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Contents

[Case Study](#)

[From the Director,
VGEC](#)

[From the Director,
VCoA](#)

[From the
Commissioner,
VDA](#)

[Focus on the VGEC](#)

[Focus on the VCoA](#)

[Innovative Method of
Paying for Long-term
Care](#)

[Beneficiaries Can Help
Stop Medicare Fraud](#)

[2001-2002
ALZHEIMER'S
RESEARCH AWARD
FUND RECIPIENTS
ANNOUNCED](#)

[SeniorNavigator.com](#)

Bridging Aging and Domestic Violence Services in Our Communities

Janett Forte, LCSW
Paula Knapp Kupstas, Ph.D.
Stephanie White, MSW

Janett Forte, LCSW, is Coordinator of the Chesterfield County Domestic Violence Resource Center. Paula Knapp Kupstas, Ph.D., is a Research Specialist at the Virginia Center on Aging. Stephanie White, MSW, is a Care Coordinator for Henrico and New Kent Counties for Senior Connections, The Capital Area Agency on Aging. All are members of the Central Virginia Task Force on Older Battered Women.

Educational Objectives

1. To describe the problem of domestic violence in later life.
2. To show how the operating principles and service approaches of aging (APS and aging network) and domestic violence service providers differ and may cause them to interpret the same situation differently.
3. To encourage aging and domestic violence service providers to share information, expertise, resources, and philosophical perspectives with one another in order to improve the community response to older battered women.

Case Study

Mrs. Daniels is a 76-year-old woman with insulin dependent diabetes mellitus, diabetic neuropathy, visual impairment, and a history of strokes, all of which have resulted in her need for assistance with activities of

[Virginia's Resource For Health & Aging](#)

[VCU Department of Pharmacy Receives Grant from the American Federation for Aging Research](#)

[Virginia Elder Rights Coalition](#)

[Unique Virginia Coalition is Honored with National Award](#)

[New Category of Medicaid Eligibility](#)

[Virginia Association of Area Agencies on Aging Appoints New State Long-Term Care Ombudsman](#)

[Calendar of Events](#)

daily living and instrumental activities of daily living. Her husband contacted the aging network service provider for assistance with her personal care needs. An aging network services worker contracted with the couple to assist with the Medicaid personal care application process, when both expressed interest in receiving the services. During subsequent home visits, the worker noticed that Mrs. Daniels usually stayed in her bedroom, and Mr. Daniels handled the couple's financial affairs. When Mrs. Daniels did meet with the worker, her husband was always present. The couple told the worker that Mr. Daniels was assisting Mrs. Daniels with her personal care needs. During the application process, the worker received a call from Mrs. Daniels' granddaughter, who said that Mrs. Daniels was staying with her, and had left her husband because he was physically abusive and neglected her personal care needs. She explained that abuse had been a part of the couple's relationship for as long as she could remember. Mrs. Daniels had left her husband several times, but always returned. Each time she left, she stayed with a family member. The worker then spoke with Mrs. Daniels, who said that she was satisfied that her family was making arrangements for her to live with one of them, and that she was still interested in Medicaid personal care. The granddaughter had also called Adult Protective Services (APS), so the aging network services worker next spoke with the APS worker, from whom Mrs. Daniels had requested assistance with a divorce and a protection order. With Mrs. Daniels' concurrence, the APS worker agreed also to facilitate the Medicaid personal care application process, and the aging network services worker closed the case. One month later, the aging network services worker received a call from Mr. Daniels informing her that his wife had returned home. He was again requesting assistance with the Medicaid personal care process. Later, when Mr. Daniels was not present, Mrs. Daniels explained that living with her granddaughter "just didn't work out," and that her husband had called her several times, apologizing and promising to provide better care if she would come home. A phone call to the APS worker indicated that the Medicaid personal care application was still in process when Mrs. Daniels returned to her husband. They agreed that the aging network services worker would resume its handling.

Domestic Violence in Later Life

Domestic violence is "a pattern of coercive control that one family member exercises over another. Abusers use physical and sexual violence, threats, emotional insults, and economic deprivation as a way to dominate their victims and get their way" (Schechter, 1987). Domestic violence is frequently viewed as affecting only women of childbearing/

childrearing age. Outreach and public awareness materials portray victims and survivors as young women, often with dependent children. But, domestic violence can and does affect older women, as well as older men. Despite statistics that report age as an important risk factor for abuse, with women between 19 and 29 years of age at greatest risk of abuse by an intimate partner (Bachman and Saltzman, 1995), there is a paucity of research on the prevalence of abuse in later life. One of few studies in this area, The National Elder Abuse Incidence Study (NEAIS), estimates that approximately 450,000 elderly persons were abused and/or neglected in 1996, and that less than 20% of suspected cases were reported to APS agencies. The study found that the majority of victims of all types of abuse were women, and "in almost 90% of the elder abuse and neglect incidents with a known perpetrator, the perpetrator is a family member, and two-thirds of the perpetrators are adult children or spouses." (National Center on Elder Abuse, 1998).

Older women might not think of themselves as victims of abuse, due in part to generational norms and views of marriage. The term "domestic violence" did not even exist when they entered into abusive relationships (Stiegel, Heisler, Brandl, and Judy, 2000). When they do self-identify as victims of domestic violence, they may be reluctant to access services that they perceive are intended for younger women. While older women share many of the same challenges that younger women face in seeking help or leaving an abusive relationship, they may be more economically vulnerable than younger women. An older woman reporting abuse by a family member may fear the loss of jointly owned assets that have been accumulated over a lifetime; the loss of health care benefits; difficulty in obtaining pension benefits, finding employment or otherwise replacing lost income; difficulty in receiving medical care and assistance because of chronic health conditions or functional limitations; and transportation problems.

