enzyme inhibitor (Viagra®, Cialis®). Cardiovascular disease, including hypertension, is the most common cause of mortality in individuals with developmental disabilities.

5) Is the person experiencing symptoms that might be an adverse drug event? Such symptoms include blurred vision, dizziness or light-headedness, sedation or decreased alertness, confusion or impaired judgment, compromised neuromuscular function, and anxiety.

#### Issues Significant for Those with Developmental Disabilities

Psychotropic medication use without a documented indication is common. Medication adherence, particularly in community settings, may be a challenge. Side effects can worsen spasticity, worsen extremity weakness or other symptoms related to the underlying disability. The risk versus benefit of each medication must be considered, and the balance may shift as the individual ages. "As needed" medications may be especially problematic, as monitoring by family and agencies may be inconsistent

at best (Kim et al, 2011).

#### Vitamin D to Reduce Fall Risk

There is a protective effect of vitamin D supplementation on fall prevention in community-dwelling older adults and among adults with intellectual disabilities. The effect of vitamin D on fall reduction is significant, when taken for longer than six months, in a dosage of 800 IU or greater, and in the form of cholecalciferol therapy (Vitamin D3) (Bischoff-Ferrari et al., 2004; Kalyani et al., 2010). Vitamin D decreases the risk of falling by improving lower extremity muscle strength and balance. It also improves calcium absorption and bone health, reducing the risk of fracture if a fall occurs.

Adults with developmental disabilities may be at increased risk of osteoporosis due to antiepileptic medications, lack of weight bearing exercise, use of steroids such as prednisone, and long term use of proton pump inhibitors for acid reflux and chronic indigestion. Any of these factors may increase the risk for osteoporosis, with the risk increasing as the number of these risk factors rises. Having osteoporosis increases the risk of a fracture when a fall occurs, so maintaining bone health is critical.

#### **Summary**

Tinetti and colleagues (1994, 2010) and others have suggested strategies to reduce risks for falling that are applicable to adults with or without lifelong disabilities. Medication review and careful scrutiny of effects, and more engagement with the primary care provider are

among these. For adults with life-long disabilities, family caregivers and agency staff may need to become more vigilant in monitoring medications, informing multiple prescribers, overseeing improvements in diet and exercise, and other steps to inform and engage these adults in their own health care. Group homes may wish to designate a medication manager. Older adults, family caregivers, and/or agency staff should keep a medication list (see [www.medsandaging.org/documents/PersonalMedList\\_000.pdf](http://www.medsandaging.org/documents/PersonalMedList_000.pdf)) and consult with a physician, nurse practitioner, or pharmacist before using over-the-counter medication or herbal supplements.

#### **Study Questions**

1. Among the many intrinsic and extrinsic risk factors for falls, why are medications a prudent place to focus?
2. The relatively scarce research on falls by older adults with lifelong disabilities identifies seizure disorders as a special risk. Why is this and what are some practical implications?
3. Identify three or more things to look for in conducting a Brown Bag review of medications as a risk factor for falls?

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## Editorials

### From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

#### *Lessons from a Sequoia Grove*

My wife and I visited Yosemite National Park in November. A highlight was the abundance of majestic Sequoia trees, especially the Mariposa Grove of Giant Sequoias. This grove (as well as other stands) dwarfs visitors with its enormous, ramrod-straight tree trunks, many being dozens of feet in diameter. The trees shoot 200 feet to the sky. Light squeezes in between these noble giants onto their comforting cinnamon-colored bark. Awe is the most common response.

These Sequoias have flourished and endured here for centuries, many for millennia. The Park Service has mounted a cross-section from a downed tree with a display legend that notes that this tree's rings can account for weather patterns dating back through the Middle Ages. I photographed my wife standing before an uprooted tree, lying on its side, its exposed roots extending about 20 feet above her head. Later in our lodge, I found a historic book that showed the same tree photographed in the 1880s with a troop of U.S. Cavalry beside and atop it; it had fallen centuries ago and still resisted decay.

It is common for these trees to grow in clusters. Our favorite was The Bachelor and Three Graces, a group of four whose roots are so interlaced that all might fall if one were to. This is the lesson for me.

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These Sequoias rise above peril; their bark is so thick as to be almost impervious to insects, fire, and infestation. But their roots are surprisingly shallow. Miniscule, given the trees' tremendous size. They thrive and endure because they intertwine their roots. They overcome the vulnerability that shallow roots present by connecting with each other, becoming a community.

Community, especially a sense of belonging to a community, has important implications for many things, from crime prevention to maintaining housing values, from watching out for neighbors to participating in activities with others. Not feeling part of a community can mean feeling separate and isolated.

A six-year study of older adults, published in the *Journal of the American Medical Association* in 2012, has identified loneliness as a predictor of declines in health and accelerated death. The authors describe loneliness as "the subjective feeling of isolation, not belonging, or lacking companionship." Loneliness has long been associated with feelings of distress, but the study's authors (Carla M. Perissinotto, MD, MHS, Irena Stijacic Cenzer, MA, and Kenneth E. Covinsky, MD, MPH) found that its impact on older adults is especially troubling. They conducted a prospective longitudinal study of 1,604 older adults (average age of 71 years) participating in the Health and Retirement Study, with repeated measures from 2002-2008.

