

Case Study

Sleep Disorders and Cardiac Consequences

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Educational Objectives:

1. Review the clear relationship between obstructive sleep apnea and hypertension.
2. Discuss the cardiac consequences of sleep apnea, including coronary heart disease, heart failure, and different dysrhythmias.
3. Understand that sleep disorders beyond obstructive sleep apnea, such as insufficient sleep itself, may have an impact on the cardiovascular system.
4. Appreciate the potential benefits of identifying and treating sleep disorders for our health.

Background

Primary care clinicians, cardiologists, and sleep clinicians are increasingly aware of the association between sleep disordered breathing and a number of different

cardiovascular disorders. The Sleep Heart Health Study and other investigations are systematically trying to determine type and extent of relationships. Much of the data linking sleep and the cardiovascular system have focused on obstructive sleep apnea (OSAS), which receives relatively greater attention here. However, we will also explore putative associations between other sleep disorders and the cardiovascular system and, in fact, the possible impact of reduced sleep duration itself on the cardiovascular system. Space limitations prevent an exhaustive review of sleep disorders and the cardiovascular system.

Obstructive Sleep Apnea Syndrome

Obstructive sleep apnea syndrome (OSAS) manifests with repeated upper airway near occlusions or temporary complete occlusions. It is estimated that some 18 million Americans have OSAS, which can lead to neurocognitive, pulmonary, and cardiovascular consequences. OSAS can be treated conservatively with weight loss, by minimizing alcohol and sedative use, as well as by unambiguously warning patients

not to drive while sleepy. Beyond conservative recommendations, the most common treatment options include nasal continuous positive airway pressure (CPAP) which employs a blower machine, tubing and mask assembly that acts as an upper airway air splint; oral appliances; and surgery. Surgical options can include soft tissue upper airway surgery, jaw surgery, and bariatric (weight loss) surgery.

The Heart and Sleep

Hypertension and Sleep

Roughly two thirds of Americans over the age of 60 have hypertension (Yoon et al., 2012). Sleep is normally associated with lowered blood pressure but this may not be so in patients with obstructive sleep apnea (so called non-dipping). The majority of data suggest that OSAS can cause elevations in blood pressure and that treatment of OSAS lowers blood pressure. Research from Australia in 1998 demonstrated that approximately 40% of patients with high blood pressure have sleep apnea, and a Wisconsin study (Peppard et al., 2000) found a “dose response” relationship

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between the severity of sleep apnea at baseline and the development of high blood pressure over the next four years. In addition, treatment resistant hypertension has been associated with OSAS in between 70 and 80% of cases. Therefore, if one has high blood pressure and, particularly, treatment resistant hypertension, OSAS must be considered.

The preponderance of data suggests that treatment of OSAS does appear to lower blood pressure. Although the absolute amount of blood pressure reduction appears to be modest, these reductions are believed to be meaningful. Most of the data showing improvements in blood pressure with treatment of OSAS derive from CPAP studies. However, there is also evidence demonstrating that oral appliances and surgery for OSAS may lead to reductions in blood pressure. Recent data suggest that sleep clinicians should look beyond just the diagnosis of obstructive sleep apnea when they consider the intersection of sleep and hypertension.

RLS, PLMS, and Sleep

Restless legs syndrome (RLS) patients describe an urge to move (predominantly the lower extremities), at rest, most prominent at night and relieved quickly by movement. Some 5-10% of Americans may have RLS and it occurs roughly twice as often in women as in men. Most RLS subjects and clinicians focus on the impact of RLS on causing insomnia. However, there are now some (*but not all*) studies that suggest an association of RLS with hypertension. A 2011 study of over 65,000 middle-aged

nurses demonstrated that RLS increased the odds of hypertension by 20% and that there was a dose response relationship between the frequency of RLS each month and the prevalence of hypertension. We must note that this study could not prove a cause and effect relationship nor did it apply to males, although earlier research in Sweden did associate RLS and hypertension in men.

Periodic limb movements of sleep (PLMS) are stereotypical lower extremity movements that occur in approximately 85% of patients with RLS, but such movements can be seen in numerous other situations, such as taking certain anti-depressants and being over 65 years of age. It may be that these leg jerks increase sympathetic nervous system activity, thereby leading to hypertension during the day. It is known that PLMS themselves have been associated with hypertension. For example, one study revealed that subjects with more severe hypertension had more PLMS than did those with lower levels of hypertension; other data reveal the complementary, namely, linking greater frequencies of PLMS with hypertension. These and other studies can be found as references in a comprehensive review of RLS and PLMS and cardiovascular consequences by Walters & Rye (2009).

We may also put ourselves at risk simply by achieving too little sleep. Studies have revealed that insufficient sleep may be associated with hypertension; i.e., sleep of less than or equal to five hours a night doubled the risk of hypertension among subjects between the ages of 32 and 59. Of interest, insufficient sleep

has also been associated with diabetes and obesity, both of which, in turn, have been linked to heart disease and cardiovascular disease.

Coronary Heart Disease and Sleep

Hypertension, diabetes mellitus, and obesity have all been associated with obstructive sleep apnea and all are risk factors for coronary heart disease (CHD). Numerous changes that occur as a consequence of sleep disordered breathing are deleterious to the vascular system. Accordingly, researchers have investigated potential associations between sleep apnea and CHD. Overall, the data linking OSAS and CHD do not appear as striking as with OSAS and other cardiovascular diseases (e.g., hypertension, congestive heart failure, and atrial fibrillation). Nevertheless, there are some provocative data linking OSAS and CHD and the possibility that treating OSAS may benefit these cardiac patients. Data from the Sleep Heart Health Study demonstrated that severe obstructive sleep apnea increased the risk of *developing* CHD in males between the ages of 40 and 70 years; this finding was not replicated in either females or males older than 70 years (Gottlieb et al., 2010).

Women are not exempt from this association between OSAS and CHD, as an older study from Sweden of more than 100 women with CHD found that over 50% had sleep apnea versus only 20% in controls. A recent study found no differences in frequency of OSAS between females and males with CHD (Zhao et al., 2014); but, in this study, the females were older and more frequently were afflicted

by kidney disease and diabetes mellitus.

In one Japanese study, the major index of sleep apnea severity was twice as high at the time of an acute myocardial infarction (heart attack) as compared to just 14 days later. OSAS may confer a worsened prognosis in patients with coronary heart disease and, thus, it is of interest to determine the impact of treating OSAS. Data suggest but do not unequivocally prove that CPAP treatment, for example, improves the outlook for those with both OSAS and CHD (Marin et al., 2005).

There is relatively little research investigating restless legs syndrome (RLS) and CHD. The Sleep Heart Health Study did find that RLS increased the likelihood for CHD. Interestingly, there was a dose response relationship for severity and frequency of RLS and risk for CHD (Winkelman et al., 2008).