Domestic Violence, APS and Aging Network Services for Older Battered Women

The challenges are complex, too, because older abused women may enter one of several service arenas when seeking help, and these service providers may have quite different operating principles and offered services (Stiegel, Heisler, Brandl, and Judy, 2000). Domestic violence victims may seek services from domestic violence programs that focus on crisis support, shelter, and advocacy. But, domestic violence programs are often ill-equipped to meet the unique needs of older women (e.g., pension/insurance counseling, need for assistance with ADLs/IADLs) and

advocates frequently lack familiarity with the issues of aging. Suspected cases of abuse of dependent adults and persons aged 60 and over may also be reported to APS. While APS professionals are experienced in the issues of aging, their elder abuse interventions tend not to focus on the dynamics of domestic violence, but instead focus on caregiver stress as a causal factor. Furthermore, women aged 60 and over may be eligible for a wide range of support services provided through the aging network. However, these providers have usually not been trained to recognize and intervene in suspected cases of domestic violence.

Working Together to Serve Older Battered Women

Aging and domestic violence service providers and other concerned individuals from the Counties of Chesterfield, Hanover, and Henrico, and the City of Richmond saw the need to address these complex challenges, and in September 1998 formed the Central Virginia Task Force on Older Battered Women. The Task Force provides a working forum for interaction and information sharing among organizations, works to increase awareness of the prevalence of domestic violence in the lives of older women, and strives to build bridges between aging and domestic violence services. The group has grown over the years, with representatives now from over seventeen aging and domestic violence service providers and other organizations. The group has developed a mission/purpose statement and collaborative agreement; organized and distributed a resource directory for allied professionals; is working to develop specialized awareness and training materials; and completed a draft project proposal for which they continue to seek funding.

Because the majority of victims in both domestic violence and elder abuse incidents are women, and domestic violence services for younger women are well-established, the Task Force has chosen to focus its efforts on older battered women. However, some of the information presented here also may be applicable to older battered men. Our definition of "older battered women" includes women aged 50 and over. Like the Wisconsin Coalition Against Domestic Violence, we have chosen to include women between the ages of 50 and 60 in our definition because these women seldom access domestic violence services, and are not yet eligible for many of the services available to women aged 60 and over (Brandl, 1997).

Collaboration is vital to meeting the needs of older adults experiencing domestic violence. As we have discussed above, neither the domestic violence nor the aging service delivery systems adequately can address

issues faced by older domestic violence victims if working in isolation. As an example from the case study, a domestic violence service provider would view Mrs. Daniels' absence from some visits coupled with the fact that she was never alone with the aging network services worker during home visits as a sign of possible domestic violence (i.e., isolation of the victim). The aging network services worker might attribute this behavior to generational norms. Unless one were aware of both possibilities, and was able to ask appropriate questions, the true explanation might not become known. To collaborate effectively, aging and domestic violence professionals must share information, expertise, resources, and philosophical perspectives. One way a service provider for the aging can share knowledge, information, and resources is to educate domestic violence service providers about services offered by the agency and information about the aging process itself and the needs of older adults. Domestic violence professionals might educate their counterparts with tools for recognizing and intervening in suspected domestic violence cases. Other tools that can be used to begin collaborative work include a forum, seminar, or workshop on domestic violence among older adults, cross training on various system responses to the issue, a needs assessment, and collaborative agreements. The resource directory developed by the Central Virginia Task Force on Older Battered Women has served as a useful tool in disseminating information to allied professionals about the services provided by member agencies and organizations.

Study Questions

1. What individual needs and service barriers experienced by Mrs. Daniels should be considered when identifying options for her?
2. What challenges do the APS and aging network workers face when attempting to assist her?
3. If you were a member of a collaborative team of aging and domestic violence service professionals, what would be your first step in assisting Mrs. Daniels?

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Virginia Family Violence and Sexual Assault Hotline
1-800-838-8238

Virginia Adult Protective Services Hotline
1-888-832-3858

National Domestic Violence Hotline
1-800-799-7233
1-800-787-3224 (TTY)

Central Virginia Task Force on Older Battered Women
Janett Forte (804) 768-4783 or Paula Kupstas (804) 828-1525

[Back to Contents](#)

From the Executive Director, Virginia Geriatric Education Center

Iris A. Parham, Ph.D.

The VGEC has been busily working on several major initiatives. On June 26th the many months of planning culminated in the presentation of the national videoconference, Beyond the Barriers: Effective Breast Cancer Early Detection Strategies for Older Women. This videoconference was sponsored by the Virginia Health Quality Center, which is the Virginia Peer Review Organization (PRO) funded by the Center for Medicare and Medicaid Services (CMMS, formerly HCFA), and the National Cancer Institute's Cancer Information Service. Additional cooperating organizations were the Instructional Development Center of Virginia Commonwealth University (VCU), the University of Virginia Cancer Center, VCU's Massey Cancer Center, and CMMS. The videoconference was presented at over 133 sites in forty states. Sites ranged from other PROs throughout the U.S., universities, sister GECs, AAAs, health departments, American Cancer Society offices, CMMS sites, and Center for Disease Control and Prevention sites.

During the same week the VGEC completed two major training sessions in the area of grantspersonship with presenters from Eastern Virginia Medical School and University of Virginia, one on the Medical College of Virginia campus of VCU and the other at the Hunter Holmes McGuire VA Medical Center. Special thanks to Drs. Angela Gentili and Tom Mulligan for assisting in the logistics of setting up these presentations.