Their instrument of measurement was surprisingly simple: a three-question questionnaire that mea-

sures components of loneliness, i.e., whether subjects feel: left out, isolated, or a lack of companionship. Their three-item questionnaire was adapted from the Revised UCLA Loneliness Scale (R-UCLA), and both have been validated and are able to be self-administered. For each component of loneliness, subjects were asked if they feel that way a) hardly ever (or never), b) some of the time, or c) often. The researchers then classified subjects as "lonely" if they responded "some of the time" or "often" to any of the three components, and "not lonely" if they responded "hardly ever (or never)" to all three components.

They then compared lonely and not lonely participants on four measures of functional decline across the period of six years: 1) Activities of Daily Living (ADL) function: participants were asked if they had difficulty in any of five ADL (bathing, dressing, transferring, toileting, and eating). A decline in ADL function was defined as difficulty in more ADL in 2008 than in 2002. 2) Difficulty in upper extremity tasks: participants were asked whether they had difficulty extending their arms above their shoulders, pushing or pulling large objects, or lifting or carrying weights heavier than 10 pounds. A decline was defined as difficulty in more tasks in 2008 than in 2002. 3) Decline in mobility: participants were asked about difficulty with four tasks (running or jogging a mile, walking several blocks, or walking one block). A decline was defined as a decrease in the distance able to jog or walk between 2002-2008. 4) Difficulty in stair climbing: participants were asked whether they had difficulty climb-

ing several flights of stairs, or one flight of stairs. A decline was defined as a decrease in the number of flights of stairs one was able to climb between 2002-2008.

Of the 1,604 participants, over 43% reported feeling lonely, i.e., reporting one of the loneliness components at least some of the time. In the three-item loneliness questionnaire, 32% reported lacking companionship, 25% reported feeling left out, and 18% reported feeling isolated at least some of the time.

Loneliness was associated with all outcome measures. Lonely participants declined faster than their not lonely counterparts. Lonely subjects were more likely to experience decline in ADL (24.8% vs. 12.5%; adjusted risk ratio [RR] of 1.59); develop difficulties with upper extremity tasks (41.5% vs. 28.3%; adjusted RR of 1.28); experience decline in mobility (38.1% vs. 29.4%; adjusted RR of 1.18); or experience difficulty in climbing (40.8% vs. 27.9%; adjusted RR of 1.31).

Most importantly, loneliness was associated with increased risk of death over the six-year period (22.8% vs. 14.2%; hazard ratio [HR] of 1.45). The researchers found that this association between loneliness and death remained significant even after adjusting for demographics, SES, depression, and other health and functional measures.

How is it that some feel lonely in the midst of others? I have written before about "assisted autonomy," which is my modification, or rather, my qualification of the blessed

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value of autonomy. Being autonomous requires having choices and being able to exercise or realize those choices. The principle of autonomy too often unthinkingly translates to independence, the enshrined deity of the American way. Independence, freedom to do one's own thing, sometimes translates in practice into benign neglect when applied to someone in need. "Leave him alone."

True independence as part of the social fabric is self-contradictory; each of us is interdependent from birth, relying on others for our nurturance, education, and satisfaction of needs from affection to income (for example, even the most hermit-like technology genius starts with information from others and must ultimately transfer ideas to others). The person living off the land in total isolation is exceedingly rare.

We are assisted by others to become autonomous, having choices we perceive as meaningful and the possibilities of achieving them. Autonomy is a product of an interdependent process. "Autonomous" comes from the Greek, meaning "ruling over oneself," and assisted autonomy does not mean taking over the lives of others but helping them to rule, to realize their choices. Philosopher Immanuel Kant posed the "categorical imperative" that one should act as if one respects someone else's autonomy. He equated autonomy with dignity. Assisting others to maintain or regain that dignity is assisted autonomy in practice. It is community.

Like the little roots that support the Giant Sequoias.

### From the **Commissioner, Virginia Department for Aging and Rehabilitative Services**

Jim Rothrock

#### *Update on DARS: An Agent and Product of Change in our Commonwealth*

Change is a constant that we are all forced to deal with in these times of fiscal uncertainty, technology evolution, and government restructuring at all levels, it seems. I once heard someone say that the only people on earth who actually like change are wet babies.

Change can challenge our basic assumptions, imply that past efforts were flawed, or cause organizational and personal fears. But in the present climate, embracing change can be a key to survival and, in many cases, growth and improvement.

There has been a great deal of angst, comment, and general concern for more than a year about the creation of a new agency that responds in many ways to the needs, talents, and abilities of Vintage Virginians and Virginians with disabilities. This past July the newest state agency emerged from two smaller but effective entities to create the Department for Aging and Rehabilitative Services, DARS. With this new agency there have been opportunities, as anticipated, to evaluate the organizational design of DARS and see what may be changed to realize improved services and programs.

