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age in action

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

Case Study

Activity Engagement for Persons with Dementia

by Barbara Braddock, PhD, CCC-SLP, and Ellen Phipps, CTRS

Educational Objectives

1. Describe a successful approach to activity engagement for persons with dementia.
2. Review three cognitive interventions useful for activity engagement for persons with dementia.
3. Discuss applications of this approach using university students in home visits.

Background: Activity Engagement

Alzheimer's disease (AD) and other dementias progressively rob persons of orientation to person, place, and time. They lose their sense of relationship to people and things around them. A key question is whether persons with dementia can be engaged in meaningful activity when that activity is structured by visitors from the community.

"Engagement in activity" is defined as any positive and relevant motor or verbal behavior exhibited by the participant in response to the structure of the activity. For example, participants may engage by painting, singing or dancing, or by listening and looking on during steps in completing the activity (Judge et al., 2000).

Often, others must structure activity, as many with dementia, even in early-stage, exhibit problem behaviors such as apathy, agitation, anxiety, and/or irritability when presented with activities beyond their level of function. Families caring for their loved ones at home may need assistance from outside volunteers to structure activity. Past service projects on these matters have shown that students enrolled in local colleges and universities can provide families with assistance by appropriately structuring activity for persons with dementia.

In one such study, students at the University of Arizona completed 10 one-hour weekly sessions of volunteer home or other community activity with persons experiencing cognitive decline (Arkin, 1996).

At the project's completion, there were apparent positive changes in the number of on-topic statements produced in discourse by seven of the 11 persons with early-stage dementia, and all involved (patients, students, and family members) reported benefits from the partnership.

The Academic Community Engagement (ACE) Project

The University of Virginia's Curry School of Education, in partnership with the Alzheimer's Association Central and Western Virginia Chapter, has implemented an activity engagement project using students from the university's Academic Community Engagement (ACE) Office of the Vice Provost of Academic Programs. In this ACE project, university students worked to engage persons with dementia in meaningful activities, setting up and guiding their activities.

The ACE grant created an opportunity for faculty in the Program of Communication Disorders to connect to public life through community service and also enabled the local Alzheimer's Association to

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enhance programs by drawing on faculty expertise. The faculty members integrated community service and community-based research components into an existing graduate level course in Communication Disorders. Graduate students in the Program of Communication Disorders enrolled in the ACE course to earn academic course credit and teamed with undergraduate students across the university who volunteered or enrolled in a research laboratory in Psychology or Education. They worked in the community over the academic semester to engage participants with dementia in meaningful activity. As part of the project, the authors guided students in community service actions through classroom lectures, direct supervision, and clinical case presentations.

The ACE intervention project draws upon fundamental principles of the profession of therapeutic recreation and those of cognitive rehabilitation (speech-language pathology). The intervention is considered strength-based and is organized around three areas: 1) relatively preserved procedural memory ability in persons with dementia; 2) use of environmental modifications to enhance function in persons with dementia (i.e., therapeutic recreational principles are used to examine personal interests prior to setting up activities that are meaningful to the participant); and 3) implementation of errorless learning strategies to limit frustration in activity completion. A brief review of the literature provides rationale for combining these three approaches into an engagement plan for persons with dementia.

Procedural memory. Generally, in early- and middle-stage Alzheimer's disease, activities that rely on procedural memory (also called implicit memory) are less affected than activities that rely on explicit memory (Bourgeois, 1991). For example, persons with dementia have more difficulty recalling past experiences (explicit memory) relative to recalling the steps in an activity (procedural memory).

Procedural memory tasks are based on ingrained, familiar sequences of movement, ranging from playing the piano and dancing, to washing hands and brushing teeth. At least for well-practiced routines, procedural memories relate to remembering the "how to" and may translate to the initiation and completion of meaningful activities around the home. This is important because persons with dementia may engage in procedural activities when environmental signals are in place; for instance, a family member sets out a laundry basket in a central location and prompts a loved one to fold clothing or sets up a "coffee center" in the kitchen and prompts making the morning coffee.

Environmental modification. Additionally, the research literature indicates that environmental modifications that enhance stimulus conditions may be useful for persons experiencing cognitive decline. Researchers report that persons with dementia require structure and order in their environment and that approaches to modify the environment are useful if the person's current level of function and personal interests are considered. One such modification is the use of external memory aids, or personalized picture and word books (Bourgeois, 1990, 1992, 2003). Still other environmental modifications may be selected to highlight or organize activity; for example, written labels, written schedules and procedures, a visible calendar, bright colors, a watch or clock with alarm, organized home spaces or inviting activity centers (Brookshire, 2007).

Another help is to use aesthetically pleasing materials taken from everyday environments to encourage participants' interest and engagement in activities (Orsulic-Jeras, Judge, & Camp, 2000). In dementia care, activities are often structured using a Montessori-based method (Judge, Camp, & Orsulic-Jeras, 2000). The method makes use of materials from the natural environment, and activities are adapted to match each participant's ability. Specifically, activities are broken down in smaller steps and each step is carefully supported to ensure success throughout the process.

Errorless learning. Environmental modifications become more central to the intervention plan as the person with dementia is governed less and less by internal reasoning and judgment and more by the external environment. As cognition declines, participants often require guidance or training to engage in activity.

One such training approach, known as errorless learning, capitalizes on procedural memory ability and serves to reduce interference created by the repetition of error response (Baddeley & Wilson, 1994). In other words, making errors interferes with correctly completing the task, for the erro-

neous step may be as likely remembered as the correct step. The basic principle of errorless learning is that every training opportunity ends with a correct response. For instance, when engaging a participant in activity, errors are eliminated or kept to a minimum at each step. This may be best achieved by asking questions with no right or wrong answers, providing choices, using written or visual cues, asking yes/no questions, and using content words and gestures to move the activity forward. A student volunteer may be trained to prompt, "Would you like to make a sandwich or go for a walk?" If the person with dementia answers "a sandwich," the student follows with "Let's go into the kitchen," while simultaneously pointing to the activity set up in an inviting space in the home. "Shall we open the peanut butter?" The student continues to guide the participant while taking great care to eliminate "I don't know" or other error responses. The aim is to reduce frustration and set the participant up for success to engage in activity.

Two Case Studies: ACE Project Participants

We feature two of the participants enrolled in the ACE project to illustrate activity engagement with individuals having different levels of dementia.

Case Study #1

Ms. M is a 66-year-old female, classified with mild cognitive impairment at the time of her enrollment in ACE. She had been diagnosed with early stage AD several months past, and was prescribed both Aricept and Namenda medications. She lives alone in a modest supported-living apartment and drives a car independently between her home and familiar locations, such as the grocery store and church. When interviewed by ACE student volunteers, Ms. M and her daughter both reported that she was creative, but was not initiating activities at home, such as art and free writing, both of which she had previously enjoyed. Using the *Leisure Interest Survey*, and with input from Ms. M, students set up three activity centers in her home: 1) art supplies with colored pencils, markers, and sketch paper; 2) a photo album with pre-selected pictures of grandsons, as well as a black marker for labeling; and 3) a journal with a brightly-colored cover and pen for writing. The students mounted a visual schedule and a calendar on the wall to assist her memory for day-to-day activities and when the students would visit.