Congestive Heart Failure and Sleep

The American Heart Association estimated in 2010 that just under six million Americans have congestive heart failure (CHF), with most of these being ages 65 and older. CHF can occur both with and without reductions in ventricular ejection fraction (heart muscle pump function). CHF has been associated with both obstructive and central sleep apnea (repetitive temporary pauses in breathing during sleep without upper airway narrowing/occlusion). One study revealed that roughly half of 81 patients with CHF (systolic dysfunction type) had sleep apnea, with central sleep apnea being more frequent in this

study than obstructive sleep apnea. In addition, it appears that the presence of OSAS may confer a worsened prognosis in some with systolic dysfunction (reduced ejection fraction).

In a recent study, those who had CHF secondary to coronary heart disease had an increased mortality risk associated with sleep apnea. OSAS may lead to numerous alterations in physiology that are detrimental to the heart and, more certainly, to the diseased heart. Increased activity of the sympathetic nervous system, increased work requirements of the heart, repetitive drops / returns to baseline in oxygen level, increased oxidative stress, and increased production of inflammatory mediators all occur secondary to OSAS. CPAP administration has been shown to reverse these changes and there are some data that indicate that treating OSAS may, over time, lead to improvements in cardiac function, such as better ejection fraction.

Given the improvements in physiology with CPAP in heart failure patients, it would appear that CPAP therapy should reduce the burden of mortality. Some data from Japan support this contention but a recent review of OSAS and CHF cautions that results to date should be treated with caution (Kasai & Bradley, 2011). It is interesting to note that the relationship between OSAS and CHF may be bidirectional. Return of extra fluid from the lower extremities during sleep can increase neck circumference and thereby further destabilize the upper airway during sleep and worsen OSAS.

Central sleep apnea and Cheyne-Stokes breathing (a waxing and waning breathing pattern often associated with congestive heart failure) have also been associated with CHF and, further, portend worse prognosis. Although CPAP with or without supplementary oxygen can be utilized, a more sophisticated (and expensive) positive airway pressure device called adaptive servo-ventilation looks to be more effective in treating these central sleep breathing disorders. Importantly, a multi-center and randomized study is underway to evaluate the possible effectiveness of this machinery in improving such important end points as mortality and hospitalization.

A burgeoning research literature suggests (but does not prove) that restless legs syndrome (RLS) and periodic limb movements of sleep (PLMS) may be associated with hypertension, a risk factor for CHF. Data from the Sleep Heart Health Study suggest a relationship between RLS and cardiovascular disease, including coronary heart disease, congestive heart failure, and stroke (Winkelman et al., 2008). However, this study's methodology could not establish a cause and effect relationship. Another study of RLS subjects found that those with more PLMS had greater risk for left ventricular hypertrophy (thickened left ventricular wall). This is important, for left ventricular hypertrophy appears to increase the risk for both heart failure and mortality. Indeed, this same study found increased rates of both heart failure and mortality in those with frequent PLMS; this study was retrospective and more data are needed to determine if RLS and

PLMS put patients at increased risk for negative cardiovascular outcomes and warrant more aggressive scrutiny and treatment by clinicians.

Atrial fibrillation and Sleep

A number of different disorders of cardiac rhythm have been associated with sleep disordered breathing. That abnormal electrical activity of the heart might occur is hardly surprising given some of the physiologic consequences of apnea that we have previously mentioned. Atrial fibrillation (an irregular heart rhythm associated with the atrium or top chamber of the heart) is increasingly common and has been noted to be even more so in older adults. Atrial fibrillation is important, in part, because it increases the risk of stroke and mortality. Studies have demonstrated that OSAS and atrial fibrillation are associated, with one study finding almost half of their atrial fibrillation patients had OSAS, and another finding that OSAS predicted an increased likelihood of atrial fibrillation after cardiac bypass for coronary heart disease (Qaddoura et al., 2014).

Treating OSAS may have salutary effects on atrial fibrillation. Patients with OSAS who are cardioverted (electrically shocked) out of atrial fibrillation are less likely to return to that abnormal rhythm if they use their CPAP than if they do not, with one study finding that those who used CPAP were about half as likely to return to atrial fibrillation at one year compared to those who did not use CPAP or used it “inappropriately.” Cardiologists can also treat atrial fibrillation with catheter ablation techniques. A meta-analy-

sis of studies revealed that OSAS patients with atrial fibrillation were more likely to return to atrial fibrillation after catheter ablation; but those who used CPAP to treat OSAS were no more likely to return to atrial fibrillation after catheter ablation than those who did not have OSAS.

The above clearly suggests that physicians and patients alike should be aware of the association of this frequent arrhythmia with OSAS, and the potential benefits of addressing sleep apnea along with atrial fibrillation. We have previously also mentioned central sleep apnea and its association with congestive heart failure. A new study reports that congestive heart failure patients with severe central sleep apnea were more likely to have atrial fibrillation.

There is much less information on putative relationships between restless legs syndrome (RLS) and/or periodic limb movements of sleep (PLMS) and atrial fibrillation. One 2013 study evaluated patients with RLS and found that patients with objectively documented frequent PLMS had a higher likelihood of developing more recalcitrant atrial fibrillation.

Ventricular Arrhythmias and Sleep

Limited data suggest that irregular heart rhythms that emanate from the lower chamber of the heart (ventricle) can also be associated with OSAS and/or central sleep apnea. The Sleep Heart Health Study data revealed that patients with heart failure and central sleep apnea manifested more ventricular arrhythmias *at night*. Cardiologists

can use implantable cardioverter defibrillators (ICD) to shock patients out of potentially lethal ventricular arrhythmias. Data demonstrate that central and obstructive sleep apnea patients are more likely to require ICDs and more likely to require “appropriate” activation of the ICD for irregular heart rhythms. A 2010 study from Japan demonstrated that after ablation therapy for ventricular dysrhythmias, patients with sleep apnea were more likely than those without sleep apnea to have recurrent disease. A recent review from the *Journal of Clinical Sleep Medicine* suggests that much more work is needed in this important area (Raghuram et al., 2014).

Sudden Cardiac Death and Sleep

We are, generally, most at risk for abrupt death from heart disease in the morning hours. OSAS confers negative consequences such as recurrent drops in oxygen level, increased clotting, and surges in blood pressure. It might follow, then, because sleep is typically an overnight experience, that patients with sleep apnea would be at greater risk for death in the middle of the night (normally a protected time) than patients without apnea. This is exactly what Gami and colleagues have shown in their 2005 research paper in the *New England Journal of Medicine*; examining the potential impact of sleep apnea on time of sudden death, they found that patients with OSAS were twice as likely to have sudden death between midnight and 0600 as those who did not carry such a diagnosis. Further, the more severe the sleep apnea (as defined by the AHI, the number of partial or com-

plete pauses in breathing per hour of sleep), the more likely one was to pass away suddenly in the middle of the night.