Some of these new initiatives offer great promise for the future and should position DARS to be more ready to respond to Age Wave issues and the demand for more community-based and quality-driven services:

- The former Department of Rehabilitative Services (DRS) had a long history of advances with Assistive Technology. Bob Krollman, a long-time DRS colleague, has been assigned to transfer some of the knowledge gained in using AT to support the independence of people with disabilities to the aging network, where it will also be successful. Bob has already reached out to several AAAs to begin this discussion;
- VDA's employment program, Title V, has been moved into the Division for Rehabilitative Services and now offers more job opportunities and resources to those hoping to re-enter the job market;
- The State Long Term Care Ombudsman program has been moved within DARS and now collaborates more effectively, when appropriate, with the Guardianship programs around the state; and with the migration of Adult Services state level management from DSS to DARS, including the oversight of APS, which is planned for July 1, 2013, the potential for service improvement and coordination is imminent;
- Interactions among AAAs, CILs, and Brain Injury programs are becoming more frequent, with potential for collaboration improving;
- Board Training for AAAs, CILs, BI programs and DARS employment programs is occurring and this improves local control and board

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functionality for more than 100 DARS partnerships;

- Due to a solid team of experts and grants-persons, the Commonwealth received a federal grant to expand respite initiatives; from the infant with medical fragility to the teenager with Asperger's, from the adult with MS to the elder with dementia, respite services will be offered statewide. It is critical to support our caregivers who are responsible for supporting thousands of Virginians who now reside in the community;
- The administrative functions demanded of all state agencies, including HR, IT, PR, accounting, payroll, and procurement, are now handled by a larger contingent of skilled DARS staff, thereby avoiding duplication and processing problems occasionally caused by absences and extended leaves; as a result, we anticipate more solid information for strategic planning and program accountability;
- DARS is blessed to have a good number of advisory boards and commissions, and now staff of these bodies representing aging, brain injury, and community-based programs meet quarterly to address common issues;
- Marcia DuBois now provides a central point of contact for discussions of housing, transportation, and livable communities and shares policy discussions with DARS partners on a routine basis; and
- Constituent requests are now shared by a broader array of experts within the DARS portfolio.

These are just a few of the initiatives that have resulted from the creation of DARS. It should also be noted that there has been no diminution of any programming or

shifts in staffing that would detract from the ultimate success of the programming, as a result of these moves.

It wouldn't be honest for me to profess that I'm a big fan of change. I do like to have a certain sameness and stability to my existence; life is easier. BUT, change is here, change can be good when managed well, and our state now has an agency better prepared and structured to meet the demands that will undoubtedly increase.

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### 2013 VDARS Meeting Calendar

#### **Commonwealth Council on Aging**

(Wednesdays)

April 10

July 10

September 25

#### **Alzheimer's Disease and Related Disorders Commission**

(Tuesdays)

March 12

May 14

August 27

October 15

#### **Public Guardian and Conservator Advisory Board**

(Thursdays)

March 21

June 13

September 12

November 21

## Ombudsmen: The Backbone in Long-Term Care

According to Merriam-Webster, the definition of an ombudsman is one who investigates, reports on, and helps settle complaints. This is correct, but there's more to this story.

"Our ombudsmen advocate for better quality of care and quality of life for people in long-term care," said Willie E. Alston, Jr., Certified Long-Term Care Ombudsman and Ombudsman Volunteer Coordinator at Senior Services of Southeastern Virginia, a not-for-profit organization. "We could not accomplish what we do without our volunteers. We have only two paid staff for this work, but we are responsible for 35 nursing homes and 78 assisted-living facilities (that's more than 7,000 beds) throughout South Hampton Roads."

Alston went on, "There are many seniors in long-term care who don't have family or who are unable to speak for themselves. The ombudsmen fill the gap. What we do best is assist, be problem solvers, educators, and facilitators. We work with residents and their families so they are aware of their rights. We help to ensure patients have the best care possible."

While Senior Services and their ombudsman program are serving South Hampton Roads, ombudsman programs are active throughout the Commonwealth and nationwide. These programs are mandated by Title VII of the Older Americans

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## COMMONWEALTH OF VIRGINIA

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

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#### 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 required to submit by **March 1, 2013**, a non-binding 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. Letters on letterhead with signature affixed will be accepted electronically. Applications (hard copy sent by carrier who date-stamps on or before the due date required; with an electronic copy also e-mailed on or before the due date) will be accepted through the close of business **April 1, 2013**, and applicants will be notified by June 21, 2013. The funding period begins July 1, 2013 and projects must be completed by June 30, 2014.
- 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.sahp.vcu.edu/vcoa/program/alzheimers.html](http://www.sahp.vcu.edu/vcoa/program/alzheimers.html)) or by contacting:

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Virginia Center on Aging  
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## Focus on the Virginia Center on Aging

Paul F. Aravich, Ph.D.



Dr. Paul Aravich is professor in the Department of Pathology and Anatomy, the Division of Geriatrics, and the Department of

Physical Medicine and Rehabilitation at Eastern Virginia Medical School. With characteristic wit, he describes himself as a square peg in a world of round holes who as a child hated every second of every day in school; since then, he's worked his whole life in higher education. He says that he comes to the Advisory Committee of the Virginia Center on Aging from a humble background, not riding an elevator, seeing the ocean or eating a Big Mac until college.

Paul grew up with two brothers in Brockway, Pennsylvania, a small town in the coal fields of the Allegheny Plateau; far Southwest Virginia reminds him of home. His grandparents were immigrants from Lithuania and Italy. His father quit school at age 14 to support his family and taught Paul to work hard. His mother taught him to dream and to take care of others. A teacher at DuBois Central Catholic High introduced him to public speaking, despite his clear preference for baseball. Paul's hero was Thomas Dooley, a Navy internist and humanitarian in South East Asia during the 1950's whose motto came from Frost: "I have promises to keep and miles to go before I

sleep." For Paul, Dooley epitomized Flexner's medical ethic of being "social change agents and leaders for the greater good."