Students visited Ms. M twice a week for one hour over eight weeks to engage her in personally meaningful activity. They emphasized procedural memory for practiced activities and guided her through the completion of activities each visit. Students used strategies, such as verbal cues and gestures, to limit Ms. M's error responses. They reset activities in Ms. M's home at the completion of each visit in order to encourage her engagement in activities between visits.

Following the initial activity set-up, Ms. M independently completed the targeted activities on a regular basis between student visits (as seen in new artwork and dated journal entries) and readily engaged in activity during visits with only minimal signs of agitation, anxiety or apathy. Her daughter reported having increased confidence in engaging her mother in activity. All participants (client, daughter, and students) reported that they benefitted from activity programming.

Case Study #2

Mr. S is 78-year-old male who was classified with moderate cognitive impairment at the time of ACE enrollment. Diagnosed with AD about five years ago, he is prescribed both Namenda and Razadyne. He spends his days at home with his wife, his primary caregiver. She has been attending a caregiver's support group for the past four years. Her biggest complaint was that her husband was "not interested in doing anything anymore. He just sits in the chair." Through the use of the *Leisure Interest Survey*, the students discovered that basketball had always been a great passion of his. Now, however, due to his physical limitations, he cannot enjoy a live game. In the past, he also played cards with friends and spent time collecting and shooting marbles.

With input from Mr. S and his wife, the project's students set up three activity centers in the participant's home: 1) marbles; 2) nerf basketball; and 3) playing cards. Game rules were relaxed and activities were adapted, based on Mr. S's physical and cognitive strengths and weaknesses. The students placed a visual schedule and calendar by Mr. S's easy chair outlining activity suggestions and upcoming student visits.

Students visited Mr. S twice a week for one hour over eight weeks in order to engage him in meaningful activity. Students emphasized procedural memory for practiced activities and guided Mr. S through activity completion each visit. Students used strategies, such as verbal cues, gestures, and hand-over-hand guidance with his permission, to limit Mr. S's error responses. They re-set activities in Mr. S's home at the completion of each visit to encourage activity engagement between visits.

Following initial set-up, Mr. S rarely completed the targeted activities on a regular basis between student visits, according to his wife. He engaged in activity during student visits with only minimal signs of agitation, disinterest, or fatigue. Mrs. S said that she had greater confidence in engaging her husband in activity, but still relied on the students to carry out the programming. All participants (client, wife, and students) reported that they benefitted from activity programming.

Conclusion

This engagement intervention is strength-based, drawing upon established practice guidelines in the fields of Therapeutic Recreation and Speech-Language Pathology (cognitive rehabilitation). We consider the intervention to be beneficial because participants with mild and moderate cognitive impairment engaged in personally meaningful activity, and the students reported a positive service learning experience. The present University-Alzheimer's Association experience may generalize to other reciprocal and mutually beneficial community partnerships. For example, communities of faith may partner with local hospice volunteer services and community youth organizations may team with state agencies to promote volunteer action in dementia care. As we move to advance dementia care, we should not overlook the enormous potential of collaborative community partnerships and networks of support.

Study Questions

1. What are some ways in which caregivers can modify the home environment prior to activity engagement in dementia care?
2. In order to limit errors and frustration, what strategies may prove useful to guide participants during activity engagement?
3. What are the basic principles of this university-chapter partnership and how might they be used with other community-based agencies to improve dementia care?

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About the Authors

Barbara A. Braddock, PhD, CCC-SLP is Assistant Professor in the Curry School of Education at University of Virginia in Charlottesville, VA. As a speech-language pathologist, she completes research in cognitive- communication intervention for persons with Alzheimer's and related diseases.

Ellen Phipps, CTRS, is co-author with Dr. Braddock of *Connections: Engagement in Life for Persons Diagnosed with Dementia, A Complete Activities Guide* and Vice President of Programs & Services at the Alzheimer's Association, Central & Western Virginia Chapter. She is a master trainer for the Alzheimer's Association.

For more information, contact Ellen Phipps at (434) 973-6122 or at ellen.phipps@alz.org or Barbara Braddock at (434) 924-4000 or at bab9c@virginia.edu.

From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

Awaken the Sleeping Giant

Eric Hoffer, the working class philosopher, wrote in *Reflections on the Human Condition* that "the hardest arithmetic to master is that which enables us to count our blessings."

In the face of the current economic straits, the tendency is to think gloom, doom, and cuts. Indeed, cut as a noun and as a verb is all around us. But let's ask ourselves if there is a way to make more of what we have in place while we work to recover. Is there an untapped resource that can be activated, opened up, and released? If so, what is it and what is the key?

To my mind, the answer is: older Virginians. They (we) are the untapped resource. Recognition and reinforcement are the keys in unlocking the wealth. Only I'm not talking about financial wealth. Let me explain. Years ago in my previous position our office was working with a senior center on the rural Eastern Shore of Maryland that was struggling to get older adults to its on-site programs. They agonized over their lack of a bus. When they redefined their problem from lack of a "bus" to lack of "transportation," numerous opportunities opened up, including systematic car pooling and jitney taxis. Energized by the subsequent, creatively produced attendance of their older adults, the center even arranged some use of idle school buses in the middle of the school day. The point is that the resources were there all along but couldn't be seen because of the traditional focus on buses. So it is, to some degree, with the current budget shortfall.

Historically, we in the broadly defined Aging Network of service providers, administrators, educators, and researchers have seen older adults as the end not the means, to mix mathematics and philosophy. We have rationalized our programs, understandably, on the needs of the older adults we have served. Carroll Estes called this *The Aging Enterprise* in her celebrated book of the same title some 30 years ago, noting that an entire system has developed around ameliorating the problems of elders in need. While the work to address needs among older adults (e.g., isolation, exploitation) continues and must continue, the process may be made more effective by recognizing and reinforcing other older adults who are not in need, those who have talents and skills they might bring to the problems. Indeed, some who receive services also have significant gifts that they are sharing or could. In other words, let's think about older Virginians as providers and as means, not only as recipients and as ends.

This resource is wide and deep. Older adults in the composite have accumulated amazingly different sets of skills, connections, spheres of influence, finances, facts, and knowledge, to name just a few differentiating characteristics. Admittedly, in this digital age, we must confess the impermanence or brief shelf-life of "knowledge." Even so,

what are we doing with these arrays of experience and talent?

I am not leading up to some grand invocation of volunteerism. Research has shown for decades that about the same small percentage of us acts on volunteering impulses at any age; it tends not to rise just because one gets older. Rather, I am trying to call attention to the latent pool of consultants, trainers, teachers, go-betweens and more that exists among older Virginians that could be brought to bear on the diverse problems vexing an Aging Network now that funds are in even shorter supply.

Think of what is all around. Many older adults see education as lifelong learning and opportunity for personal growth, not merely as something completed early in life. Every state in the country now has some form of reduced tuition program in higher education for its older citizens. Adult education and lifelong learning institutes are spreading. How are we in the Aging Network connecting with these pools of growing minds? Do we collaborate with higher education and lifelong learning centers in mutual or reciprocal training or problem-solving? Do we visit these schools and centers to explain who we are and what goals we seek? Do we informally or formally invite them to be part of the solution?