Case Study #1

Mr. W., a 77-year old retired accountant, comes to the sleep medicine office at the request of his primary care physician. His wife accompanies him. Mr. W. notes that at a recent primary care visit his blood pressure was elevated. He states that both his primary care physician and his wife suspect that he may have a sleep disorder. Mr. W.'s wife describes her husband as having a long history of snoring and, more recently, she has witnessed him to have gasping respirations during sleep. Mr. W. states that he has been more apt to nap during the day, but ascribes his day napping to boredom. He is currently taking medications for hypertension and hyperlipidemia. He drinks alcohol only modestly and never smoked.

On physical exam, he is obese, with a body mass index of 31kg/m². His vital signs are normal except for a blood pressure of 156/98. His cardiovascular exam is normal. The sleep medicine specialist describes the association of hypertension with sleep apnea. A nocturnal polysomnogram (sleep study) reveals severe sleep apnea that responds in large part to the application of continuous positive airway pressure (CPAP). Mr. W. initiates nasal CPAP after discussion with both his sleep medicine specialist and primary care physician, with positive results.

Case Study #2

Ms. D., a 74-year old widowed, part-time nurse, presents for consultation at the request of her cardiologist. Her cardiologist is evaluating and treating Ms. D.'s congestive heart failure and atrial fibrillation. The cardiologist and patient both wonder if the patient's atrial fibrillation could relate to an intrinsic sleep disorder. Ms. D. notes that she obtains about 7-8 hours of sleep each night, but that her sleep is not restorative and she takes a prescribed sleeping pill approximately once a week. She obtains about 45 minutes more sleep with sleeping pill administration but feels no more refreshed for using it. Ms. D. does not share the bed and cannot report if she currently snores or has witnessed pauses in respiration during sleep.

Physical exam reveals normal body mass index, evidence of an irregular heart rhythm (atrial fibrillation) and clear lungs. Records from the cardiologist's office confirm the diagnosis of atrial fibrillation and document significantly diminished cardiac pump function with an ejection fraction of 30%. The sleep medicine physician orders a sleep study, which demonstrates evidence of both obstructive and central sleep apnea (AHI moderately elevated at 27) with only modest drops in oxygen level. There are also mild (20/hour) periodic limb movements of sleep. Ms. D. elects to utilize a continuous positive airway pressure (CPAP) machine for her sleep apnea and to follow conservatively her mild periodic limb movements of sleep. After a month of treatment, she reports improved sleep and awaits follow-up by her cardi-

ologist for input on her cardiac status.

Conclusion

Those in sleep medicine and throughout medicine are increasingly aware of the impact of sleep and sleep disorders on our health. It is important for older adults to do the same. Insufficient sleep itself has negative metabolic and cardiovascular effects. A gradually maturing literature demonstrates the association of sleep disordered breathing (both obstructive and central apnea) and numerous cardiovascular consequences. It is also apparent that treating sleep disordered breathing may be cardio-protective. More research is needed in this important area. What is less clear is if restless legs syndrome (RLS) and periodic limb movements of sleep (PLMS) are also problematic for our cardiovascular system. Given the high prevalence of RLS/PLMS, further research in this area would also be instructive.

Study Questions:

1. What are the options for treating OSAS?
2. Does treating obstructive sleep apnea reduce blood pressure?
3. What is the most dangerous time of day from the standpoint of our cardiovascular system? Does it differ for those with obstructive sleep apnea?

References

(Space limitations required an abridgement of references supporting this paper. For a full list of the 48 references originally cited, please contact the author at

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About the Author



Robert Vorona, M.D., is an Associate Professor in the Division of Sleep Medicine at Eastern Virginia Medical School (EVMS) in Norfolk, Virginia. In addition, he is the Program Director for the EVMS Sleep Medicine fellowship. He has cared in practice for adults with the gamut of sleep disorders for over 25 years. His primary research interest of late has been the impact of high school start times on teens' sleep and safety.

Editorials

From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

We Happy Few: Accomplishments in Calendar 2014

O.K., it is a stretch to cite Shakespeare's *Henry V* and the king's inspirational speech before Agincourt. But I am so encouraged by the initiative and resourcefulness of our VCoA staff in their diverse activities, and how so few can accomplish so much.

This past year our small staff worked meaningfully in confronting elder abuse and domestic violence in later life; building and improving lifelong learning opportunities across the Commonwealth for mid-life and older adults; delivering interprofessional geriatrics training for health care providers and measuring the impacts of this training upon the patients they care for; training clinical students to partner across professions to improve geriatrics care; developing and delivering education and training programs to audiences in state, regional, and national conferences and webinars on topics ranging from gerontological education to aging with lifelong disabilities, community health to interdisciplinary teamwork; partnering with other organizations to identify innovations in family caregiving; administering the most productive seed grant program for dementia research in the country; and more.

All through the year we partnered with other organizations, groups,

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and individuals to help make the work successful. There were, in fact, so many such partners as to preclude listing them. But, as the saying goes, “They know who they are” and we are grateful.

I asked our staff to identify their three proudest accomplishments in 2014. Here are just a few, sometimes combined by focal area:

Bert Waters: 1) Served as core faculty for the VCU Donald W. Reynolds Interdisciplinary Partnership in Geriatric Education, being a preceptor for over 60 students from Social Work, Nursing, Pharmacy, and Medicine in the Interprofessional Virtual Geriatrics Case, a semester-long, web-based case system to overcome barriers to interprofessional education; 2) Co-authored two presentations for the federally-funded Richmond Health and Wellness Program (directed by Pam Parsons, Nursing, and Patty Slattum, Pharmacy) at the All Together Better Health, VII: The 7th International Conference on Interprofessional Practice and Education, in Pittsburgh, PA in June, 2014. The presentations were titled: *Social Acceptance: Working with Community Members in an Interdisciplinary Community Health Model, and Evaluating the Financial Sustainability of the Richmond Health and Wellness Program.*

Paula Kupstas, Ruth Anne Young, and Lisa Furr: 1) Our Domestic Violence in Later Life (VSTOP) project was among six Violence Against Women Act-funded programs from Virginia recognized in the White House report, *1 is 2 Many: Twenty Years Fighting Violence Against Women and Girls,*

thanks to our nomination by the Virginia Sexual and Domestic Violence Action Alliance. VCoA’s Lisa Furr was quoted in the report; 2) Four partners from the Central Virginia Task Force on Domestic Violence in Later Life delivered the eight-hour Elder Abuse Training for Law Enforcement to 32 participants from eight different localities at the Henrico Training Center; this was a concentration of a normally two-day training and it received very strong evaluations; 3) Completed all of the trainings required by our USDOJ OVW grant which is focused in Bristol, and Washington County in far Southwest Virginia, including two basic trainings on abuse in later life for law enforcement, two basic abuse in later life victim services trainings, and one advanced law enforcement training on financial exploitation; The community now has 26 victim and aging services professionals and 39 law enforcement professionals who have received basic training in how to apply these key points to their work in addressing abuse in later life. Twenty additional professionals added the advanced law enforcement training to their credentials as well; 4) Completed the community needs assessment required by the OVW grant and identified three needs to propose to OVW for funding: an abuse in later life specialist position to be created, an emergency fund for victims of abuse in later life, and a coordinated shelter program with the facilities to assist victims who need emergency housing and have caregiving needs.