His undergraduate days at Villanova taught him the critical importance of a liberal arts education, laying the groundwork for his commitment to the biopsychosocial model of pathology, including outreach from kindergarten to Congress. He attended a master degree program at Rensselaer. Even though he did not graduate, he met his wife Michele McGrath in inter-library loan and is, to this day, especially fond of librarians. Their son, Zachary, is a music and philosophy student at William and Mary.

Paul's doctoral dissertation at the City University of New York focused on the brain and obesity. He credits Anthony Sclafani for giving him a chance and for teaching him to think like a scientist. His postdoctoral mentors in Neurology and Neurobiology/Anatomy at the University of Rochester Medical School, Celia Sladek, John Sladek, Paul Coleman, and David Felten, introduced him to neural plasticity and brain aging. At the age of 38 he got his first real job at Eastern Virginia Medical School. One mentor at EVMS was Jack Franklin. Paul watched him and Desmond Hays build the geriatrics program at EVMS. Jack taught him much about vision and leadership. His most important influences are, however, his students and persons with disabilities; they humble and inspire him, and he very much relishes being with them.

Paul believes Miss Frizzle, the driver of the Magic School Bus, who says, "Take chances, make mis-

takes." This is how he came to head the Virginia Brain Injury Council, its neurobehavioral position paper committee on challenging behaviors, the Virginia Public Guardian and Conservator Advisory Board, and to serve on the Advisory Committee of the Virginia Center on Aging. He is proud of his expertise on brain aging, TBI, serious mental disorders, Parkinson's, Alzheimer's and bioethics, but champions greater collaboration among experts in these fields.

He once asked Faye Wells, an aviator colleague of Amelia Earhart from Northern Virginia who was featured in *National Geographic*, the key to successful aging. She answered, "Pursue the unexpected opportunities life offers." Unexpectedly, he finds himself working with brain injury, youth depression and suicide, geriatric mental health, Alzheimer's disease, Huntington's disease, and the American Brain Coalition. In each instance, he left his comfort zone and, like Woody Allen, just showed up.

Past honors for Paul include an Alpha Omega Alpha Glaser Distinguished Teacher Award, one of the highest awards for medical education in the United States and Canada, and an Outstanding Faculty Award from the State Council of Higher Education of Virginia for excellence in teaching, research, and service. His vision is to change the world one brain at a time, including those with challenging behaviors.

Paul and his wife live in Hampton; his interests include art and medicine, and he loves ethnic food.

## 2013 Helen J. Napps Award of Excellence: Call for Nominations

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The Helen J. Napps Award of Excellence, established by the Virginia Coalition for the Prevention of Elder Abuse (VCPEA), **recognizes professional excellence by individuals who work in the area of elder abuse prevention and/or elder abuse protection.** Helen Napps served the Commonwealth for many years as the Western Regional Adult Services Program Consultant. Her no-nonsense, uncanny ability to assess quickly and provide meaningful, resourceful solutions to many older adults and their families raised the bar for everyone in the field of adult services to act with integrity, attitude, adaptability, and "moxie," perhaps one of the best terms used to describe her. Helen undoubtedly set the standard for elder abuse professionals in the Commonwealth. "It can't be done" was definitely not in her vocabulary!

VCPEA presents the award at its annual conference in Virginia Beach in odd-numbered years. Nominees shall have made substantial contributions to the prevention of and/or response to the neglect, abuse, and exploitation of older Virginians. Nominees shall demonstrate moxie, integrity, attitude, and adaptability in their actions. They may work in adult protective services (APS), domestic violence services, aging services, mental health services, health services, rehabilitation services, law-enforcement, legal services, health care, academia, guardianship, research, volunteerism, or any other discipline that

participates in elder abuse prevention and/or protection.

VCPEA will be accepting nominations beginning in February for the 2013 Helen J. Napps Award of Excellence. Guidelines for submitting written nominations will be posted by February on the VCPEA website at [www.vcpea.org](http://www.vcpea.org). The award recipient will be recognized at the VCPEA annual conference in late May 2013 and will receive a complimentary hotel stay and free registration at the conference.

## Shepherd's Center Instructor Honored

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The Shepherd's Center of Richmond is pleased to announce the establishment of the **Wiltshire Scholarship** to provide tuition assistance for senior citizens to attend classes at the Center's Open University. The scholarship is given in honor of **Suzanne Wiltshire** by her French class at the Open University, where Mrs. Wiltshire is in her fifth year of teaching. She also serves on the Board of the Shepherd's Center and is an active member of several committees.

In addition to the 24 weeks of classes offered each year by the Open University, the Shepherd's Center also coordinates a corps of volunteers who provide senior citizens with free transportation to doctors' appointments or to the grocery store, as well as handyman services and personal calls. The Center's goal is to enrich the lives of senior citizens and help them enjoy independence as long as possible. The Wiltshire Scholarship helps serve this goal.

## Call for AGE Virginia Awards Nominations

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In anticipation of its AGE Virginia Awards, the VCU Department of Gerontology is accepting nominees for the following awards:

The **Commonwealth Award** is given in recognition of a resident of the Commonwealth of Virginia who personifies optimal aging and generativity.