Older adults are also the unpaid foundation of long-term care, providing more hours of chronic care than the sum of our formalized health and institutional systems. If these family caregivers were to go on strike tomorrow, the fabric of our state and national budgets would tear, costing taxpayers billions more for care to fellow citizens at risk. So how do we recognize and reinforce these pillars of chronic care? The most modest investments in our Area Agencies on Aging would enable our training family caregivers in such topics as correct lifting, nutrition, basics of medication management, and self-health. With this training they could continue doing want they want most, *to be left alone.* The modest investment might be monetary and it might be identifying relevant expertise among other older adults in the community and deploying it.

Variability among older adults increases with time. For each of us there is a personal profile of what we consider "meaningful activities." Our research some time ago, focused on mid-life and older adults, showed that the greater the number of meaningful activities a person engages in, the greater is his/her life satisfaction. We found that it was better for one's self-perceived life satisfaction to engage in, say, five activities for three hours each than to invest in two activities at seven and a half hours each. Apparently breadth of activity correlates with a fuller sense of satisfaction with life. In other words, can we offer the opportunity for meaningful activities to older adults in our communities, thereby benefiting both them and us?

It seems to me that, in order to maintain our commitment to quality, we in the Aging Network need to invest in the future despite the monetary problems of the present. In Virginia, older Virginians are a remarkable resource for our future.

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

Linda Nablo

Annual Election Period (AEP)

While Congress and the White House struggle with Health Care Reform, let's not forget to be vigilant about one part of the existing health care system of particular importance to older Virginians, Medicare Part D.

The Annual Election Period, otherwise known as AEP, is upon us. This is the time during which Medicare beneficiaries can enroll in or disenroll from a prescription drug plan, switch to a different plan, and change between original Medicare with a prescription drug plan (PDP) and a Medicare Advantage plan with prescription drug coverage (MA-PD). The AEP is six weeks long and runs from November 15 - December 31, 2009 with coverage beginning on January 1 of the following year. Enrollment into a new plan will automatically disenroll someone from the current plan effective January 1.

Whether you work with older individuals in your day-to-day work, try to assist your own aging family and friends, or are receiving Medicare yourself, this is a time to pay attention, get information, and act smart. Each year, significant changes occur as insurance companies change their plans, premiums, and what drugs they cover. Additionally, in 2010, several plans are not renewing their contracts with Medicare and will no longer be

available. Marketing for plans begins on October 1 of every year. Beneficiaries should be looking for their Annual Notice of Change (ANOC) document from their current plan to review changes that could be occurring for the next year. Plan details are released on October 15 of each year and beneficiaries can use Medicare's prescription drug Plan Finder tool at that time to evaluate and compare plans. It is very important that all Medicare beneficiaries review the changes being made by their current plan and compare it to make sure it still meets their needs.

Extra Help for Medicare Beneficiaries

Medicare beneficiaries with limited income and resources have access to substantial financial help with the cost of Part D. A program called the low-income subsidy (LIS) or "Extra Help" provides assistance to beneficiaries with limited income and resources. The subsidy helps to pay a portion of the Part D plans' costs, including the monthly premium, the annual deductible, and co-payments or co-insurance amounts for covered drugs. The amount of the beneficiary's income and resources will determine the level of subsidy the beneficiary receives. The annual income must be no greater than 150% of the Federal Poverty Level or $16,245 for an individual and $21,855 for a married couple. Resources must be limited to $12,510 for an individual or $25,010 for a married couple living together. Resources include such things as bank accounts, stocks, and bonds. Houses and cars are not considered as a resource. Two major changes are being made to the LIS eligibility criteria beginning in 2010. Assets and resources, including in-kind assistance (assistance provided by a family member, friend, church, etc. with monthly expenses) and the cash value of life-insurance policies, will no longer be considered when applying for LIS. If you applied in the past and were not eligible for one of these reasons, you may be eligible starting in 2010.

Where to get help

If you have questions regarding AEP or other insurance-related questions, please contact the Virginia Department for the Aging's **Virginia Insurance Counseling and Assistance Program (VICAP)** at (800) 552-3402, or visit VDA's website at www.vda.virginia.gov. You can also contact Medicare directly at (800) MEDICARE or visit Medicare's website at www.medicare.gov.

The Virginia Insurance Counseling and Assistance Program (VICAP) provides personalized counseling and assistance to Virginia's approximately 1.1 million Medicare beneficiaries and their caregivers who need help navigating the increasingly complex health care system, including the Medicare program. VICAP counselors can assist beneficiaries in understanding and comparing benefits, applying for the low-income subsidy, resolving problems, filing appeals, exploring other options, and informing beneficiaries of their rights. All counseling offered by VICAP is confidential and VICAP counselors are not licensed to sell insurance. VICAP services are provided free of charge to all beneficiaries. There are 22 local area agencies on aging that participate in VICAP. To find the agency that serves your county, please contact the Virginia Department for the Aging.

Take it from me. I have personally consulted VICAP twice and it has resulted in significant savings for my own mother. Do not make the mistake of assuming that you don't need to reexamine the choices each year.

2009 Diversity and Aging Forum

Back by popular demand, AARP Virginia will be sponsoring the 2009 Diversity and Aging Forum. The first forum, held in 2007, sold out and featured such notable people as Governor Tim Kaine, former Governor and Richmond Mayor Doug Wilder. It marked the first time in Virginia that the issues of diversity and aging were organized into a high-level event. This year's event will be held at the Virginia Holocaust Museum on November 12, from 8:00 a.m. to 4:30 p.m. The registration fee is $25, which includes materials and lunch.

Many topics relevant to an aging and more diverse Commonwealth will be discussed. These include financial security, the housing crisis, health care reform, and older workers. My Lan Tran of the Virginia Asian Chamber of Commerce and Jim Naggles, an attorney with the Virginia Poverty Law Center are co-chairs for the forum.

For more information, or to register, call (877) 926-8300.

Listen to the Still and Quiet Voice Within

Paul Raia, Ph.D.
V.P., Clinical Services
Alzheimer's Association,
Massachusetts/New
Hampshire Chapter

Alzheimer's is an audacious disease that can wrap its tendrils around all those within the range of love and turn the way we see things topsy-turvy. Most often, we see only the sorrows and losses of this life-sapping disease, but with practice we can *learn how* to open our hearts and our spirits, and acknowledge that Alzheimer's can, indeed, reveal many life-strengthening gifts to us.

The Old Testament tells us that we can convert our sorrows, if we but listen to the "still and quiet voice within us." To hear this voice, we must first learn to quell all the distracting noise associated with caregiving so that we can hear.

Peter is one caregiver who was able to hear that voice and allow it to help him focus on what was truly important in his relationship with his wife.

A while back, I visited Peter, a 94 year-old, who was conscientiously caring for his 93 year-old wife, Celeste, who was in the later stages of Alzheimer's disease. The two met in first grade, married as teenagers, raised five children, and for more than 75 years shared their love with each other and their family. As Celeste lost the capacity to run her household, she delighted in watching the scores of birds drawn to the 20 bird feeders atop five tall poles in her back yard.

Each morning Peter, who used, simultaneously, a cane and a crutch (a scary wonder to behold), would toddle along from pole to pole in his backyard with a bag of seed around his neck. Once at the pole, he would shed his orthopedic aids and ascend a ladder that looked near the age of the climber. Replenishing each feeder took several minutes of deliberate climbing--hand to rung, pull, groan-- hand to rung, pull, groan. Twenty feeders, seven days a week, rain or shine.