We are finalizing the graduate course, Geriatric Interdisciplinary Team Training and completing the last training for the Virginia Department of Social Services (VDSS) contract on Individual Service Plans. The new contract for 2001-2002 from VDSS has been signed and the topics are: Managing Aggressive Behavior; Caring for the Cognitively Impaired; Employee Relations; Activities; Nutrition; and two programs for "Train the Trainer"-Individual Service Planning and Orientation for Assisted Living Employees.

Lastly, Dr. Welleford and myself are off next month to a meeting of the GECs exploring all areas of distance learning. Also, enjoy the photos from the 25th anniversary celebration, the graduation of the class of 2001

and scenes from our national videoconference on breast cancer early detection strategies.

[Back to Contents](#)

From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

We are embarking on what promises to be a benchmark project on the relationships of compulsive behaviors like gambling, smoking, and alcoholism, to depression and suicide in older adults. Drs. Nancy Osgood (VCU Gerontology) and Constance Coogle (Virginia Center on Aging) have received a substantial contract from the State of Delaware's Division of Services for the Aging and Adults with Physical Disabilities for their project, "More Life Left to Live." For the next three years they will be conducting research among older drivers (ages 60 and above) regarding their gambling, smoking, alcohol use and abuse, depression, and suicidal thoughts and behaviors. With data in hand, Drs. Osgood and Coogle will lead the project team in developing and evaluating a statewide model education program in disease prevention and health promotion for older adults and service professionals in gambling, aging, health, mental health, and substance abuse services. A "train the trainer" approach will ensure implementation of the program in all regions of Delaware.

Several features common to the lives of many older adults help trigger the development of gambling problems, including greater opportunity, as venues for gambling spread almost everywhere; boredom in retirement; loneliness and isolation; a desire to escape from everyday life; and the gambling industry's marketing practices to attract older people. In order to expand the horizons of older adults mired in compulsive, addictive behaviors and to promote healthy, self-developmental growth, the project will emphasize alternatives such as inter-generational programs, lifelong learning, stress management, pets, creative activities, health promotion and disease prevention, and other opportunities. The current project draws upon previously successful work by Drs. Osgood and Coogle, especially their federally funded project, "The Statewide Program for Detection and Prevention of Geriatric Alcoholism in Virginia." We expect that the Commonwealth's citizens will inevitably be beneficiaries of this promising undertaking in Delaware.

[Back to Contents](#)

From the Commissioner, Virginia Department for the Aging

Ann Y. McGee, Ed.D.

Older Citizens: Changing the Face of Community Service

The largest generation of Americans in the country's history is reaching the age of 55 and many of them will be leaving the workforce. Fortunately, this group will have many more options available to them than existed for their predecessors. Some may choose to continue working, either full or part-time, in the fields to which they have devoted most of their lives. Others might decide to seek education or employment in areas of interest they have not yet had a chance to explore. In addition, many of these individuals will seek personal fulfillment by channeling their skills and talents into volunteer activities focused on making positive changes in their communities. This year, the Virginia Department for the Aging joins the rest of the world in celebrating 2001 as The International Year of the Volunteer, and encourages volunteerism by those Virginians who are among the 79 million Baby Boomers ready to retire. This group comprises the largest, most active and fastest growing senior population ever to exist in the nation's history.

People volunteer for a wide variety of reasons, most often citing a personal desire to help others. Today's volunteers also expect to reap benefits for themselves from their volunteer experiences. This may seem at odds with the tradition of seeing volunteering as a form of charity, based on altruism and selflessness. The best volunteer efforts, however, should be viewed as an exchange. The volunteer desires to meet both personal goals and the needs of others by donating time and experience to a worthy cause. Volunteers currently serve in more than 63,000 public, private, and non-profit organizations nationwide, contributing to community activities that range from testing water for environmental safety to conducting safety patrols on behalf of local police. More and more, organizations are relying on efforts by volunteers to accomplish their mission by filling gaps caused by a shortage of personnel or funds.

Over the next decade a majority of teachers in elementary and secondary schools will reach retirement age. A shortage of teachers is predicted, as there are currently not enough education majors to fill the anticipated

demand. The field of education will be ripe with opportunities for retiring professionals to step in as volunteers or paid assistants. These older citizens can mentor or tutor young people, as well as assist in libraries, art programs, classrooms, lunchrooms and extracurricular activities. By working in the schools, they can help meet the needs of their local schools, pass on their wealth of experience and talent to the next generation and stay connected to their community, all while gaining personal satisfaction.

If the energy of today's aging Baby Boomers can be harnessed, a tremendous force for tackling some of society's most difficult problems will be created. These are exciting times for older citizens, as a wealth of opportunities exists to help shape the future of the Commonwealth and the nation.

For more information on volunteer opportunities in your local community, please contact your local Area Agency on Aging or the Virginia Department for the Aging at **1-800-552-3402**.

[Back to Contents](#)

Focus on the Virginia Geriatric Education Center

Tracey Gendron

Tracey Gendron joined the Virginia Geriatric Education Center in April as a Research Specialist. Tracey will be working part-time on various projects connected to the 2000-2005 grant.

Tracey graduated from the University of Central Florida with a Bachelor of Arts in Psychology in 1992 and received her Masters of Science in Gerontology from Virginia Commonwealth University in 1995.