The **ACE Award** is given in recognition of an individual or organization who demonstrates excellence in Advocacy and Community Engagement in the professional field of Gerontology.

The **TIME Award** is given in recognition of an individual or organization who demonstrates excellence in Theoretical Innovation and Maintaining Evidence-based practice in Gerontology.

Send nominations with a paragraph outlining the reason for nomination to [agingstudies@vcu.edu](mailto:agingstudies@vcu.edu) no later than **March 1, 2013**. Information on event sponsorship and tickets may also be received by e-mailing [agingstudies@vcu.edu](mailto:agingstudies@vcu.edu) or by calling (804) 828-1565. The AGE Virginia Awards will take place the evening of Saturday, April 6th at the Hilton Richmond Short Pump.

## Commonwealth Council on Aging 2013 Best Practices Awards

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The Commonwealth Council on Aging is sponsoring the 2013 Best Practices Award Program, funded by Dominion Power and targeted to organizations serving older Virginians and their families. As we struggle to meet the challenges of serving a rapidly aging population during a time of budget cuts and growing demand, we need to share our best practices and applaud our successes. Instructions, nomination forms, and information on previous Best Practices Award Winners are on the website of the Commonwealth Council on Aging, [www.vda.virginia.gov/council.asp](http://www.vda.virginia.gov/council.asp).

This is the seventh year of the Best Practices Award Program and the Council is pleased to offer monetary awards to the top winners: The first place program will receive \$5,000; second place, \$3,000; and third place, \$2,000. The Council will also recognize three honorable mention programs. **Nominations for the 2013 Awards must be received by March 1, 2013.**

The awards will echo the message to develop and support programs and services that assist older adults to age in the community. This invites an opportunity to recognize creativity in services that foster “Livable Communities” and/or “Home and Community Based Supports,” from transportation to housing, from caregiver support to inter-generational programming. We believe the door is wide open for creative best practices.

## Ombudsmen, *continued from page 9*

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Act to protect the patient. The watchdog group that drives policy nationally is Consumer Voice, based in Washington, DC. They serve as a resource for ombudsman programs and provide lobbying efforts for resident rights issues, such as receiving the best quality care and maintaining a strong quality of life. Consumer Voice helps the ombudsmen to have an impact in nursing homes, rehabilitative facilities, as well as home health care.

There is a culture change in facilities and home health care as they make the shift towards patient-centered care. Simply, patients can choose to do what they want, when they want. People are living longer, so the need for ombudsmen grows. Statewide, ombudsman programs meet annually with the Virginia Department for Aging and Rehabilitative Services to further best practices in all of their programs.

Funded by the Virginia Department for Aging and Rehabilitation Services, Senior Services provides free volunteer ombudsman training in mediation, communication and listening skills, and laws and regulations governing long-term care facilities. It features sessions on abuse, neglect, and financial exploitation, and on the role of ombudsmen and the federal and state laws that back up the work of ombudsmen.

Volunteer ombudsmen at Senior Services can come from any walk of life, but many are retirees who want to help other older adults in

their communities. “Some come from academic backgrounds, others are persons who know what it means to have cared for elderly parents, others are retired from health-care professions. We’ve had retired CPAs, a judge, and even a journalist,” Alston said.

Volunteer ombudsmen are trained on what to listen for and to observe possible problems that a resident or patient cannot put into words. “The ombudsman then takes the concern to the management of the facility with the expectation that the issue will be addressed and the complaint resolved,” Alston said. “Most facilities are responsive and are willing to work with us. Most providers appreciate having another set of eyes to learn about a concern in their facility. We tell them we are all working toward the same goal: satisfaction of the resident or patient and an improved quality of life.”

February 8, 2013, is the deadline to sign up for the next round of free training sessions, which will be held from 9:00 a.m. to 4:00 p.m. on March 14, 15, and 18 at the main offices of Senior Services in Norfolk. Volunteers must attend all three days of training. Senior Service’s ombudsmen serve the cities of Norfolk, Portsmouth, Suffolk, Chesapeake, Virginia Beach, and the counties of Southampton and Isle of Wight.

To become a volunteer ombudsman, please contact Willie E. Alston, Jr. at (757) 461-9481, Ext. 114, or [walston@ssseva.org](mailto:walston@ssseva.org).

## Keeping the Conversation Going: A Daughter Speaks to Her Mother Across the Memory Loss Divide

by Margaret Morganroth Gullette

*This article first appeared in The Jewish Daily Forward on October 5, 2012, and is reprinted with permission.*

When my mother started to lose memories in her 90s, she moved into a residential community near me, in Cambridge, Mass.

I had been a cultural critic of age in America, an “age critic,” for decades. But the focus in my books, beginning with *Safe at Last in the Middle Years*, had been on midlife. I was working toward a new book, eventually to be called *Agewise*, about how and why ageism was growing worse in the United States, even targeting the baby boomers, none of whom were yet 65. I was not anticipating writing about my mother in this book, although she had played major roles in earlier books. Nor was I planning to have a chapter on memory loss in *Agewise*.

What changed me, both as a daughter and as a writer? I found first that I had a lot to learn from my indomitable mother about living well with mental impairment and, later, with physical frailty. And as I was figuring out how to help her hold up her end, I was shocked to discover how harsh the social world can be toward old people with cognitive impairments. Eventually, the

story of my mother’s last years became a chapter of my book.