When I asked him why he didn't let one of his children do this chore for him, he said: "I married Celeste for better or for worse, and we haven't come to the worse part yet. Celeste's joy in watching those birds is the gift she gives to me."

It took me many months to understand what he was telling me. The challenges associated with late stage Alzheimer's care can be interpreted as "gifts" that enable us to live our love for one another. The trick is to let go of all the turmoil and deafening psychic clatter and learn to see and focus on the important features of our lives. Peter saw that Celeste's disease fortified his life, strengthened their love, and for that he was truly grateful.

There are many life-strengthening gifts that can come from Alzheimer's disease. Olivia Hoblitzelle, in her wonderful, Zen-inspired book *The Majesty of Your Loving*, spoke of the six perfections (gifts) that can come with thoughtful caregiving: patience, generosity, discipline, diligence, contemplation and wisdom. Peter, indeed, accepted and held dear each of these gifts.

If we let it, Alzheimer's disease can make us more human, more aware of emotionally connecting with others, more empathetic. Again, let me illustrate this gift with an example.

I belong to an antique car club. One member of the club, Tom, is in middle stage Alzheimer's. Tom, now 67 years old, is a proud Marine and Vietnam veteran. One sunny summer Sunday we took Tom for a ride in our antique car to get some ice cream. As always, Tom was wearing his bright red Marine Corps jacket and a hat that read "US Marine Corps," "Gunnie," and "Vietnam Vet." Tom was so impaired that it took me five minutes to get him in the car. I had to bend his legs, sit him down, lift his legs into the car and buckle him in. With the top down and the wind in his face, he brightened. As we pulled into the roadside ice cream stand, lined up in front of the store were dozens of gleaming Harley Davidson motorcycles parked perpendicular to the curb inches from one another. Behind the row of bikes were hordes of burly leather clad, tattooed, bearded "bikers." Before coming to a complete stop, Tom, seeing the bikes, (a Harley owner himself) unfastened his seatbelt himself, opened the car door and jumped out of the car to examine the phalanx of two-wheeled art.

I was terror struck, thinking that if he touched one of those bikes they would tumble like dominoes and the guys in leather would not be happy. Tom attempted to talk to one of the men, but couldn't get the words out. Seeing how impaired

Tom was and noticing his Marine Corps garb, one of the men barked "Gunnie on deck," they all stood at attention, and saluted him (contrary to military protocol). They were all Marines themselves. They took Tom around and showed him their bikes, many with Marine Corps insignia etched in the chrome. They knew how impaired their brother Marine was and they connected with him most tenderly via emotion.

Abraham Lincoln described this essential act of humanness when he said, "Calamity reveals the angels of our better nature." Alzheimer's can, if we allow it to, bring out the best in us. I see this every day in my work with support groups, where the veteran caregivers with an ever so gentle hand shepherd the neophyte caregivers through their journey with the disease, "the angels of our better nature."

I know that it may be hard to acknowledge this while still in the throes of caring for someone you love who is living with dementia, but our experience with this disease can make us better individuals. It can strengthen our families. It can help us see what is truly important in our lives.

To clear the psychic noise so that we can attend to "the still and quiet voice within us" is not so easy. Caregivers, above all, must dispel the notion that it is selfish or indulgent to carve out personal time. Respite, that is, time away from the act of giving care, time devoted to activity that will replenish the caregiver's soul, is an essential step in revealing that voice within.

Steps to take:

1. Identify a regular, predictable time each week (at least four consecutive hours) where you are free of caregiving responsibilities.
2. If it is early in the course of the dementia, talk with the person at the most visceral level possible, and agree that you are on this journey together, not as individuals, but as a single bound entity, a kind of "karmic pact."
3. Talk regularly with a confidante about how you are doing.
4. If you are not sleeping well (seven to eight hours nightly), find out why and do something to help you sleep better. Exercise may be helpful in this regard.
5. Learn how to do short deep breathing exercises and do it seven times a day or, whenever you feel stressed.
6. Find and appreciate the humorous situations that can emerge along this journey.
7. Listen to music regularly.
8. Spend some time thinking about what is truly important in life and your relationships with others.
9. Eat a healthy diet.

And 10, Cup an ear daily to listen for that "still and quiet voice within you." It will be there, and it can direct you to the life-strengthening gifts of Alzheimer's disease.

SGS Annual Meeting in Richmond April 2010

The Southern Gerontological Society (SGS) will hold its 31st Annual meeting at The Jefferson Hotel in Richmond, Wednesday, April 7th to Saturday, April 10th, in 2010. The meeting theme is *Applied Gerontology as Community Engagement.*

SGS's annual meeting attracts staff from aging-related agencies, academics, policy makers, providers in heath care, social services, and other direct services, and others committed to the quality of later life. The Society aims to build bridges and interconnect researchers, educators, and practitioners, with the annual meeting being a focal point for these bridges.

The Call for Presentations is at **www.southerngerontologicalsociety.org**. SGS is inviting presentations related to community engagement, partnerships between academics and service providers, best practices in applied research, and other creative projects. Presentations may be given as a paper, poster, workshop, or combined into a symposium.

For more information about The Jefferson, one of the few hotels in all of North America with both Five Star and Five Diamond designation, visit www.jeffersonhotel.com.

FINAL PROJECT REPORT SUMMARIES FROM THE 2008-2009 ALZHEIMER'S RESEARCH AWARD FUND

The Alzheimer's and Related Diseases Research Award Fund (ARDRAF) was established by the Virginia General Assembly in 1982 and is administered by the Virginia Center on Aging at Virginia Commonwealth University. Summaries of the final project reports submitted by investigators funded during the 2008-2009 round of competition are given below. To receive the full reports, please contact the investigators or the ARDRAF administrator, Dr. Constance Coogle (ccoogle@vcu.edu).

Virginia Tech — **Paul R. Carlier, Ph.D. (Department of Chemistry) "Hydroxyethylamine isostere triazole-linked BACE1 inhibitors for Alzheimer's disease"**

This investigation pursues the long term objective of developing new therapeutics that slow or arrest the clinical progression of the Alzheimer's disease (AD) by preventing the formation of plaques in the brain. The build up of Aβ in the brain, by cleavage of the amyloid precursor protein (APP), is thought to be a major mechanism for the disease. Aβ is formed by the action of β secretase (BACE1 or Beta-site amyloid cleaving enzyme) on APP. Using the enzyme to assemble its own inhibitor through *in situ* and copper catalyzed click chemistry, over 150 new compounds were investigated in this study to identify new potent and effective BACE1 inhibitors. Although eight compounds were found to inhibit BACE1 with moderate potency, they were not deemed sufficiently effective to merit further investigation in more sophisticated AD models.
(*Dr. Carlier may be contacted at 540/231-9219*)

Old Dominion University — **Gianluca De Leo, Ph.D. (School of Medical Lab & Radiation Sciences) "Improving quality of life and short-term memory loss in patients with Alzheimer's dementia: Smartphone application for capturing daily life moments"**