Sung Hong: 1) Published (with Connie Coogle) a critical review in the *Journal of Applied Gerontology*

that prominently featured the ARDRAF and its administration by VCoA. The study began with an examination of Dr. Toni Calasanti’s 2003 ARDRAF-funded project report, *Gender Differences in Informal Care Work for Persons with Alzheimer’s Disease*, and her ensuing published articles. A literature review through the deductive process determined that her core thesis of caregiving as a gender-based tiered entity remained quite plausible in the literature throughout the subsequent years; 2) Completed the compilation “Violations of regulations in assisted living facilities with special care units in Virginia,” which reveals the relative magnitude of citations by inspectors during the past 30 months, and may provide long-term care professionals and advocates with insights into the administration/operation of dementia care facilities.

Jenni Matthews and Myra

Owens: 1) Provided an online environment for the Virginia Geriatric Education Center (VGEC) Faculty Development Program in Blackboard to facilitate scholar/faculty communication and centralize course materials for participants; 2) Presented a research poster at the 2014 Annual Meeting of the Southern Gerontological Society in Arkansas demonstrating how we measured the collaborative success of the VGEC consortium; 3) Collaborated with Connie Coogle, NTACC, the Maine GEC, and others in conceiving and writing a manuscript about our Evidence Based Practice (EBP) program on falls prevention and intervention, which has been accepted for publication; 4) Reviewed, with Connie Coogle and Lewis Hackett

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(EVMS), the de-identified medical records of 346 PACE participants to document the degree that healthcare practitioners in the VGEC EBP have adopted our protocols to reduce falls among community-based older adults.

Jeffrey Ruggles, Catherine Dodson, and Rachel Kelly:

1) Increased the number of Road Scholar programs conducted, from 22 in 2013 to 25 in 2014, and increased the number of participating Road Scholar learners, from 551 in 2013 to 673 in 2014, up 22 percent; 2) Established a new Road Scholar location for programs at Big Meadows Lodge in the Shenandoah National Park; 3) Regenerated our Road Scholar Genealogy program, with sufficient success to warrant multiple offerings annually; 4) Maintained the Lifelong Learning Institute (LLI) in Chesterfield County, founded and co-sponsored by the Virginia Center on Aging, Chesterfield County Public Schools, and Chesterfield County, for mid-life and older adults. In 2014, its 11th year of growth, the LLI had 734 members, including 191 new members; it offered 485 classes with 13,060 registrations in three full semesters of daytime, nonresidential, college-level courses and related activities, for 86,385 total classroom hours taught by 211 instructors; LLI's lifelong learners represent 29 different zip codes.

Connie Coogle: 1) Worked, at the suggestion of the Alzheimer's Disease and Related Disorders Commission, to broaden the awareness and impact of the Alzheimer's and Related Diseases Research Award Fund (ARDRAF) by having the results of ARDRAF-funded projects

(2008-2013) included in the International Alzheimer's Disease Research Portfolio, an online portal and database sponsored by the National Institute on Aging and the Alzheimer's Association; this process will help them (and the ARDRAF) better target funding efforts, identify gaps, and facilitate opportunities for collaborative research; using a Common Alzheimer's Disease Research Ontology, results revealed that ARDRAF funding aligns with the proposed revisions to the Commission's *Dementia State Plan: Virginia's Response to the Needs of Individuals with Dementia and their Caregivers* (Goal V.A.1); 2) Conducted follow-up surveys of previous ARDRAF awardees to determine their research trajectories and subsequent ARDRAF award-related funding, i.e., grants enabled by the results of their ARDRAF pilot study findings; determined that, since its inception in 1982, ARDRAF has solicited, third party-screened, and awarded \$3.33 million for Virginia-based pilot studies which have produced 275 research journal publications and \$36.7 million in subsequent non-state grants obtained, for a return on investment (ROI) of \$11 for every \$1 appropriated.

Lastly, **Ed Ansello:** 1) Conducted with partners in the Area Planning and Services Committee (APSC) on aging with lifelong disabilities both the annual June statewide conference and November workshop on issues related to the well being of these adults and their family and formal caregivers; 2) Partnered with colleagues in the Lindsay Institute for Innovations in Family Caregiving, led by Senior Naviga-

tor and named for legendary geriatrician Dick Lindsay, in identifying high tech and low tech resources for those who shoulder the lion's share of long-term caregiving; 3) Celebrated the gift of having such dedicated and creative partners in the Virginia Geriatric Education Center (VGEC), our VCoA, the School of Allied Health Professions, and elsewhere across the Commonwealth. Thank you.

2015 DARS Meeting Calendar

Commonwealth Council on Aging

(Wednesdays)
January 28, 2015
April 8, 2015
July 8, 2015
September 23, 2015

Alzheimer's Disease and Related Disorders Commission

(Tuesdays)
March 10, 2015
May 26, 2015
August 25, 2015
December 1, 2015

Public Guardian and Conservator Advisory Board

(Thursdays)
March 26, 2015
June 11, 2015
September 10, 2015
November 19, 2015

For more information, call (800) 552-5019 or visit <http://vda.virginia.gov/boards.asp>.

Editorials

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

Guest Editorial by Bob Brink,
Deputy Commissioner

It's been just over six months since I stepped down as a member of the House of Delegates and accepted Governor McAuliffe's offer to join his administration as Deputy Commissioner for Aging Services. Since then, many people have asked me if I miss being in the General Assembly. As a recovering politician, my straightforward answer is "Yes and No."

On the one hand, I loved being in the House. My State Senator often told people I enjoyed the job so much that I ought to be paying the Commonwealth, instead of the other way around. Through my legislative efforts, I felt I made a difference in many Virginians' lives, and I'll cherish the friendships I made among my colleagues on both sides of the aisle.

But at the end of the day, I don't miss my old job that much, because my new one is so critical. I have a chance to work on one of the greatest challenges facing Virginia and the nation: getting ready for the Age Wave.

I have a personal stake in making sure we get it right. I never thought I had much in common with Dolly Parton, Cher, and Sylvester Stallone, but it turns out I do: Dolly, Cher, Sylvester and I all were born in 1946, at the front end of the post-

World War II Baby Boom that ran all the way to 1964, with the birth of (among several million others) Sandra Bullock, Keanu Reeves, and Rob Lowe. Last year, that tail end of the Baby Boom turned 50: by 2030, as they turn 65, we Baby Boomers will number 1.8 million people here in Virginia, 20 percent of the population.

To get an idea of how Virginia is doing in managing the Age Wave, for the past several months I've been on the road, visiting local Area Agencies on Aging across the Commonwealth. I logged over 3,000 miles, travelling from Bristol and Big Stone Gap to Virginia Beach and the Northern Neck, to Culpeper, Loudoun, and Charlottesville. What I saw reinforces my belief that, even in a geographically and demographically diverse Virginia, our differences are outweighed by the issues that unite us.