My mother had always been animated, funny, and engaging. And gregarious: She liked to talk. After she moved to Florida in her 60s, I accompanied her on mile-long walks along the beach. Dozens of people greeted her. Between interruptions, she provided well-crafted Jewish jokes, news about relatives, and fascinating information about generations past.

Through her, my world expanded back into the early 20th century. Her heroes (Paul Robeson, John Dewey, Maggie Kuhn) and her film stars (Bette Davis, Cary Grant) became mine. She was Heritage Central. Some people dismiss old stories and historical allusions. But as I grew closer to her in her 90s, I came to love her jokes and stories even more. She died two years ago, and I am sorry I didn’t record her speech. She wouldn’t mind my telling the story of her memory loss: She wanted her life to be useful.

At first, focused as I was on her stories and commentaries, I was not alert to her memory loss. But *she* was. My mother made discoveries about her cognitive processes as if she were a neurologist. “I have no frame of reference,” she stated, factually, about people she remembered knowing well. She, with her great executive abilities, reported, “I have lost initiative.” I believed in her right to know whatever I was learning about cognitive impairment, a subject that her life had suddenly made urgent.

“It’s not Alzheimer’s,” I told her.

Her doctor didn’t think so then, and neither, marveling at her Scrabble moves, did I. A 2011 study that suggested that Alzheimer’s was wrongly diagnosed 50% of the time had yet to be released, but I was already becoming wary of misdiagnosis and its nefarious effects on self-esteem and social relations. “You’re over 90, after all,” I told her. “Old age is a factor.” Sometimes she was saddened by thinking, “My memory is an abyss.” Other times she said serenely, “My memory is my worst enemy and my best friend.”

She seemed less frightened than I was. Listening to her, even when she gossiped or sang “*Avanti Popolo*,” I felt angry at first, exhausted by the steepness of my learning curve. I had put my book on hold, with some bitterness. But for my own sake, I started reading brilliant gerontologists who work with the memory-impaired. They made sense. Tom Kitwood, in *Dementia Reconsidered: The Person Comes First*, convinced me that I was right to overcome my anger and focus on her strengths. My mother, too, was a self — living, often contentedly, on islands of land in the abyss.

I made a decision to live with her on those islands. I kept in mind the line from Mozart’s “*Magic Flute*”: “Love leads back to duty.” Whatever conversational scrap I offered, she responded to with pleasant sentences. I started retelling the stories she was forgetting. “When you were six, you told me, your mother made you a potato latke and covered it with sugar, and you ate it sitting in the window, so everyone in the street could see you eat it.” We both enjoyed that story, many times. I lost my fear, developed in

adolescence, of hearing myself repeat things.

I developed new views of memory loss from going through my mother's experience empathetically. Forgetfulness seemed to make her more quotable. Once I asked her what wisdom was and she answered unhesitatingly, "The greatest part of wisdom is kindness." Many people still don't recognize how much of the mind is left as memories depart. When people with cognitive or other impairments have appreciative listeners, what they can access improves. Sadly, I did not observe, on the part of most of the nurses, doctors, and social workers we eventually encountered, any attempt to attend to the qualities and powers that remained.

My mother stayed in her assisted-living apartment and paid to have aides more hours of the day. It occurred to me that if I wrote up her biography, the aides would know what to talk to her about, aside from their own lives. I knew her bio well: Brooklyn College B.A., Bank Street M.A. Gifted school teacher. She met my father at a family wedding where he was, for the only time in his life, drunk. When my father contracted Lou Gehrig's disease, she cared for him at home, as he wished. After retirement, she ran a non-profit cultural organization for the Brandeis Women's Committee. She fell in love at age 77. I described her values as a feminist, unionist, and socialist, as well as her preferences in clothes, food, music, and activities.

The aides could read back to her portions of her useful and loving

life, including excerpts from the chapters in my books where she figured as a model, and restore her selfhood when she felt it had abandoned her. When hospice aides eventually came to the apartment, I made sure they too read the short bio; conversation was part of their job description.

As she weakened, I asked the aides to start a second log, not for meds, but for recording her witticisms, songs, and the advice she gave them. I later jettisoned the medical logs. But these other logs I save, because they confirm how much she remained Betty Morganroth deep into cognitive impairment and weakness.

We all want to play our parts in the conversation as long as we can before the final silence. But in the last months, the conversational style that suited my mother had to change. It had no low notes about the struggling economy and omitted sad family news. But it had warm silences, singing, joking, and teasing. Until four days before she died, I could count on her for repartee. Since she was free of pain, I often asked, "How do you feel, Mum?" so she could answer, in her tender, reassuring way, "Perfectly well, baby." She was teaching me how to be, as always.

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*Margaret Morganroth Gullette is the author of "Agewise: Fighting the New Ageism in America," winner of a 2012 Eric Hoffer Award. She is a resident scholar at the Women's Studies Research Center at Brandeis University.*

## Memories in the Making

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### *Training for Home Care and Activity Professionals Working with Individuals with Dementia*

Expression through art gives those struggling with memory loss a way to tell their stories. Even when words are no longer possible, they can express their feelings in the language of paint, music, or dance. Studies show that art activities reduce anxiety, stress, and depression, while improving motor skills, attention, and focus.