This project was intended to determine if a slide show comprised of a set of daily life moments captured by a smartphone could improve the short term memory of patients with Alzheimer's disease. The study examined the feasibility of carrying the smartphone using a lanyard and software applications for capturing images automatically every five minutes during the day. Images collected during the first week were combined into a slide show and saved on a DVD that was viewed for four continuous weeks. The study provided positive satisfaction/ usability results and evidence of an increase in the number of events remembered after seeing the slideshow.
(*Dr. De Leo may be contacted at 757/ 683-6733*)

UVA — **Manoj K. Patel Ph.D. (Dept. of Anesthesiology) "Cleavage of sodium channel β3 subunit by BACE1 and γ-secretase modulates sodium channel activity in neurons"**

Two enzymes are known to generate the Aβ protein deposits, BACE1 and γ-secretase. In addition to this action on APP, BACE1 and γ-secretase also cleave the sodium channel auxiliary subunits, β1- β4. A consequence of this cleavage for one of the β subunits is a reduction in the sodium channel surface expression levels, and in other studies, the activity of sodium channels was also altered. Sodium channels play a major role in the neuronal excitability responsible for the generation and conduction of electrical signals in the brain (i.e., action potentials). Since β subunits are important for fine tuning this activity, their cleavage could play a role in the progressive dementia associated with AD. This study showed that β3 co-expression in cultured hippocampal neurons resulted in changes in the activity (gating) of expressed sodium channels and a decrease in the total sodium channel current. These changes in activity likely accounted for the increases in activity of the neurons. Neurons expressing β3 had altered membrane properties and a higher action potential firing frequency than non-transfected neurons. Continuing studies to examine the effects of BACE1 and γ-secretase inhibitors are underway.
(*Dr. Patel may be contacted at 434/924-9693*)

Virginia Tech **Karen A. Roberto, Ph.D., Rosemary Blieszner, Ph.D., and Jyoti Savla, Ph.D. (Center for Gerontology) "Caring for a spouse with Mild Cognitive Impairment: Daily challenges, marital relations, and physiological indicators"**

Although by clinical definition Mild Cognitive Impairment (MCI) is associated with minimal interference in activities of daily living and personal relationships, preliminary studies of effects on patients' families suggest a notable impact. This investigation assessed the daily frequency and intensity of the behavioral symptoms and challenges of persons diagnosed with MCI, examining associations with the psychological and physical health and well-being of their spousal care partners. Significant fluctuations in symptoms, behaviors, and outcomes for the care partners across days (within-person variation) as well as across individuals (between-person variation) were documented. Problem behaviors had a significant influence on the positive or negative outlook of care partners and on their marital interactions. On days when care partners experienced more stressors in situations not concerning the person with MCI, they reported more physical health symptoms. In contrast, on days when care partners reported memory-related problems in their spouses, they had higher levels of salivary cortisol and alpha-amylase. These atypical, stress-related hormone reactions may put the care partners' physical health at greater risk. Significant differences across care partners suggest that various types and levels of interventions will be effective according to the needs and personal characteristics of the care partners.
(*Dr. Roberto et al. may be contacted at 540/231-7657*)

UVA **Timothy Salthouse, Ph.D. (Department of Psychology) "Detection of preclinical Alzheimer's disease"**

Because an effective treatment for Alzheimer's disease will likely have the greatest chance of success before the disease has progressed, there is a great deal of interest in achieving the earliest detection. This research project capitalized on the infrastructure developed with an NIH-funded project to investigate cognitive and psychosocial predictors of cognitive decline in adults under and over 70 years of age. Individuals were classified as intact or impaired at the second occasion of testing on the basis of scores from a global screening test, the Mini-Mental Status Exam (MMSE). Analyses employing a battery of sensitive cognitive variables and a variety of self-report psychosocial measures of depression, anxiety, and personality were conducted to identify predictors of status at the second occasion, as well as changes in MMSE scores across occasions. Although MMSE scores were found to be related to reasoning and vocabulary abilities in adults of all ages, significant change in MMSE was associated with significant reductions in memory ability only among adults over 70 years of age. Declining memory appears to be one of the most sensitive indicators of late-life cognitive impairment, while other cognitive abilities or psychosocial variables may not be indicative at all. (*Dr. Salthouse may be contacted at 434/982-6323*)

VCU **Shijun Zhang, Ph.D. (Department of Medicinal Chemistry) and Tailiang Guo, Ph.D. (Department of Pharmacology and Toxicology) "Bivalent ligands targeting amyloid-β-pep tide and lipid rafts"**

Although the etiology of AD remains elusive, the amyloid hypothesis has long been the dominant explanatory theory. Recently the consensus recognition of soluble Aβ oligomers as the major toxic species has made Aβ oligomerization an attractive target in the development of effective AD treatments. Recent convincing evidence has implicated the important role of lipid rafts, the highly packed microdomains in cell membrane, in facilitating Aβ oligomerization and toxicity. In addition, a number of small molecules (including curcumin, a natural product mainly used as a food coloring agent) have been discovered to disrupt this process, although no strategically distinct Aβ oligomerization inhibitors are currently available. The goal of this research was to: 1) optimize the linker, the linker length, and the linker attachment positions on curcumin, and 2) evaluate a a series of bivalent multifunctional ligands (BMFLs) containing curcumin and cholesterol analogs connected through a linker. Results from these preliminary studies indicate that: 1) the C-4 position on curcumin is optimal for producing favorable Aβ oligomerization inhibition; 2) the cell membrane anchor pharmacophore with basic nitrogen connected to the spacer is important; and 3) the spacer length is an important structural determinant for Aβ oligomerization inhibition. Ultimately, the development of these novel chemical tools will help the investigators unravel the role of Aβ oligomers in the pathogenesis of AD.
(*Dr. Zhang may be contacted at 804/628-8266; Dr. Guo may be contacted at 804/828-6732*)

Is the Geriatrician an Endangered Species?

by Richard W. Lindsay, M.D.

I was looking up something about the dodo bird recently for a talk I was to give, and I found that the dodo was a flightless bird endemic to the Indian Ocean island of Mauritius. It became extinct around the year 1690 and has become imbedded in our lexicon through such phrases as "dead as a dodo" or "gone the way of the dodo bird." After reading about this strange bird, I read a medical article entitled "Will Geriatrics Survive?" and suddenly a synapse fired in my head. I asked myself, "Am I one of a dying breed of geriatricians about to go the way of the dodo?" As we confront both the aging of our country and proposals to change our health care system, this is an important question. I want to examine the continued existence of geriatricians and some of the factors that might lead to either their demise or protection.

The Age Wave

Imagine that you are sitting in your living room watching television when the following comes on the screen. FLASH!!! THERE IS AN AGING TSUNAMI IN THE CHESAPEAKE BAY. IT IS BEARING DOWN ON THE COMMONWEALTH OF VIRGINIA AND THE NATION!! If this were a real TV flash bulletin, there would be mass evacuations underway throughout the Eastern Shore, Tidewater, and the rest of the coast, accompanied by a massive and coordinated response involving emergency services throughout the areas. But wait. You didn't read the warning carefully. This is not a giant wave of water, but is a giant wave of aging citizens. In the case of this latter age wave, Virginia has not responded with an appropriately massive and coordinated effort and may be in danger of being engulfed.