Tracey has worked in the field of Gerontology for the past eight years. She worked as a Senior Center Director in New York for two and a half years. Her responsibilities included providing advocacy for the elderly and their families, overseeing a daily catered meal program, supervising social work services for the elderly, and planning programs, trips and classes. Through grants from local politicians, community support, and private donations, she developed the Computer Learning Lab for Seniors. The computer lab provided each student with instruction, access to the Internet and an email address. Tracey also

worked at the Hebrew Home for the Aged in New York as a Project Coordinator responsible for researching various gerontological issues. During that time, she co-authored a paper titled, "Decision-making capacity to execute a health care proxy: Development and testing guidelines," which appeared in the Journal of the American Geriatrics Society, Feb 2000; Vol. 48 (No. 2): pp. 179-187.

Tracey was born and raised on Long Island, New York. She moved back to Richmond in March where she lives in Chesterfield with her husband, Joe and their new son Elijah. She loves spending time with her family and friends, reading and writing.

[Back to Contents](#)

Focus on the Virginia Center on Aging

Matthew Webster

Matthew Webster began working with the Virginia Center on Aging (VCoA) in May as a research specialist, analyzing data and writing reports for several of VCoA's on-going grants.

Matthew graduated in 1998 from Rhodes College in Memphis, Tennessee with a B.A. in psychology. After graduating, he collected data with the Criminal Justice Jail Diversion Project, at the University of Tennessee at Memphis, which assessed the relative efficacy of treatment for the mentally ill versus incarceration, for limiting recidivism. Here, he developed a strong interest in the cognitive processes of the mentally ill, particularly among schizophrenics.

In the fall of 2000, Matthew started his M.A. studies at University of Richmond in Psychology, where he works under Jane Berry, Ph.D., researching cognitive changes with age, including speed of processing and memory. This spring, he presented findings from this work at the Eastern Psychological Association's Annual Meeting, in Washington, DC. Recently, Matthew was awarded the honor of Outstanding Graduate Student from the Department of Psychology at University of Richmond.

Matthew is currently beginning data collection for his thesis, which investigates similarities in speed of processing and memory function between schizophrenics and older adults without psychopathology. He plans to earn his Ph.D. in Clinical Psychology, and is currently in the application process. He enjoys art, and has been an accomplished photographer.

[Back to Contents](#)

Innovative Method of Paying for Long-term Care

Mike Jones
Senior Advisor,
Seniors Planning Services

Many reports today claim that almost 50% of the population will need some form of long-term health care at some point in their lives. Since the public has not known about long-term care insurance for much more than ten or fifteen years, and since a large percentage of the population is in denial about the need for this type of coverage, families are forced to scramble to look for assets and income to cover the soaring costs of long-term care when the need arises.

For those of sufficient means, paying for the care may not be a problem. For those with few or no assets, Medicaid may offer assistance, but most or all assets must be spent before coverage begins. There are some exceptions to this rule, but that's another issue. The person or couple with moderate assets are the ones who really have to try to stretch their money so they are not forced onto Medicaid.

An individual or couple with a modest retirement income and \$200,000 to \$500,000 in other liquid assets can see that money disappear quickly at \$35,000 to \$50,000 per year in care expenditures. For example, consider an 80-year-old man who has been diagnosed with moderate Alzheimer's disease. He has about \$800 a month in Social Security income and \$250,000 in invested assets. His family has been unable to take care of him at home, and has placed him in an Alzheimer's care facility that costs \$4,000 a month, or \$48,000 a year. His invested assets generate about \$15,000 yearly, and his Social Security pays him \$9,600 a year. That leaves him over \$23,000 short of what he needs to pay for his care. The only choice is to start using his principal, which means his money generates less and less each year, until there is nothing left.

One innovative idea could be the answer for this man and his family. Called a "medically underwritten immediate annuity," it is a contract with an insurance company where, for a lump sum premium, the insurance company will guarantee a monthly income for a fixed period of time or for the life of the applicant, or a combination of both. Typically the

contract payout is based simply on the life expectancy of the applicant using his/her age only and the current interest rate. Once the contract is made, the applicant gives up the right to his/her principal. In other words, if the applicant dies before life expectancy, the insurance company benefits. However, if the applicant lives far beyond life expectancy, the individual and his family benefit.

Let's look back at our 80-year-old man previously mentioned. If he wanted to generate \$3,200 monthly, or \$38,400 annually, the difference between his care costs and his Social Security payments, it would take a lump sum premium of about \$275,000, which is more than he has.

However, if he were to go to a company that medically underwrites immediate annuities, taking his age and health into consideration, because he has Alzheimer's and his life expectancy is more of an unknown, it may cost only \$126,000 in premium to generate the same income. That means he would still have almost one half of his invested assets left for his family to enjoy in the future. He would have the guaranteed income he needed to pay his care expenses, and he would probably never have to rely on Medicaid.

You may be thinking "but long term care costs don't stay the same, they keep going up." You are right. Costs do keep increasing. However, there are several companies offering medically underwritten immediate annuities that also offer a rider that will allow the monthly payout to increase 5% each year, for a slightly higher premium.

Other readers are probably thinking "that sounds great if the man lives a long time, but what if he dies after six months. The money is gone, isn't it?" This is true. However, in addition to offering a lifetime payout, some companies offer an income payout that is guaranteed for a fixed period of time, such as five to ten years, for example. If the applicant lives longer, the income stream will continue until death.

We should consider how we will pay for the care we may need later in life. If you or a loved one has waited too long, and you need to pay for the care now, a medically underwritten immediate annuity may be worth investigating

[Back to Contents](#)

Beneficiaries Can Help Stop Medicare Fraud

Marian Dolliver

Virginia Association of Area Agencies on Aging

WHO PAYS? YOU PAY!