The first region I visited was the far southwestern corner of the state. (I wanted to get out there before the first snows of the season.) The southwestern AAAs are doing incredible work serving a disproportionately aging population. While in Virginia overall about 15 percent of the people are 65 or older, every one of the localities in the District Three AAA is well over 20 percent, and in the city of Galax, 36 percent of the people are 65 or older. A weak economy puts severe strains on the region's ability to provide needed services, and this has traditionally been a severely medically underserved area.

Even the lay of the land makes things tough. This is largely moun-

tainous terrain, and the people are spread out. The four counties of the Appalachian Area Agency on Aging have a population density of 65 people per square mile. In Albemarle County, it's 720 people per square mile, and in Fairfax it's 2,750. (Of course, none of them holds a candle to my old stomping grounds of Arlington with its 8,000 people per square mile.) This means that it's a constant struggle to link people up physically with vital services such as nutrition and health care.

Those are just a few of the many challenges we face. When I visited Senior Services of Southeast Virginia, which includes Norfolk, Virginia Beach, Chesapeake and surrounding areas, I learned that they, like AAAs in other parts of the Commonwealth, must constantly maintain and replenish a volunteer corps that itself is aging in place.

Here in Virginia we have to deal with increased demand for services in the face of uncertain economic times. In the short term, new and unexpected revenue shortfalls this year forced us to tap into the state's Rainy Day Fund, and Governor McAuliffe asked the agencies to come up with spending cuts of five percent this year and seven percent next year.

But while these steps take care of the immediate problem, in the longer term we have to be prepared for the possibility of a slowdown in our traditional, federal government-oriented economy. If the federal budget wars resume across the Potomac and full sequestration cuts go into effect in a few years, Virginia will face the loss of tens of

thousands of high-paying jobs and a retrenchment in our economy, especially in Northern Virginia and Hampton Roads, which traditionally have been the Commonwealth's economic engines. This is a test of our ability to adapt to new circumstances, and Governor McAuliffe is meeting it head-on by leading us toward a stronger, more diversified "New Virginia Economy."

To deal with this new reality and provide the level of service and support that the Age Wave demands, the Aging Division of DARS will be aggressive in encouraging innovation in service delivery, through formation of public-private partnerships and expanding the revenue base at both the local and state levels.

I'm excited by what I saw at the local level, where the needs of the community can be assessed and solutions can be developed that meet those particular needs. Already, seven regions in Virginia have developed active, comprehensive Age Wave plans through collaboration between Area Agencies on Aging, foundations, businesses, and other community partners. I'm confident we can meet the challenge of the Age Wave because those who are involved first-hand in planning for it are so forward-looking and open to innovation. I look forward to working with individuals and organizations across the Commonwealth as we ride the Age Wave together.

Advance Care Planning Coalition Launched in Eastern Virginia

Four Area Agencies on Aging have partnered with four regional health systems to form the Advance Care Planning Coalition of Eastern Virginia. The Coalition is promoting understanding of advance care planning and individual engagement in the completion of Advance Directives to adults 18 and older in the community-at-large. The Coalition sponsors are Bon Secours Hampton Roads, Chesapeake Regional Medical Center, Riverside Health System, and Sentara Healthcare. Coalition partners are Bay Aging, Eastern Shore Area Agency on Aging, Peninsula Agency on Aging, and Senior Services of Southeastern Virginia. After three years in development, this special collaboration of health and human service providers launched their public program and brand, *As You Wish Advance Care Planning*, in October 2014.

With a baseline of 20 percent, the main goal of the program is to create a three percent annual increase in the number of individuals with Advance Directives at the time admitted to the sponsor hospitals.

An appreciation of Advance Care Planning and conversations about the advantages of having an Advance Directive need to be held early and often in the community. "As a community based and client-centered model, *As You Wish* presents a proactive and complementary extension of the education and

Advance Directive facilitation efforts conducted by our health providers within the medical environment," said David Murray, Executive Director of the coalition. Through the leadership of the Area Agencies on Aging and their extensive network of partners providing home and community based services, the *As You Wish* program is designed to serve as a single platform for all adults in the community to receive information on Advance Care Planning and access to guidance, toward the individual completion of one's Advance Directive.

In just over 90 days of public promotion, including the November 24 launch of the *As You Wish* website: www.asyouwishvirginia.org, the program has been promoted to 2,100 adults and the website has had 1,118 visits including 524 downloads of the program's Virginia Advance Directive for Health Care.

Visit Our Websites

The website for the Virginia Center on Aging is www.sahp.vcu.edu/vcoa. Visit to learn about programs from lifelong learning to geriatrics training, to access the archives of issues of *Age in Action*, ARDRAF reports, and more. The website of the Virginia Department for Aging and Rehabilitative Services is www.dars.virginia.gov. Visit to learn about services, commissions, boards, and councils on adult protective services, aging, Alzheimer's, guardianship, independent living, and more.

Toolkit for Healthcare Providers to Better Serve Adults with Lifelong Disabilities

There's a new resource available on-line, a truly impressive toolkit for health care providers containing information on care of adults with intellectual and developmental disabilities. Developed by the Developmental Disabilities Primary Care Initiative (2005-2014) in Toronto, Ontario, with funding by the Ontario Ministry of Community and Social Services, Ontario Ministry of Health and Long-Term Care, and Surrey Place Centre Charitable Foundation, it is a trove of valuable practical information. The Vanderbilt Kennedy Center for Excellence in Developmental Disabilities, supported in part by the U.S. Administration on Developmental Disabilities, received permission to modify and distribute this "E-Toolkit" in the United States to improve the primary care of people with intellectual and developmental disabilities. There are also helpful materials for individuals with lifelong disabilities and their families.

The website's information is an adaptation for U.S. use of a Canadian book, *Tools for the Primary Care of People with Developmental Disabilities*, which is based on consensus guidelines and is peer-reviewed.

Tools on the website include **Generic** topics like Communicating Effectively, Informed Consent, Informed Consent Checklist, and Office Organizational tips; **Physical Health Issues** like Male and

Female Preventive Care Checklists; and **Health Watch Tables** for various lifelong disabilities, including Autism, Down Syndrome, Fragile X, and Prader-Willi.

There are summaries for providers of **Behavioral and Mental Health Issues**, prefaced by acknowledgment that treatment may be challenging because of difficulties communicating with individuals with certain lifelong disabilities and the risk that the provider might mistakenly attribute behavioral problems to the lifelong disability itself, called "diagnostic shadowing."

The Health Watch Tables are helpful, offering disability-specific "considerations" and "recommendations" when conducting exams of: Head, eye, ears, nose, and throat; Dental; Cardiovascular; Sleep; Respiratory; Gastrointestinal; Sexual Function; Neurological; etc.

Tips and Resources, produced by Vanderbilt Kennedy Communication and Dissemination Services, discuss the science of specific disabilities, the effects disabilities might have on the individual and family, and treatment and service options.