In fact, the United States has been undergoing an exponential increase in the number of its older citizens for decades. People 65 years of age and older already comprise about 12 percent of the population and will likely increase to 20% by 2030. In absolute numbers this represents an increase from 37 million in 2005 to more than 70 million in 2030. In Virginia, a similarly dramatic increase will result in 1.8 million residents ages 65 and older by 2030, representing 19% of the population. Unfortunately, this increase will usher in a significant rise in the numbers of individuals with chronic illnesses, which, in turn, will mean rapidly growing numbers of older adults limited in their ability to carry out activities of daily living, which, in turn, will require greater levels of health care and caregiving. While making up only 12 percent of our population nationally, Americans 65 years and better account for 26 percent of physician office visits, 35 percent of hospitalizations, and 34 percent of all prescriptions. Simply, older adults will be major players in the health care of the near future.

What about geriatricians to meet these demands? Since 1988 the American Board of Internal Medicine, the American Academy of Family Practice, and the American Board of Psychiatry and Neurology have been offering a certifying examination for a Certificate of Added Qualification in Geriatric Medicine (CAQGM). Certification provides formal recognition of expertise in geriatrics for internists, family physicians, and psychiatrists who have completed their residency training. Currently, applicants may take the certifying exam after only one additional year of geriatric fellowship. What have been the results from the existing geriatric fellowship training programs over the last two decades? Unfortunately, very discouraging. The number of certified practicing geriatricians in the United States dropped to 7128 in 2007, a 22% drop from 2000, with a continuing fall likely.

To its credit, Virginia has made significant strides in geriatrics since the beginnings in the 1970s. All of our medical schools, including that recently opened at Virginia Tech, have geriatrics in some form. They offer required clerkships in geriatrics to medical students, postgraduate fellowship training in geriatrics, and one in geriatric psychiatry. Unfortunately, in Virginia as is the nation, fellowship positions remain unfilled each year. Nursing schools have made similar progress, with additions of geriatric material to their curricular offerings and clinical training. Is it enough? Virginia resembles the national picture that says the answer is NO. In a 2007 national survey of graduating medical students, almost 40 percent did not agree that they were "well prepared" to care for older adults in long-term health care settings, and 14 percent said they were not exposed to expert geriatric care by the attending faculty of their medical program. In 2006 Governor Kaine created a

Health Reform Commission and it contained a work group which examined workforce issues. The group's report included many recommendations that dealt with geriatric staffing and the geriatric health care workforce, but many recommendations remain to be enacted, not a promising prospect in Virginia's current budget status.

Contributors to the Shortage

Why are geriatric fellowship programs not filling? Drops in choice of primary care and huge tuition debts are part of the cause. The problem begins upstream because the major sources of candidates for geriatric fellowships are residents finishing primary care programs in internal medicine, family practice, and psychiatry. In the last five years the percentage of U. S. medical students entering residencies in family medicine and internal medicine has declined dramatically. This drop in primary care career choice by U. S. graduates has led to an increased dependence on international medical graduates (IMGs), those trained outside this country, to fill the primary care training positions.

Today about 80% of US medical school graduates leave school with an average debt of between $130,000 and $150,000. If they defer repayment until after completing their residency, the added interest can result in a figure closer to $240,000. So U.S. medical school graduates are choosing careers in more lucrative subspecialties. Compared to an office-based primary care generalist, a specialty physician can have greater control over personal life and family time, while earning sufficient income to pay off student debt more quickly. For example, the annual income of a radiologist or an orthopedic surgeon approaches three times the income of a primary care physician.

Geriatricians serve Medicare patients mainly and derive the majority of their practice-generated income from them. Medicare reimburses at a rate significantly below that of the market. This rate, moreover, is now being threatened further by proposed Medicare payment reductions. Small wonder about the flow of graduating medical students into careers in anesthesiology, dermatology, radiology, and ophthalmology, and away from geriatrics.

Academic Training Programs Affected

This limited ability to generate income from practice also hinders the allocation of institutional resources within academe to geriatric training programs. When deans and department heads examine what geriatric programs generate financially, they see figures considerably below that of other specialty sections. This reflects the practical reality that it takes longer to interact competently with a patient with multiple chronic diseases, and this time spent is not adequately reimbursed under the current system that reimburses for quantities of patients seen. Time-intensive geriatric care leaves academic geriatricians little time to consider grant-making and research, making geriatrics positions even more tenuous in the academic tent. The nation would need 36,000 geriatricians by 2030 and our current training output will not even come close to that. The answer lies in adequate geriatric training for all primary care physicians and focused deployment of fellowship-trained geriatricians. The latter would deliver patient care, become critically needed faculty in academic training programs, and serve as consultants for many of the most difficult geriatric problems seen by the primary care practitioners. Trained geriatricians would also assist in planning at the community level for senior services. Another part of the answer to our Aging Tsunami lies in better utilizing other professional members of the health care team, activating true interdisciplinary teams that include nurse practitioners, physician assistants, social workers, pharmacists, and others in expanded roles consistent with a "patient-centered medical home" practice model.

Facing the Tsunami with Action Steps

Academic Faculty. We must, first and foremost, have in place an adequate number of geriatric faculties in academic training programs. Without them there can be no increased production of geriatricians or adequate geriatric training of other health care specialties and disciplines. In its 2008 report *Retooling for an Aging Workforce*, the Institute of Medicine noted that several specialties that treat large numbers of older patients, including ophthalmology, general surgery, and dermatology, do not include any requirements for geriatric training. Geriatric faculties are also needed to enable the expansion of existing geriatric fellowship programs and to teach the prospective

increased numbers of medical and-nursing students. In medicine, career choice by medical students is often made as a result of a mentoring experience with a faculty member perceived as a role model. At present we lack sufficient numbers of academic geriatricians to allow such experiences. Geriatrics provides those who practice it with an opportunity to participate in one of medicine's most satisfying careers. However, unless our medical students have the opportunity to work side by side with a geriatrician and experience the rewards and satisfaction, there is little to offset the financial disincentives.

Reimbursement. One of the most basic changes needed for the survival of geriatrics is to have an appropriate reimbursement system. There must be reimbursement for the expanded roles and chronic care disease management practices that are part of the medical home model. It must also include payment for the coordination of geriatric patient care services.

Health Professions. Many of the other key members of the geriatric health care team are also in short supply, including nurses, pharmacists, dentists, physical therapists, and social workers. Only 2-4% of pharmacists specialize in geriatrics and fewer than 4% of social workers do so. Many other disciplines suffer from a lack of geriatric material in their curricula. In 2007 only one of the eight schools of podiatry had a discrete course devoted to the care of the geriatric patient. My colleague Dr. John Rowe summed it up when he said we have a workforce that is "woefully unprepared" and he expressed his concerns that the U.S. health care system is in denial about the impending demands of this aging wave.

On the Job Training. People providing geriatric care today also need reinforcement. We need additional geriatric faculty members across Virginia to assist in the training of the already critically understaffed geriatric health care workforce, both the paid and the informal caregivers. These major providers of care to the elderly include CNAs, home health workers, home health aides, and family members. They have reached shortage levels that appear to be worsening.

Public Awareness. We can work, meanwhile, to call public attention to the Aging Tsunami, and the challenges and opportunities it brings to Virginia and the nation. I would recommend including information about the breadth of jobs and professions related to geriatric health at all career fairs for high school students. I would also offer community electives in geriatric heath care experiences in nursing homes and assisted living facilities. Further, aging-related issues should be included in the high school curricula of courses from biology to literature to physical education to social and political sciences, optimally with qualified elders serving as adjunct faculty.