When Medicare or Medicaid fraud is committed, you as a taxpayer pays. Last year \$11.0 billion was paid in waste, fraud and mistakes to providers. If you think your provider has billed Medicare or Medicaid for a service that you did not receive call, **1-800-938-8885**. We would like to talk to you. Programs on how to identify health care fraud are offered throughout Virginia. Call the above 800 number to schedule a presentation or ask about volunteer opportunities.

Medicare and Medicaid fraud is big business in this country! You, the beneficiary can be the "first line of defense" against health care fraud by carefully examining your Explanation of Medicare Benefits (EOMB) or your Medical Summary Notice (MSN) to be sure that you did receive the services that your provider told Medicare he or she rendered to you. Ninety eight percent of the providers have your ethics and mine. Ethical providers want the unethical providers out of business as much as you and I do.

Senator Charles Grassley, R-Iowa, chairman of the Senate Finance Committee, which writes Medicare law said, "Every dollar wasted is a dollar that doesn't help a patient."

A provider who is committing health care fraud is hardly interested in giving you quality health care. In 1999, \$13.5 billion dollars were recovered from providers convicted of fraud.

The FBI has 3,000 cases open and health care fraud is the number two priority, immediately behind drug dealers. In fiscal year 2000, the government collected \$717 million in judgments, settlements or administrative penalties in health care fraud cases and proceedings.

Of that amount, \$577 million was returned to the Medicare trust fund according to the January report issued by the Health and Human Services and Justice departments. We know that having 39 million beneficiaries'

eyes and ears watching and listening works, because the waste, fraud and mistakes rate has dropped 50 percent in the last five years.

In 1996, the improper payments cost \$23.2 billion dollars, which represented 14 percent, that is 14 cents on every dollar paid unnecessarily for services not delivered in the manner they should have been.

Inappropriate billing happens in any arena that you can use your Medicare card: hospitals, home health services, physicians, durable medical equipment suppliers, nursing homes, hospitals, laboratories, hospice, mental health services and transportation services.

Marian Dolliver is project director for the Senior Medicare Patrol Project Volunteer retirees who serve as community educators, work with Virginians to identify and report waste, fraud and abuse in Medicare and Medicaid programs. The project is funded by the Administration on Aging, U.S. Department of Health and Human Services.

[Back to Contents](#)

COMMONWEALTH OF VIRGINIA

Alzheimer's and Related Diseases Research Award Fund

2001-2002 ALZHEIMER'S RESEARCH AWARD FUND RECIPIENTS ANNOUNCED

The Alzheimer's and Related Diseases Research Award Fund (ARDRAF) was established by the Virginia General Assembly in 1982 to stimulate innovative investigations into Alzheimer's Disease along a variety of avenues, such as the causes, epidemiology, diagnosis, and treatment of the disorder; public policy and the financing of care; and the social and psychological impacts of the disease upon the individual, family and community. The ARDRAF competition is administered by the Virginia Center on Aging at Virginia Commonwealth University in Richmond. The five grant recipients of the 2001-2002 awards are as follows:

UVA Erik J. Fernandez, Ph.D. (Department of Chemical Engineering)
"Revealing Amyloid- β Structure and Oligomer Distributions Using Mass Spectrometry"

Alzheimer's disease (AD) and a growing number of related diseases are known to involve protein aggregation and fibril formation. In the case of AD, the β -amyloid peptide (A β) plays an important role in neurotoxicity. However, the structure of the toxic form of the peptide and the mechanism by which it interacts with a cell to cause toxicity are

unknown. This research will develop several new approaches to identify and characterize forms of protein aggregates responsible for toxicity. Once these tools are established, the investigators will be poised to investigate aggregation mechanisms and develop strategies to prevent neurotoxicity. (Dr. Fernandez may be contacted at 434-924-1351)

UVA Carol Manning, Ph.D. and Kathleen Fuchs, Ph.D. (Department of Neurology)

"The Subjective and Objective Experience of Women at Genetic Risk for Alzheimer's Disease"

Concern about the onset of dementia is especially high among women with a parent diagnosed with AD. However, little research has been done to examine cognitive and emotional functioning in those who have first degree relatives with AD. Moreover, little is known about whether the subjective experience of cognitive decline represents lower cognitive functioning than in individuals who do not have first degree relatives with AD. The investigators will explore the relationship between risk of developing AD, subjective experience of memory deficits, objective performance on cognitive tests, and level of psychological distress both in women with a parent diagnosed with probable AD and in women of similar age and education who do not have any known risk factors for dementia. Results from this study will increase understanding of the biological, cognitive, and emotional experiences of women at increased risk of AD. (Drs. Manning and Fuchs may be contacted at 434-982-1012)

UVA John Savory, Ph.D. and Othman Ghribi, Ph.D. (Department of Pathology)

"Stress in the Endoplasmic Reticulum Mediates Active Neuronal Death in Experimental Neurodegeneration"