To access this excellent toolkit on specific medical and behavioral concerns of adults with lifelong disabilities that also includes resources for individuals and families, visit: <http://vkc.mc.vanderbilt.edu/etoolkit>.

Commonwealth Council on Aging 2015 Best Practices Awards

The Commonwealth Council on Aging is sponsoring the 2015 Best Practices Award Program, which is funded by Dominion Resources, 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 can be found at <http://vda.virginia.gov/council.asp>.

Nominations for the 2015 Awards must be received by March 2, 2015.

This is the tenth 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.

The awards will be given to innovative 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 intergenerational programming. We believe the door is wide open for creative best practices.

Improving the Health of Older Adults with Chronic Conditions through Partnerships and Evidence Based Programs

by Fran Anderson
Director, Center for Aging,
Senior Services of
Southeastern Virginia

Ms. Rosa has just returned home after her second hospital stay within a month. She is 66 years old and has several chronic conditions with 12 prescribed medications. Ms. Rosa sees two doctors and uses two different pharmacies. Her medications were adjusted during her inpatient stay, resulting in several new prescriptions. She feels overwhelmed by all the instructions she received in the hospital, and is confused about the medication changes. She is the caregiver for her husband, who has dementia, and also often babysits her grandchildren. Ms. Rosa knows she needs to take better care of herself, but she is worried that she can't do that when so many others are relying on her. Fortunately, support is available.

According to a recent report, 18 percent of Medicare patients will be readmitted within 30 days of a hospital discharge (Rau, 2013). Research also shows that 72 percent of adverse events following a hospital stay are related to medications and that medication errors are the fifth leading cause of death among older adults (HomeMeds.org). Many hospitalizations and medication related problems are preventable.

Senior Services of Southeastern Virginia (SSSEVA), a private non-profit Area Agency on Aging, is addressing preventable hospitalizations and medication issues for adults age 60 and older with chronic conditions. Two partners in the effort are Sentara Healthcare System and Hampton University School of Pharmacy.

SSSEVA is implementing two evidence-based programs with the patients referred by the hospital: The Care Transitions Intervention (CTI) and HomeMeds. These models have proven to be effective in assisting older adults to remain in their homes, reducing hospitalizations, promoting health, and reducing healthcare costs.

The focus of CTI is empowering patients to take a more active role in managing their chronic condition with the assistance of SSSEVA's certified "Transition Coach." The Coach visits the patient in the hospital prior to discharge and then follows up with one home visit and three phone calls. The patient is coached in self-care skills during the 30 day CTI intervention, including medication self-management, increased awareness of symptoms, better communication with treatment providers, and recognizing warning signs that trigger the need for care and how to respond. Transition Coaches have access to the hospital's EMR, making discharge and readmission information easily obtained.

Coaches implement HomeMeds as well during the home visit. HomeMeds is a web-based medication management program that can be used in the home to identify and

resolve medication problems. The program features a risk screening tool that issues an "alert" for high risk medication problems. The alert system triggers consultation with a pharmacist who will review medications in light of diagnoses, symptoms, and other issues to evaluate whether a true problem exists. Students from Hampton University's School of Pharmacy serve as the consulting pharmacists. Working under close supervision by their instructors, pharmacy students take action. They may call the patient or caregiver to provide education on the disease state, dieting, or to clarify the strength/dose of medication. The prescribing physician may be contacted to recommend that a medication change be ordered. Coaches follow up on recommendations.

To date, SSSEVA has exceeded its goal of reducing 30 day readmission by 30 percent, compared to hospital baseline data gathered at the start of the pilot. Of the patients screened for medication issues, 38 percent had some type of alert. Pharmacists made recommendations for medication changes in almost half of the cases they reviewed.

It is estimated that the savings from reduced hospital admissions because of these programs total approximately \$280,000. The overall health care cost savings is much higher, considering the number of adverse events prevented through identifying and resolving medication issues.

Ms. Rosa's story ended successfully. She was able to establish and achieve goals she set for managing

her health. She learned early warning signs of her conditions. She gained confidence in discussing concerns or questions with her doctor. She felt comfortable managing her medications, which were ultimately reduced. She was connected to respite care resources. Ms. Rosa has not been back to the hospital for three months.

Resources

Rau, Jordon. Rehospitalization rates fell in first year of Medicare penalties, December 2013. <http://kaiserhealthnews.org/news/rehospitalization-rates-fell-in-first-year-of-medicare-penalties/>. Accessed December 22, 2014.

[HomeMeds.org](http://www.homemeds.org/articles/1,1.html). Cost-effective medication management interventions for low-income seniors in home care minimizes drug errors, saves lives, raises standard of practice. www.homemeds.org/articles/1,1.html. Accessed December 22, 2014.

Would You Like to Switch from Postal to E-Mail Delivery?

We currently publish *Age in Action* in identical print and PDF versions. *Age in Action* will be transitioning over time to an electronic version only. If you now receive hard copies by postal mail, please consider switching to e-mail distribution. Send an e-mail listing your present postal address and best e-mail address for future deliveries to eansello@vcu.edu.

SGS Annual Meeting to be Held in Williamsburg

The Southern Gerontological Society (SGS) will hold its 36th Annual Meeting in Williamsburg from **April 15 - 18, 2015**. This year's theme is *Communities Engaging Aging: A Two Way Street*.

SGS is a network of the South's most respected gerontology professionals. The annual meeting attracts academics, policy makers, providers in health care, social services, and others committed to the quality of later life.

Conference attendees have much to look forward to, as the presentations will cover a wide range of important topics including aging in place, age-friendly communities, gerontechnology, end-of-life care, and more. This conference features a special track on Alzheimer's disease and other dementias, sponsored by the Virginia Geriatric Education Center (VGEC), with notable presenters in workshops and sessions, including one focused on films related to dementia and dementia care.

This conference will not only include a broad range of informative and inspirational topics, but will also allow time for attendees to enjoy the many delights of historic Williamsburg.

The conference hotel is DoubleTree by Hilton, and registration is now open. For more information, visit www.southerngerontologicalsociety.org/meeting.html or call (866) 920-4660.

Federal Website on Elder Justice

The Elder Justice Initiative at the U.S. Department of Justice has launched a website on combating elder abuse and financial exploitation. It has separate tabs for victims, prosecutors, and direct service providers that offer support and resources for victims, targeted resources for law enforcement and prosecutors (pleadings and statutes), and training resources for providers. There's also a section for researchers that contains a database of over 3,000 abstracts and publications, all listed in a searchable bibliography. Visitors will need a Media Player for DVDs on the website.

As the website states: "Here victims and family members will find information about how to report elder abuse and financial exploitation in all 50 states and territories. Simply enter your zip code to find local resources to assist you."

The Elder Justice Initiative maintains that "This website is intended to be a living and dynamic resource. It will be updated often to reflect changes in the law, add new sample documents, and provide news in the rapidly evolving elder justice field" and hopes that "this website serves as a forum to share information and resources so that, as a nation working together, we can fight elder abuse and financial exploitation and get to a place where we are all proud of how this nation supports its older citizens."