Public Policy. Policy initiatives might include loan forgiveness for health care professionals who train in geriatrics, scholarships, and direct financial incentives to practice primarily with older patients. The Commonwealth can do this, for it is in its own (and our) best interest. Federal geriatric work force development programs under Title VII and VIII should be maintained and increased, as well as the Geriatric Academic Career Award program which develops geriatricians as researchers and educators. Medical schools, already besieged to incorporate ever-changing breakthroughs in imaging, robotics, miniaturization, and technology, should nonetheless remember the basics: we are all getting older. Curricula should integrate aging into all courses and expanded clinical training in all the settings, from independent living to assisted living and skilled care.

The Verdict?

Stay tuned. If we fail to have in place adequate numbers in our geriatric workforce, we run the ultimate risk of not surviving the Aging Tsunami, drowned in overwhelming health care costs without the most appropriate care. Even if sufficient numbers of geriatric faculty were magically to appear tomorrow, the shortage would continue because of the lengthy time needed to train geriatricians, about eight years from medical school entrance to the completion of fellowship.

In closing, I know almost everyone is aware of the government's system of color coding that deals with the level of threat of a terrorist attack. Code Red is the highest level of threat. The urgency of Virginia's mission to prepare a competently trained geriatric workforce to meet the aging Tsunami makes me shout CODE RED. CODE RED!!!!

Alcohol and Aging Awareness Group Welcomes New Partners and Opportunities

by Franklin P. Hall
Commissioner,
Virginia Department of Alcoholic Beverage Control

The need to diagnose and treat geriatric patients with substance abuse problems appropriately is not a new issue. However, a study published this summer in the *American Journal of Psychiatry* indicates binge drinking is on the rise among Americans 50 and older. Here in Virginia, the Alcohol and Aging Awareness Group (AAAG) is attacking this problem through dynamic and creative approaches designed to reach both lay people and geriatric health professionals.

The AAAG was formed subsequent to a meeting in March 2007 convened by staff at the Virginia Department of Alcoholic Beverage Control (ABC). Represented by more than 25 public and private organizations, the AAAG's initial goals were to: determine education and prevention services available regarding older adult alcohol and medication abuse, identify gaps in these services, and establish points of collaboration.

Starting from Scratch

The group's initial step toward informing the public was to draft informative literature for a general audience. "The Best Is Yet to Come" brochure features a positive message and photographic illustrations, as well as succinct bulleted information points including:

- Changing metabolism and proportions of body fat and body water with age contribute to greater effects of alcohol on an older adult's body
- 83 percent of people over age 65 take some form of prescription medication
- Alcohol (even small amounts) can interact with up to 50 percent of the most commonly prescribed medication to produce a host of adverse effects.

The brochure promotes older adults' maintaining a healthy lifestyle and directs people to resources available, if help is needed. The information in the "Best Is Yet to Come" brochure was adapted for design of a Web page that has evolved in tandem with the AAAG. Visit this page at: www.abc.virginia.gov/Education/olderadults/aging.html.

In 2008, in conjunction with May's designation as Older Americans Month, the ABC distributed the brochure to ABC stores statewide. The agency issued a news release publicizing the brochure's availability that generated favorable newspaper and TV news coverage.

Hidden Epidemic Conferences

From its inception, the AAAG identified a need for training and networking opportunities for individuals and organizations that service the aging population in Virginia. The AAAG first realized this goal on April 29, 2008 when 200+ health professionals and others gathered at Virginia Commonwealth University (VCU) for the conference *The Hidden Epidemic: Alcohol, Medication & the Older Adult.* Planned in five months with $10,000 in Geriatric Training and Education funds awarded by the Virginia Center on Aging, the conference featured 20 speakers, including keynote Debra Jay, a nationally-known specialist in older adult intervention. Conference attendees participated in sessions from statistics and legal issues to pharmacotherapy and withdrawal protocols, and interacted with experts who discussed every facet of the older adult substance abuser.

At the conference, and subsequent sessions for service providers, attendees received a "Get Connected" Toolkit developed by the federal Substance Abuse and Mental Health Services Administration in partnership with the National Council on Aging and supported by the Administration on Aging. The toolkit provides strategies to link geriatric service providers with substance abuse and mental health experts and organizations in their communities.

To meet the demand for additional training, the AAAG presented *The Hidden Epidemic: Best Practices* conference on April 7, 2009 at VCU to an audience of 200+ substance abuse counselors, nurses, service providers, and social workers. At this conference, the AAAG honored the Jefferson Area Board for Aging and the Fauquier Department of Social Services with Best Practice Awards for their innovative programs serving older adult substance abusers.

Taking It to the Tubes

While planning the 2009 Best Practices conference, AAAG partners embarked on the next phase of the group's media campaign, production of a television commercial/public service announcement (PSA). With a $15,000 grant from the Virginia Department of Health, Division of Injury and Violence Prevention, and a variety of generous supporters who donated script writing, sets, human and canine acting talent, and the use of an ambulance and crew, the 30-second "Best Is Yet to Come" commercial premiered in the spring of 2009.

Grant money paid for five TV stations (three in Richmond and two in the Roanoke/Lynchburg area) to air the commercial during the noon news hour during April (Alcohol Awareness Month) and May (Older Americans Month). The Virginia Beer Wholesalers Association, a new member of the AAAG, underwrote the cost of additional airings of the "Best Is Yet to Come" commercial.

In a series of vignettes, the commercial informs viewers about the dangers of mixing alcohol and medications and directs viewers to call 211 or contact SeniorNavigator.com for help. Given the progressive nature of the AAAG, it's fitting that the "Best Is Yet to Come" video was one of the first posts to ABC's YouTube site www.youtube.com/vaabc. As AAAG organizations gain experience with additional social media networks like Facebook and Twitter, the group will use these channels to reach an even broader audience.

In addition to carrying messages and linking with more interested parties, the Internet will figure prominently in the AAAG's future training efforts. The group is exploring opportunities to create Web-based training for geriatric service providers. AAAG member Dr. Michael Weaver, Associate Professor of Internal Medicine and Psychiatry at VCU, is exploring a partnership with the Boston University School of Public Health to provide older adult-specific screening and brief intervention training for physicians at hospitals across the Commonwealth.

Business Is Booming for the Speakers' Bureau

The Virginia ABC Education Section is responsible for coordination of the AAAG Speakers' Bureau. Since 2007, the AAAG has provided speakers for 32 venues and participated in 13 exhibit fairs to disseminate resources available on this topic. Bureau members include physicians, pharmacists, and prevention professionals located in different regions of the state. Upcoming events include presentations to the Virginia Association of Community Psychiatrists, Virginia Alliance of Social Work Practitioners, Virginia Assisted Living Association, Virginia Personal Care Provider Conference, and the Diversity and Aging Conference.

Infinite Opportunities for Collaboration

The AAAG has been innovative in its collaboration with potential stakeholders. In an effort to deliver its mission message to a broad target audience, relationships have been established beyond the scope of aging agencies. The AAAG forged an association with the Virginia Department of Fire Programs after three fatal fires involving older adults, within a six-week period, were unofficially attributed to alcohol misuse. Likewise, collaborative relationships with others, such as the Virginia Triad/S.A.L.T. Council, a program of the Attorney General's Office that focuses on Seniors and Law Enforcement Together to keep older citizens safe, have assisted the AAAG in spreading its important public safety health message to older Virginians.