The Alzheimer's Association will present an all day workshop to train care providers to facilitate an art program for people with dementia. This workshop will include practical tips and interactive activities. It will be held at the Association office at Markel Plaza Building, 4600 Cox Road, Glen Allen on **June 11, 2013 from 9:00 a.m. – 5:00 p.m.**

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 charge for the workshop, but registration is required. To register, call (804) 967-2580, or e-mail [fran.foster@alz.org](mailto:fran.foster@alz.org).

## Life's Turning Points So Often Shaped by Others

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by Charles F. Bryan, Jr., Ph.D.

*This essay originally appeared the Richmond Times-Dispatch on September 12, 2012 during the recent presidential campaign and is republished here with the permission of the author and the newspaper. We think that Dr. Bryan's message is timeless.*

The responsibility for success in life has become a hot-button issue in the current presidential election. Republican TV ads accuse President Obama of saying that someone's accomplishments come from outside forces, not the initiatives of the individual. Democrats respond that is a misrepresentation of the president's words. Although this issue has been trivialized for political purposes by both sides, it is one that should not be ignored. It says a lot about who we are as a nation.

*New York Times* columnist David Brooks addressed it by asking an important question: Should you regard yourself as "the sole author of all your future achievements and the grateful beneficiary of all your past successes?" For several years, I have posed a similar question to a number of prominent Americans in a personal research project I call "Turning Points."

History is marked by turning points such as Abraham Lincoln's assassination and Pearl Harbor. These events changed the course of history and were the result of the decisions and actions of people, indi-

vidually or collectively. People also have turning points, profound decisions they made or something that happened to them after which their lives were not the same. Through interviews I have conducted, I noted that these people held something in common relating to their turning points. All cited various individuals who played crucial roles in shaping their lives. Most mentioned certain opportunities that came their way that helped them to become successful.

John Glenn told me about the dynamic high school civics teacher who inspired him to a life of public service, and the senior NASA official who insisted that Glenn not be dropped from the astronaut program because he did not have a college degree. Former ABC News anchor Charlie Gibson related how his wife persuaded him to follow his dream by taking a low-paying job as a reporter at a Lynchburg television station rather than accept a full scholarship to the University of Michigan law school.

Former Virginia Gov. L. Douglas Wilder explained how the G.I. Bill enabled him to finish college and to attend law school, making his future brighter than African-Americans of previous generations. Ken Burns credits his father-in-law, a psychologist, with inspiring him to pursue a career in filmmaking "in which people long gone come back alive," and the National Endowment for the Humanities for the funding he needed to get started.

David Brooks observes that when you reach the later stages of life you become "a sociologist, understanding that relationships are more

powerful than individuals." You realize that you did not succeed by yourself. Other people helped. Yes, government helped.

I occasionally find myself thinking about what allowed me to succeed in life: the Social Security payments my mother received after my father's premature death; the G.I. Bill that helped me earn a Ph.D. and receive a low-interest loan on my house; the special unit at McGuire VA Medical Center that has enabled me to cope with Parkinson's disease.

I also think about the people who helped form my life: my mother; my grandfather; the uncle and aunt who took me, as a high school student, to far-away places; the college professor who flunked me but became my father-in-law and a dear friend; the VMI upperclassman who forced me to study with him every night so that I would not flunk out; the former professor who persuaded a reluctant me to apply for the directorship of the Virginia Historical Society. My list goes on and on.

I owe them a debt of gratitude that I cannot possibly repay, but at least I can thank them. To those people who are still living, I've started writing letters.

I recently thanked my VMI mentor for saving me from leaving school. We had not communicated in 45 years. I thanked my widowed aunt for taking me to exotic lands. Although I failed to acknowledge the professor who talked me into contending for the Virginia Historical Society job before he died, I did write his widow to let her know what her husband meant to me.

Everyone I wrote appreciated it, and to a person, they said they were not aware that what they did for me then helped shape my life. Neither was I.

Now I know. With age comes wisdom, says the old adage. That may or may not be true, but I know that as we grow older and our perspectives broaden, the more we realize that the power of the individual pales in comparison to those greater forces in life shaped for us by others and things bigger than we are.

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Charles F. Bryan Jr., Ph.D., is president and CEO emeritus of the Virginia Historical Society. You may contact him at [cbryan69@comcast.net](mailto:cbryan69@comcast.net).

## Correction

We would like to apologize for an error in the Fall 2012 issue of *Age in Action*. In the article, **Diagnosed with a Visual Impairment: Now What?**, the author's contact information was inadvertently left out.

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## Factsheets for Individuals Aging with Lifelong Disabilities

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The Florida Center for Inclusive Communities (FCIC), a University Center for Excellence in Developmental Disabilities Education, Research and Service at the University of South Florida, has released its new Factsheets under its "Education for Lifelong Health Series." They are designed for people with mild intellectual disabilities to learn about health conditions that become more common with increasing age. There are five Factsheets: Good Health and Hygiene; Diabetes; Osteoporosis; Cancer; and Cancer Treatment. Each is available for free download at FCIC's health section, under the Materials and Resources tab, at <http://flfcic.fmhi.usf.edu/program-areas/health.html>.