The website can be found at www.justice.gov/elderjustice.

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 \$45,000 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 in Virginia.
- Schedule:** By March 2, 2015 prospective applicants are required to submit a non-binding letter of intent that includes a descriptive project title, contact information for the principal investigator, 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 on the due date. Applications (hard copy sent by carriers who date stamp 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, 2015, and applicants will be notified by June 19, 2015. The funding period begins July 1, 2015 and projects must be completed by June 30, 2016.
- 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 found at www.sahp.vcu.edu/vcoa/program/alzheimers.html or by contacting:

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Slow Dancing with a Stranger

(It's unusual to review a book in Age in Action, but this warrants it for its personable yet unvarnished exposure of the grind of care.)

The "Stranger" is Alzheimer's disease and the slow dancing refers to the almost 20 years that Meryl Comer has been dealing with her husband's early-onset dementia. For her and her husband, it's a dance that never ends, despite expectations that it would be relatively short.

Writing with the clarity and effectiveness of the skilled reporter she is, Comer, in *Slow Dancing with a Stranger* (Harper One Publisher, 2014), recounts the usual and the idiosyncratic instances one experiences when dementia insinuates itself into what had been the commonplace of everyday life. Her husband, Harvey, was a renowned physician-researcher at NIH in his mid-50s when his erratic behaviors began to interfere with the routines of their marriage, his research, and his care of patients. As for so many of us, this was far too early in life to have had retirement plans and resources firmly in place, to say nothing of long-term care supports. Comer goes to extraordinary lengths to find diagnoses and treatments, to find a place where her husband might be cared for and recognized as a person. She quits her work as an Emmy-awarded reporter and devotes herself to finding ways to keep some semblance of what used to be.

Harvey's symptoms, presenting so

early in life, eluded diagnosis by clinicians at the best centers, including those at Johns Hopkins. He was misdiagnosed, treated in psychiatric units, physically restrained, isolated, prescribed various drug regimens, over-medicated, ostracized in and rejected from different long-term care settings, and ultimately taken home by Comer for round-the-clock personal care that has lasted for years.

Readers witness her relentless efforts to "normalize" her life with her husband in the face of progressive, plateau-like declines in his abilities and the slow, irreversible erosion of his person and spirit.

She discovers, almost accidentally, that 12 years into Harvey's disease, she had not taken even rudimentary care of herself, no physical check-ups of any kind, including a pap smear or mammogram. Like everything else, they all "had gone by the wayside." Yet another part of the slow dance with a stranger. Then, late in the years of caring for Harvey, she took on the care of her mother with late-stage dementia.

After allowing film crews into her home to document family caregiving, her writing of essays, and appearing on PBS and network television to champion the needs of caregivers, Comer was invited to join the Geoffrey Beene Foundation as president and CEO of its Alzheimer's Initiative, to advocate for caregivers, research, and greater recognition of the widespread impact of Alzheimer's disease and other dementias on millions of individuals and their families. "My hard-won expertise had come from years of trial and error fueled by a

determination to battle each stage of Harvey's disease as the fight of our lives. Caregivers deserved to be validated and empowered, not forgotten. I could be an advocate on both fronts." (p. 186)

Comer shares remarkable insights throughout *Stranger*. A columnist asked her, "Can you have true intimacy with another human being without shared memories?" Comer reflects that "everything that I have done for my husband has been intimate, more than any adult would ever consider desirable. A caregiver must cross personal boundaries. The intimacy of total dependence and loss of control is one we all fear ...but Harvey cannot communicate either pleasure or gratitude. Shared memories must be built on both. Memories warm us. Separated from our memories, good or bad, who are we? In this sense, we have both lost out on an intimate life. But unlike Harvey, I still have memories that intensify my sense of loneliness." (p. 211) So her answer to the columnist's question is "No"; true intimacy requires shared memories.

With more determination than self-pity, Comer sums her caregiving experiences this way; "When I stare in the mirror, I see only exhaustion and 20 years lost. I am still looking for the same thing I wanted when I first learned that Harvey had Alzheimer's disease: a way out for all of us." (p.216) Her battles now are against the seeming acceptance by so many, especially policy makers, that dementia is a hopeless fact of life. We know that she will continue her advocacy for research and awareness of the under-recognized heroes of dementia care.

Circle Center Adult Day Services To Bring Dementia Care Expert Teepa Snow to Richmond



Circle Center Adult Day Services will be bringing nationally known dementia care expert Teepa Snow to Richmond for an

all-day seminar, *Dementia Care: Creating a Positive, Partnering Experience*, on **April 25, 2015**, at the University of Richmond Jepson Alumni Center. The event will provide information and comfort to families dealing with dementia care issues.

Teepa Snow, MS, OTR/L, FAOTA, is a national leader in dementia care. Teepa is a licensed occupational therapist with over 33 years of experience in geriatrics and independent practice in dementia care and dementia education. She has developed several training videos and published many articles. She presents over 350 programs each year throughout the U.S. and Canada on a variety of topics to a wide variety of audiences.

Ms. Snow has clinical appointments with Duke University's School of Nursing and UNC-Chapel Hill's School of Medicine. She is a Fellow of the American Occupational Therapy Association and has received many awards for her clinical and teaching skills from a wide variety of organizations. She has also provided care to a variety of her own family members with

dementing illnesses.

This full-day, intensive, skills-based workshop is designed for family and professional caregivers who want to move from "dealing with" dementia-related behaviors to creating a more positive experience for the person in need of care and their care partners. Attendees will learn a structured approach to recognizing and coping with challenging behaviors, as well as combinations of helping techniques for individuals with varying degrees of impairment.

Tickets for this public education event are on sale now and may be purchased on the Circle Center website at www.circlecenterads.org or by calling Holly Thornton at (804) 355-5717.

Professionals: \$75
(includes lunch)
Family caregivers: \$40
(includes lunch)

For professionals, Continuing Education Credits (CEUs) will be available for an additional fee of \$20. Opportunities for sponsorship and exhibit space are also available.

For complete details, visit www.circlecenterads.org.

About Circle Center Adult Day Services: Circle Center Adult Day Services has provided the Richmond community with high-quality, cost-effective licensed adult day services for frail or functionally-impaired older adults, and respite, education and support for their caregivers since 1976. The Center's award-winning programs and services are structured to support

continued community living, maintain and improve functional abilities, develop coping skills, and improve the quality of individual and family life. The caregiver, knowing the loved one is engaged and supervised, gets respite and time for other responsibilities. Circle Center's vision is that older adults continue to live with their families with purpose and dignity in a supportive community.

VCU Gerontology Alumni News

We are thrilled to report recent accolades received by our esteemed alumni, Cathy Saunders, Sonya Barsness, and Ryan Duffy. Cathy (MS '82) was recently honored as a nominee for the VCU Alumni Services Awards. A reception was held on October 24, 2014, to honor Cathy and the other nominees and awards recipients. Cathy's tireless efforts on behalf of the Department of Gerontology, School of Allied Health Professions, and the entire VCU community are so greatly appreciated!