Although I am one of the AAAG's newest associates, I have had the pleasure of advocating for Virginia's aging population for more than three decades. During my almost 34 years in the House of Delegates, I supported legislation and programs beneficial to older adults in Virginia. I have been honored to work closely with the dedicated staff of the Virginia Center on Aging for many years. With my recent appointment as an ABC Commissioner, I will continue to champion programs that will help proactively to address the coming "age wave."

There's Room for You, Too

The professional diversity of AAAG members and the energy they devote to this issue illustrate both the wide reach of the issue of alcohol and aging and the scope of the challenge. Any individual who takes a moment to reflect on his or her relationships is surely able to think of an older family member, friend or colleague who has a

substance abuse issue. As the AAAG approaches its third year, members are busy balancing long-range concerns such as grant funding and strategic planning with managing day-to-day business items like coordination of the very busy Speakers' Bureau. The AAAG meets monthly at the ABC headquarters in Richmond. If you'd like to get involved, we would welcome you. Contact AAAG Chair/ABC Education Coordinator Regina Whitsett at regina.whitsett@abc.virginia.gov or (804) 213-4445; or Constance L. Coogle, PhD, Virginia Center on Aging, and AAAG Co-Chair, at clcoogle@vcu.edu or (804) 828-1525.

Better Jobs, Better Care: How a Coalition Aims to Bring about Improved Outcomes in Long-term Care

by Margaret Edwards

It started in 2003 as a small group of concerned family and friends of Charlottesville-area nursing home residents. From that informal beginning, the Community Partnership for Improved Long-term Care evolved into a broad coalition seeking to promote and support Family Councils and to address the broader issues of education, training, support, and recognition of the challenges faced by direct caregivers.

Led by attorney Claire Curry, Director of the Legal Aid Justice Center's Elder law program, the Partnership has successfully brought together family and friends of current nursing home residents, health professionals, nursing facility staff, business and insurance professionals, as well as other local groups, such as the Alzheimer's Association Central and Western Virginia Chapter, and the Jefferson Area Board on Aging (JABA) and its Ombudsman Program.

One particularly strong example of how such an alliance can be helpful is the Partnership's work over the summer with Trinity Mission Health and Rehabilitation of Charlottesville as it prepared its application to the Virginia Department of Medical Assistance Services' program, *Virginia Gold*. This program awards grants for the improvement of care and reduction of staff turnover. Trinity Mission agreed to work with the Partnership in designing its program, with members of the Partnership actively working on projects with nursing facility staff. In August, that hard work paid off when Trinity Mission became one of five facilities around the state chosen for the two-year pilot by the Virginia Department of Medical Assistance Services.

Building on the success of the past several years, the Partnership is planning to host *"Working Together: Third Annual Community Conference on Senior Care,"* February 16-17, 2010. Open to all involved in direct care, the conference will celebrate the accomplishments of long-term care workers and will provide training in areas of daily concern when working in long-term care, such as:

- Positive approaches to working with persons who are living with dementia
- Prevention, identification, and reporting of elder mistreatment
- Stress reduction and self-care as a component of successful caregiving and avoidance of burn-out
- Pressure ulcer prevention and care
- Caregivers as leaders: developing teams, teaching peers
- Improving home care through a best practices approach
- Meeting the special care needs of dialysis patients
- Better jobs for better care; reducing staff turnover

For more information on the Partnership for Improved Long-term Care, as well as how to participate in the conference, please go to www.justice4all.org.

Calendar of Events

October 10, 2009
Fall Prevention Summit. Presented by the Northern Virginia Fall Prevention Coalition. Free. Ida Lee Park, Leesburg. 10:00 a.m. - 2:00 p.m. For information, contact Lynn.Reid@loudoun.gov.

October 21, 2009
The Many Faces of Dementia. Piedmont Geriatric Hospital, Burkeville. 9:00 a.m. - 3:30 p.m. $30.00 a person, $47.00 with optional CEUs. For information, call (434) 767-4521 or visit www.pgh.dmhmrsas.virginia.gov/PGIWeb/pgihome.htm.

October 22-25, 2009
34th Annual Meeting and Conference of the National Consumer Voice for Quality Long-Term Care. Hamilton Crowne Plaza Hotel, Washington, DC. For information, visit www.nccnhr.org.

November 4, 2009
Research & Care. 2009 Estes Express Conference on Dementia. Annual conference of the Alzheimer's Association Greater Richmond Chapter. Sheraton West Hotel, Richmond. For information, call (804) 967-2580.

November 5, 2009
Healthy Communities and Tobacco Use Control. Use Control Project's Annual Meeting. Marriott Richmond West, Glen Allen. For information, contact Bunny Caro-Justin at (804) 864-7876 or ba.caro-justin@ vdh.virginia.gov.

November 5-6, 2009
Centralina Area Agency on Aging's 2009 Aging Wise Conference. Friendship Missionary Baptist Church, Charlotte, NC. For information, call Patricia Whitten, Centralina Council of Government, at (704) 688-6505.

November 6, 2009
Best Practices in Dementia Care. Alzheimer's Association Central and Western Virginia Chapter's 8th Annual Alzheimer's Education Conference. Salem Civic Center. 9:00 a.m.- 5:00 p.m. For information, call (434) 973-6122 or visit www.alz.org/cwva.

November 10, 2009
There Is No Place Like Home: Supporting Aging in Place. Sponsored by the Area Planning and Services Committee on Aging with Lifelong Disabilities. Cost is $15. Deep Run Recreation Center, Richmond. 9:00 a.m. - 3:00 p.m. For information, call Eric Drumheller at (804) 358-2211, ext 33.

November 12, 2009
2009 Diversity and Aging Forum. Sponsored by AARP Virginia. Virginia Holocaust Museum, Richmond. 8:00 a.m. - 4:30 p.m. Registration fee of $25 includes all sessions, materials, and lunch. For information, call (877) 926-8300.

November 15-17, 2009
Changing Times, Changing Strategies: Working Together to Strengthen the Safety Net. Virginia Association of Free Clinics & Virginia Rural Health Association Joint Annual Conference. The Homestead, Hot Springs, VA. For information, visit www.VRHA.org.

January 27, 2010
Virginia Center on Aging's 24th Annual Legislative Breakfast. St. Paul's Episcopal Church, Richmond. 7:30 a.m. - 9:00 a.m. For information, call (804) 828-1525.

April 7-10, 2010
Applied Gerontology as Community Engagement. 31st Annual Meeting of the Southern Gerontological Society. The Jefferson Hotel, Richmond. For information, visit www.southerngerontologicalsociety.org.

May 24-25, 2010
Virginia Association for Home Care and Hospice Leadership Conference. Wyndham Virginia Beach Oceanfront. Virginia Beach. For information, contact Debbie Blom at (804) 285-8636 or dblom@vahc.org.

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

Linda Nablo
Commissioner, VDA

Kimberly S. Ivey, M.S.
Editor

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Virginia Center on Aging

at Virginia Commonwealth University, Richmond, Virginia

www.vcu.edu/vcoa

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