While there, examine other relevant resources for adults with lifelong disabilities and for caregivers who work with them, including FCIC's *My Health Passport*. This is a health advocacy document that describes the unique supports, characteristics, and preferences of an individual with lifelong disabilities. It reflects who that person is and can help guide appropriate interactions with health care providers. Dr. Liz Perkins designed the *Passport* so that it would be shared with healthcare providers, in clinic and hospital settings; the *Passport* can be especially helpful for providers who have limited experience providing care to individuals with intellectual or other developmental disabilities.

## Year of Elder Abuse Prevention

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The Administration on Aging (AoA) has designated 2012 - 2013 the Year of Elder Abuse Prevention (YEAP). AoA has a wealth of well-designed materials on their website ([www.aoa.gov/AoARoot/AoA\\_Programs/Elder\\_Rights/YEAP/index.aspx](http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/YEAP/index.aspx)) which can be downloaded and used to raise public awareness about elder abuse and shed light on the importance of preventing, identifying, and responding to this serious, often hidden problem. The YEAP toolkit includes an outreach guide; event planning materials; fact sheets (e.g., 10 Things Anyone Can Do to Protect Seniors); a Frequently Asked Questions booklet; web banner designs; a YEAP poster; as well as customizable YEAP templates for newsletters, Power Points, and event flyers. The webpage also contains information on social media outreach, including posts to help promote elder justice information and activities across platforms like Facebook and Twitter.

While the materials focus only on older adult victims, the information is also relevant to Adult Protective Services (APS). There are several references in various brochures to reporting suspicions to APS. Also, organizations hosting elder abuse prevention workshops and conferences are encouraged to include APS among their presenters. Area Agencies on Aging are encouraged to sponsor Elder Abuse Prevention activities. You may want to contact your local AAA to see what may be underway in your locale and get involved.

## Calendar of Events

### February 5, 2013

*Oral Health Education Training.* Washington County Health Department, Community Services Building – Room 120, Bristol, VA. 9:15 a.m. – 12:00 p.m. Appropriate for all family educators, family support workers, school nurses, and associated staff from any home visiting or family education program. To register, e-mail [kami.piscitelli@vdh.virginia.gov](mailto:kami.piscitelli@vdh.virginia.gov) by 12:00 p.m. on January 31st.

### February 28 - March 3, 2013

*Waves of Change: Charting the Course for Gerontology Education.* 39th Association for Gerontology in Higher Education Annual Meeting and Educational Leadership Conference. Hilton St. Petersburg Bayfront, St. Petersburg, Florida. For information, visit [www.aghe.org/am](http://www.aghe.org/am).

### March 12-16, 2013

*Aging in America.* 2013 Annual Conference of the American Society on Aging. Chicago, IL. For information, visit [www.asaging.org](http://www.asaging.org).

### April 2-4, 2013

*Virginia Assisted Living Association's Annual Spring Conference.* Holiday Inn Koger Conference Center, Richmond. For information, visit [www.vala.alfa.org](http://www.vala.alfa.org).

### April 4-7, 2013

*34th Annual Meeting of the Southern Gerontological Society.* Hilton Charlotte University Place, Charlotte, North Carolina. For information, visit [www.southerngerontologicalsociety.org](http://www.southerngerontologicalsociety.org).

### April 17-18, 2013

*Caring for Our Elders: Sixth Annual Senior Care Conference.* The University Area Holiday Inn, Charlottesville. For information, visit <http://seniorcareconference.wordpress.com> or call Tannis Fuller at (434) 295-2235.

### May 21-24, 2013

*40th Annual Conference of the Virginia Association of Nonprofit Homes for the Aging.* The Homestead, Hot Springs. For information, visit [www.vanha.org](http://www.vanha.org).

### May 29-31, 2013

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

### June 3, 2013

*2013 Conference of the Area Planning and Services Committee on Aging with Lifelong Disabilities (APSC).* Holiday Inn Select, Koger South Conference Center, Richmond. For information, e-mail [eansello@vcu.edu](mailto:eansello@vcu.edu).

### July 30- August 2, 2013

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

### November 5-6, 2013

*30th Anniversary Annual Conference and Trade Show of the Virginia Association for Home Care and Hospice.* The Founders Inn, Virginia Beach. For information, visit [www.vahc.org](http://www.vahc.org).

### November 20-24, 2013

*66th Annual Scientific Meeting of The Gerontological Society of America.* Sheraton New Orleans & New Orleans Marriott, New Orleans, LA. For information, visit [www.geron.org](http://www.geron.org).

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#### Age in Action

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**Hilton Richmond Hotel & Spa, Short Pump/Richmond**

- Diverse 20-hour program of continuing education for clinicians that care for older patients. Medicine, Pharmacy, Nursing, and Social Work CE credits will be offered.
- Expert speakers from multiple disciplines who are on faculty at Virginia Commonwealth University, the University of Virginia, Eastern Virginia Medical School, Old Dominion University, and Johns Hopkins University will provide up-to-date, information-rich, and practical information about a variety of common problems in geriatric care. These include cancer treatment, back surgery, hypertension, diabetes, pain, depression, bone health, incontinence care, thyroid disease, multi-morbidity, pharmacotherapy, falls, team-based care, liver disease, stroke, and men and women's health.
- There are a limited number of conference scholarships for first or second time attendees who are not formally trained in geriatrics and are providing care in Virginia.
- Register soon before the meeting and hotel are full. Early Registration discounts are available.

**For more information or to register, visit**  
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