Recent studies have implicated apoptosis in the progressive and selective loss of neurons that characterizes AD. Although apoptosis under mitochondrial control has received considerable attention, the mechanisms utilized within the endoplasmic reticulum (ER) and the nucleus which mediate apoptotic signals are not well understood. A growing body of evidence is emerging to suggest an active role for the ER in regulating apoptosis. Thus, the ER may occupy a central role in the pathogenesis of neurodegenerative disorders, in particular, AD. The goal of this research is to test the hypothesis that direct injection of A β 1-42 into the brains of New Zealand white rabbits induces activation of ER-resident proteins and genes, decreases in the antiapoptotic, increases in the proapoptotic protein levels, and thus, apoptosis. It is also hypothesized that pre-treating animals with a molecule that up-regulates antiapoptotic protein levels in the ER, glial cell line-derived neurotrophic

factor (GDNF) will protect against A β 1-42-induced neurotoxicity. (Drs. Savory and Ghribi may be contacted at 434-924-5682)

VCU/MCV Jurgen Venitz, M.D., Ph.D. and Yuxin Men, M.D.
(Department of Pharmaceutics)

"Pharmacokinetic/Pharmacodynamic (PK/PD) Modeling of the Interaction of IV Scopolamine and Physostigmine in Healthy Elderly Volunteers"

This research involves a prospective, randomized, placebo-controlled clinical study in healthy, elderly volunteers receiving scopolamine, a competitive cholinergic antagonist that temporarily mimics the symptoms of AD, and physostigmine, an acetylcholinesterase inhibitor used to treat AD patients. It is hypothesized that physostigmine can reverse the cognitive impairment induced by scopolamine. The time course of reversal is determined by the physostigmine concentrations in blood achieved in each individual. Sophisticated PK/PD modeling will be used to analyze cognitive functioning changes (mimicking AD symptoms), heart rate and saliva flow changes (known side effects of physostigmine), and blood concentrations of scopolamine and physostigmine. This analysis will allow the investigators to estimate the parameters for optimizing the clinical dosing regimen of physostigmine in AD patients. Furthermore, this approach will be useful in dose individualization and therapeutic monitoring of acetylcholinesterase inhibitors in clinical practice. This clinical reversal paradigm may also be useful in screening potential anti-AD compounds early in the clinical drug development process. (Drs. Venitz and Men may be contacted at 804-828-6249)

VCU/MCV Janet H. Watts, Ph.D., O.T.R. and Jodi L. Teitelman, Ph.D.
(Department of Occupational Therapy)

"Alzheimer's Disease Caregiver Occupational Performance, Respite as a Mental Break, and Program Implications"

Recent research suggests that caregivers of persons with AD need more than simple physical distance from care recipients to truly experience respite. Caregivers need to feel free and confident that their loved ones are not just safe, but meaningfully engaged, so that they experience a mental break from their concerns. This study will expand on these findings, using a client-centered approach and focusing on the function of respite to qualitatively explore what it means to experience the mental break that is the essence of respite. The study will also describe caregiver daily functioning for use in planning follow-up studies on the relationship of caregiving and daily functioning. This descriptive information will supplement qualitative data on caregiver functioning and ability to achieve respite. Study findings will guide development of an intervention

to help caregivers identify respite opportunities and integrate these into their daily lives. (Drs. Watts and Teitelman may be contacted at 804-828-2219)

2001-2002 Awards Committee

Paul Aravich, Ph.D.
Eastern Virginia Medical School

Ralph Barocas, Ph.D.
George Mason University

John W. Bigbee, Ph.D.
Virginia Commonwealth University

Frank J. Castora, Ph.D.
Eastern Virginia Medical School

Wendell Combest, Ph.D.
Shenandoah University

Mary A. Corcoran, Ph.D., O.T.
George Washington University

Babette Fuss, Ph.D.
Virginia Commonwealth University

Alison Galway, Ph.D.
Virginia Tech Adult Day Services

Nitya R. Ghatak, M.D.
Virginia Commonwealth University

Pheophilus Glover, Pharm.D.
Hampton University

David Hess, Ph.D.
Virginia Commonwealth University

Peter Kennelly, Ph.D.
Virginia Tech

Elizabeth O'Keefe, M.D.
Virginia Commonwealth University

James L. Olds, Ph.D.
George Mason University

Jeanne L. Sorrell, R.N., Ph.D.
George Mason University

Russell H. Swerdlow, M.D.
University of Virginia

Patricia A. Trimmer, Ph.D.
University of Virginia

[Back to Contents](#)

SeniorNavigator.com **Virginia's Resource For Health & Aging**

Gigi Amateau
SeniorNavigator.com

Busy professionals across the state are learning about a new tool designed to increase their productivity and effectiveness in serving seniors, their families and caregivers. SeniorNavigator.com, is a free, confidential website that provides health and aging information, services and links — all just a click away.

This is a website you can trust — a not-for-profit subsidiary of the Virginia Health Care Foundation, in collaboration with the AOL Time Warner Foundation and the CollisWarner Foundation— SeniorNavigator.com is endorsed by the Virginia Association of Area Agencies on Aging, Virginia Association of Nonprofit Homes for the Aging, Virginia Health Care Association, Virginia Hospital and Healthcare Association, Arthritis Foundation, Virginia Chapter and AARP Virginia. (To learn more about the sponsors and partners that make SeniorNavigator.com possible, go to About Us - Sponsors and Partners).

SeniorNavigator.com offers in-depth information in four broad topical areas: Health Information, Legal and Financial Health, Housing and

Health Facilities, and Community Center. Information on locally available services and resources includes descriptions of services and providers, hours of operation, cost and method of payment, eligibility criteria, maps, available transportation, contact names and numbers and more. SeniorNavigator.com collects and maintains a database of some 16,000 comprehensive service profiles so you don't have to!

Many helpful features, such as Ask An Expert and My Library are available by registering free of charge. Can't find an answer to your client's question? Ask An Expert is a timely and private way to communicate with health and aging experts across the state. My Library allows you to create a personalized library of customized articles to use for your own reference or to print and share with a client.