Both Sonya Barsness (MS '99) and Ryan Duffy (MS '11) are featured in the new second edition of Joanne Grabinski's *101+ Careers in Gerontology* (Springer Publishing) for their work in the emerging field of Entrepreneurial Gerontology. Sonya and Ryan are paving the way for future Gerontologists to create new careers in aging as well as for the the recrafting of existing careers to support the person-centered care of our aging population.

Fresh Fruit and Better Health

Daily consumption of fresh fruit substantially reduces risks for fatal heart attacks and stroke, according to research presented at the 2014 Congress of the European Society of Cardiology and summarized in the December issue of the Consumer Reports newsletter *On Health*. The seven-year follow-up study of almost 500,000 people in China found that daily consumption of fresh fruit lowered the risk of coronary heart disease (CHD) by 15 percent and the risk of stroke caused by blood clots by 24 percent. Compared to those who never ate fruit, people who ate 1 1/2 servings of fruit a day cut their risks for fatal CHD and for fatal strokes by 27 percent and 40 percent, respectively. Fruits (and vegetables) are rich in phytochemicals, fiber, and minerals that may act as protective anti-oxidants. A small apple or an orange equals "one serving," while a half-cup of sliced fruits and berries is "one serving."

The Antioxidants Research Laboratory at Tufts University reports these additional benefits of fruits: Blueberries have great antioxidant power and can improve insulin sensitivity in overweight adults and pre-diabetic adults without raising blood sugar. Strawberries are packed with vitamins C and bone-building K, and dietary fiber, and can help reduce high blood pressure, inflammation, and hyperglycemia. Raspberries are high in fiber, calcium, vitamins C and K, and several B vitamins, and may help as a natural treatment for arthritis.

New Destinations in 2015 for VCU Road Scholar

by Jeffrey Ruggles

A mountain lodge and an historic river port are sites for new VCU Road Scholar programs. In addition, one of Virginia's oldest hotels is getting a makeover and VCU Road Scholar will be there, too.



Big Meadows Lodge opened in 1939 in Shenandoah National Park, when the park and Skyline Drive were new and the trees hadn't yet grown back on the Blue Ridge. By 1960 Big Meadows had expanded to include a number of cabins and other accommodations, but meals are still served in the original Spotswood Dining Room featuring ceiling timbers, a fireplace, lots of windows, and a view of the Valley. Join VCU Road Scholar for natural edification and moderate hiking. Program #17170, July 19-24, September 13-18.



Downtown Fredericksburg melds 18th, 19th, and 20th century architecture into a friendly and peaceful gestalt of shops, museums, eateries, and riverfront. Field trips go to historic sites of similarly varied periods and staying in the historic downtown offers a perfect opportunity to explore. One day's expedition will travel east down the picturesque and ancient Northern Neck to Chesapeake Bay, capturing

the isolated peninsula's mix of great-family home places and village life on the water. Program #21955, September 20-25.



Natural Bridge has offered lodging since Thomas Jefferson built a cabin there before 1820 with an extra room for visitors. Nobody would accuse today's Natural Bridge Hotel of unnecessary exterior elegance (frankly, it's as they say "plain-looking") but on the inside it does have a hospitable heart. The new owners have embarked on a commendable plan to convey the stone arch to the state for a park, and to improve the hotel facilities for guests. VCU Road Scholar's Natural Bridge programs in 2015 will see this plan in progress. The Chautauqua #16228, March 22-26, August 9-13; Civil War Generals #19288, April 26-30, September 27 - October 1; Blue Ridge Culture #10029, May 10-15, October 18-23.

For all VCU Road Scholar dates, prices, and to register, visit www.roadsscholar.org, or call (877) 426-8056.

Calendar of Events

January 28, 2015

Virginia Center on Aging's 29th Annual Legislative Breakfast. St. Paul's Episcopal Church, Richmond. 7:30 a.m. - 9:00 a.m. For information, call (804) 828-1525.

January 28, 2015

Seniors and Their Medicine. The Senior Center presents a *Healthy YOU* event featuring experts from Bremono Pharmacies, Plaza Professional Pharmacy, and VCU's School of Pharmacy. 11:00 a.m. - 12:00 p.m., followed by lunch. Senior Center of Greater Richmond, Imperial Plaza, Richmond. For reservations, call (804) 353-3171 or e-mail SeniorCenterRVA@gmail.com.

February 26 - March 1, 2015

The Changing Face of Aging around the World. 41st Annual Meeting and Educational Leadership Conference of the Association for Gerontology in Higher Education. Sheraton Nashville Downtown, Nashville, TN. For information, visit www.aghe.org/am.

March 11-13, 2015

2015 Independent Owner Leadership Conference: How to Survive Medicaid Managed Care as an Independent Owner. Presented by the American Health Care Association. Westin Beach Resort and Spa, Fort Lauderdale, FL. For information, visit www.ahcancal.org.

March 16-18, 2015

2015 PEAK Leadership Summit. Presented by LeadingAge. An exclusive opportunity for CEOs and leaders of aging services organizations to come together, network, and learn best practices from their peers. Washington Marriott Wardman Park Hotel, Washington, DC. For information, visit www.leadingage.org/PEAK_Leadership_Summit.aspx.

March 23-27, 2015

Aging in America. Annual conference of the American Society on Aging. Chicago, IL. For information, visit www.asaging.org/aia.

March 24-25, 2015

Virginia Assisted Living Annual Spring Conference and Tradeshow. Embassy Suites Hotel, Spa, and Convention Center, Hampton. For information, visit www.valainfo.org.

March 31, 2015

Intervention Strategies to Address Behavioral, Mental Health, and End of Life Needs of Older Adults with Cognitive Impairment. Third Annual Northern Virginia Dementia Conference. George Mason University, Fairfax. For information, contact Margaret Rodan at mrodan@gmu.edu.

April 11, 2015

VCU Department of Gerontology's Annual Age Virginia Awards. Join us in celebration of Gerontological Excellence. Hosted by Imperial Plaza, a Brookdale Senior Living Community. For information on awards, event sponsorship, or tickets, please email agingstudies@vcu.edu.

June 1, 2015

2015 Conference on Aging with Lifelong Disabilities. Presented by the Area Planning and Services Committee on Aging with Lifelong Disabilities (APSC). Doubletree by Hilton Richmond-Midlothian. For information, contact eansello@vcu.edu.

June 3-5, 2015

42nd Annual Conference and Trade Show of the Virginia Association of Nonprofit Homes for the Aging. The Hotel Roanoke, Roanoke. For information, visit www.vanha.org.

July 27-30, 2015

Generation ADA: Rise Up! 2015 Annual Conference on Independent Living. Presented by the National Council on Independent Living. Grand Hyatt, Washington, DC. For information, visit www.ncil.org.

Age in Action

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