SeniorNavigator.com also works with community professionals and volunteers (SeniorNavigators) to bridge the digital divide by ensuring that those without computer access can still obtain the information they need to find appropriate services and make informed decisions. Find out what the excitement is all about - log on to www.seniornavigator.com today. For more information or to schedule a training session in your area, visit our website or call 804-827-1280.

[Back to Contents](#)

VCU Department of Pharmacy Receives Grant from the American Federation for Aging Research

Virginia Geriatric Education Center

Dr. Patricia W. Slattum, Assistant Professor for the VCU Department of Pharmacy, recently received a \$49,530 grant award from the American Federation for Aging Research (AFAR). The purpose of these awards is to support the development of junior faculty to study the aging process. The grant award includes travel to a conference for AFAR grantees to enhance their grant writing skills and provide opportunities for interaction with senior scientists in the field of aging.

Dr. Slattum's research will be on age-related differences in the sensitivity and development of acute tolerance to ethanol in humans. The hypothesis guiding this research is that the elderly have decreased central nervous system reserve causing increased sensitivity to the acute intoxicating effects of ethanol than young volunteers. In addition, the elderly do not develop acute tolerance to the subjective effects of ethanol to the same

degree observed in young volunteers. This is a parallel group study designed to 1) characterize the pharmacokinetics and pharmacodynamics of intravenous ethanol in elderly volunteers using modeling techniques, 2) determine whether the elderly are more sensitive to acute ethanol intoxication by comparing model parameters to those measured in young subjects, and 3) determine whether the elderly develop acute tolerance to the subjective effects of ethanol to the same extent observed in younger volunteers. There is a need to identify age-related changes in the response to ethanol in an attempt to explain, in part, differences in alcohol consumption patterns and development of dependence with increasing age.

[Back to Contents](#)

Virginia Elder Rights Coalition

The Virginia Elder Rights Coalition is a network of organizations, agencies and individuals working together to promote the rights and autonomy of older Virginians through statewide leadership and support of:

- legislative advocacy;
- administrative and individual advocacy to secure benefits and services promised under law;
- increased responsiveness of government entities to elder rights issues;
- education and training to understand elder rights; and
- empowerment of older persons to exercise their rights.

The Virginia Elder Rights Coalition sponsors a statewide listserv (vaelderightscoalition@egroups.com)

This is an electronic email broadcasting mechanism for posting widespread elder rights information, such as state and federal legislation, court rulings, and upcoming conferences. The listserv is a way for those interested in elder rights issues to communicate easily by email, posting questions and sharing information with other listserv members. To join the listserv, contact Jay Speer at jay@vplc.org

[Back to Contents](#)

Unique Virginia Coalition is Honored with National Award

The Virginia Senior Medicare Patrol Project was honored in the nation's capital for its work in exposing fraud, waste, and abuse in the Medicare and Medicaid programs and educating Virginians to participate in the statewide initiative. This Project is operated by the Virginia Association of Area Agencies on Aging based in Richmond.

On May 10th, the coalition received the National Committee to Preserve Social Security and Medicare's "Medicare, Fraud, Waste, and Abuse Prevention Award" for vigorously rooting out Medicare fraud and abuse and identifying ways to reduce waste.

"These programs and the leaders who run them should be thanked for their hard work and pointed to as models to be copied by communities across the country," says Martha McSteen, President, National Committee to Preserve Social Security and Medicare.

The Virginia Senior Medicare Patrol Project is funded by the Administration on Aging, U.S. Department of Health and Human Services. This diverse and growing statewide coalition is operated by the Commonwealth of Virginia's 25 Area Agencies on Aging in conjunction with the TRIAD, a partnership between law enforcement, the Commonwealth of Virginia Office of the Attorney General's Medicaid Fraud Unit, the U.S. Attorney's Offices, the Federal Bureau of Investigation, the Medicare Part B Carrier, and other organizations.

The Virginia Association of Area Agencies on Aging is led by Mr. Harris Spindle, CEO, and Mrs. Marian Dolliver, Project Director of the Senior Medicare Patrol Project. Volunteer retirees who serve as community educators work with Virginians to identify and report waste, fraud, and abuse in the Medicare and Medicaid programs. Representatives of rural areas, multicultural groups, disability groups, state government, and the business community comprise its volunteer advisory board. The program has 25 local projects that serve more than 17,000 individuals annually. In addition, the program has more than 200 volunteer trainers, has educated more than 5,500 beneficiaries, and has reached more than 901,932 individuals through the media and other public outreach activities.

[Back to Contents](#)

New Category of Medicaid Eligibility

Jill Hanken
Virginia Poverty Law Center

A very important new category of Medicaid eligibility for the aged and disabled began on July 1, 2001. Virginia implemented the optional category found in §1902(m) of the Social Security Act which allows coverage of the aged and disabled with income up to 100% of the federal poverty line.

Virginia set eligibility at 80% of the poverty line. For individuals, the income limit (after the \$20 disregard) is \$573 a month. This represents a \$43 per month increase in the eligibility level for individuals. People who meet this income level (and resource requirements) will qualify for full Medicaid coverage without a spend-down.

For couples, the income limit (after \$20 disregard) is \$774 a month. While this level is under the current Supplemental Security Income (SSI) benefit level for couples, the SSI payment itself will not be counted. Thus, SSI couples will still be helped by the significant changes in the evaluation of resources.

Federal law requires the §1902(m) category to follow SSI resource standards and methodologies. Thus, the resource standard (the limit on countable resources) will remain \$2,000 (for individuals) and \$3,000 (for couples). However, a major change is that Virginia can not impose resource rules that are stricter than SSI rules on the category. Resource restrictions such as the contiguous property rule, treatment of unprobated estates, and treatment of the former home of people in institutions will not apply. There is also an exemption for real property whose sale would cause undue hardship (i.e., loss of housing) to a co-owner. In these ways, some SSI recipients in Virginia may be eligible for Medicaid for the first time!

The new category also enables many Qualified Medicare Beneficiaries (QMBs) to receive full Medicaid coverage (including desperately needed prescription drug coverage). Again, QMBs must meet the new income limits and the resource standards (which are lower than the standards used for the QMB eligibility).

At this time DSS does not plan to shift eligible QMBs automatically to the new category or to notify aged/disabled people recently denied Medicaid due to excess income. When people report changes in circumstances, file new applications, or go through redeterminations, eligibility under the new category will be evaluated.

For more information call your local Area Agency on Aging, legal aid, or health clinic.

[Back to Contents](#)

Virginia Association of Area Agencies on Aging Appoints New State Long-Term Care Ombudsman

The Virginia Association of Area Agencies on Aging is pleased to announce the appointment of Ms. Joani F. Latimer as the State Long-Term Care Ombudsman. Ms. Latimer, who has a Master's degree in Gerontology from Virginia Commonwealth University, has served as the Assistant State Long-Term Care Ombudsman for the past five years. Currently, she is a member of several boards, including the National Citizens Coalition for Nursing Home Reform and the Senior Center of Richmond. Previously, she served on the Long-Term Care Professional and Technical Advisory Committee to the Joint Commission on Health Care Organizations, a national accrediting body. Ms. Latimer brings 20 years of experience with aging services to her new position.

The Long-Term Care Ombudsman Program serves as an advocate for residents of long-term care facilities and elderly persons who receive long-term care services in their homes or communities. The program educates seniors and their families about their rights, investigates complaints, and works to improve the quality of care in Virginia's nursing homes and assisted living facilities. Ms. Latimer oversees local Ombudsman programs operated by Virginia's 25 Area Agencies on Aging, and represents the interests of elderly and disabled long-term care consumers before state agencies and the General Assembly.

If you have questions or concerns about the care a relative or friend is receiving, or if you would like more information about long-term care services, contact the Office of the State Long-Term Care Ombudsman at (804) 644-2804 or your local Area Agency on Aging.

[Back to Contents](#)

Calendar of Events

July 15-18, 2001

New Directions in Alzheimer's Care. 10th National Alzheimer's Disease Education Conference from the Alzheimer's Association. Hyatt Regency Chicago, Chicago, IL. For info contact (312) 335-5790 or www.alz.org

August 13-16, 2001

Florida Conference on Aging 2001 - Connections and Directions. Wyndham Resort and Spa, Ft. Lauderdale, FL. For info contact (850) 222-8877 or www.fcoa.org

August 28-30, 2001

Unified Psychogeriatric Biopsychosocial Evaluation and Treatment 2001. Approaches to Clinical Care of Older Veterans: Integration of Behavior Health and Primary Care. Hyatt Regency Washington on Capitol Hill, Washington, DC. For info contact June Wright at (314) 894-5703

September 6-7, 2001

From Enactment to Action. U.S. Administration on Aging Conference on the National Family Caregiver Support Program. Washington Hilton and Towers, Washington, DC. For more info go to www.aoa.gov/carenetwork/conference09-6-7-2001.html

September 25-29, 2001

Adding Life To Our Years. 23rd Annual Southwest Society on Aging Professional Development Institute & Trade Show. Plaza Hotel, Phoenix, AZ. For info contact (405) 744-7511 or www.SWSAging.org

September 28-October 3, 2001

The High Cost of Poor Care. National Citizens' Coalition for Nursing Home Reform Annual Meeting. Crystal Gateway Marriott, Arlington, VA. For info contact (800) 228-9290

October 4-5, 2001

Aging Well in Rural Areas. 2001 West Virginia Conference on Aging. Presented by West Virginia University Center on Aging. Lakeview Scanticon Resort, Morgantown, WV. For info contact (304) 293-0628 or www.hsc.wvu.edu/coa/

October 15-16, 2001

Governor's Conference on Aging: Touching Lives with Creative Solutions. Radisson Fort Magruder Hotel and Conference Center, Williamsburg, VA. For info contact (540) 231-2041 or www.conted.vt.edu/aging.htm

November 9, 2001

Fraud, Scams & Slams. Southwest Society on Aging 2001 Oklahoma State Forums.

Norman Regional Hospital. For more info contact loriann@okstate.edu

November 15-18, 2001

2001-A Gerontological Odyssey: Exploring Science, Society and Spirituality. The Gerontological Society of America 54th Annual Scientific Meeting. Chicago Hilton and Palmer House, Chicago, IL. For info contact (202) 842-1275 or geron@geron.org

January 22, 2002

Legislative Breakfast. Annual gathering sponsored by the Virginia Center on Aging to report to the General Assembly and colleagues. St. Paul's Episcopal Church, Richmond, VA. For info contact (804) 828-1525

February 28-March 3, 2002

Teaching and Learning about Aging through Interdisciplinary, Intergenerational, and International Programs. The 28th Annual Meeting of the Association for Gerontology in Higher Education. Hilton Pittsburgh and Towers, Pittsburgh, PA. For more info go to www.aghe.org/annmeetinfo.htm