

Case Study

CPR and DNR Decision Making

by Viki Kind, M.A.

Educational Objectives

1. Examine the complexities of end-of-life care and obstacles to good DNR decision making.
2. Discuss CPR and its perceived vs. actual chances for success.
3. Demonstrate best practices for communicating about CPR.
4. Consider how the signing of the DNR is just one component of end-of-life care.

Background

Older adults and their loved ones are being asked to make difficult end-of-life choices about CPR (cardiopulmonary resuscitation) and its refusal, DNR (do not resuscitate). These decisions are fraught with angst and misinformation. CPR or cardiopulmonary resuscitation used to be simple to understand. "Cardio" refers to the heart, pulmonary the lungs, and resuscitation means to revive from death. In the past, we used CPR only with patients who

were having a heart attack and who might benefit from receiving CPR. When a patient died, someone would push on the person's chest to try to restart the heart, while giving mouth-to-mouth resuscitation to help the person breathe. Over time, CPR has become more complex, as healthcare professionals have discovered different and advanced ways to try to bring the person back to life. The patient may be given medications, his heart may be electrically shocked with paddles placed on the chest, and he may be placed on a ventilator to help him breathe. Every year, researchers find new ways to adapt the CPR process to try to save more lives. What seemed like an easy question, "Does the person want CPR?" has turned into a more complicated decision. Now we use it for everyone, including those in a terminal state, whether it will work or not.

Because the general public does not understand the advances in CPR, the first step of the DNR conversation should not be, "Do you want CPR?" but "What do you know about CPR?"

CPR and DNR in Practice

Today, many do not realize that, when the doctor says CPR, she is including medications, intubation, and ventilator support. A common misunderstanding occurs when people are given the misleading choice of a "chemical code only." As nurses and doctors will attest, if the doctor gives the medicine but does not make the chest compressions to move the blood around, the medicine will not circulate in the body. Without circulation, the medicine cannot do its job.

Another factor is that the decision about CPR has become, inappropriately, an indicator of a person's complete end-of-life wishes; but the decision about CPR should be only one part of the treatment plan. A patient may want chemotherapy, surgery, radiation therapy or other kinds of aggressive treatments and still may not want CPR. Or the person may not want other medical treatments but still wish to receive CPR. These are all separate decisions and any combination is possible.

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The doctor may at some point ask the family decision maker, “Should the patient be made a DNR?” DNR means *Do Not Resuscitate* or do not do CPR. The answer given may depend on how the question is asked. One positive change is that the language of DNR has been modified to “Do Not Attempt Resuscitation” (DNAR) or “Allow Natural Death” (AND). Both of these semantic changes help to clarify the confusion. Do not attempt resuscitation truthfully explains that just because CPR is attempted, there is no guarantee that it will work. If one were to ask healthcare professionals, “How many of you would like to die by CPR?” no one would ever raise a hand. What they know, but do not always share with their patients, is that the chance of CPR working is minimal, sometimes nil. On television shows like *ER*, CPR brings the patient back to life about 75 percent of the time (Diem, Lantos & Tulsky 1996), while in real life it only works, at best, about 17 percent of the time on healthy patients (Peberdy, et al. 2003). In many real-life situations, the chance of success is zero. Gordon (2009) and Ehlenbach (2009) both note that CPR is most likely to succeed when the heart is the problem, such as in an ongoing heart attack or a heart rhythm disturbance, but that its prospects for success with someone in intensive care with a serious infection and multiple organ failure are unlikely.

The newest term, Allow Natural Death or AND, is a more gentle way of saying do not resuscitate. Instead of stating what would not be done for the patient, the physician is offering to allow the patient a peaceful, natural death and will

not attempt resuscitation. The CPR/DNR decision is about more than medicine. It frames the dying experience for the patient and the loved ones. For those who are making the CPR/DNR decision, it is important to balance the chances of CPR working and bringing the person back in a good condition with the desire for a good, peaceful, and dignified death. This is why healthcare professionals wouldn’t want to die by CPR; there is nothing peaceful or dignified about this type of death.

Improving Communication

How can the healthcare team help guide a significant other or adult children through this decision making process? What are the underlying issues that will make the decision more difficult to make? What statistical information might make the decision easier? What grief support can the healthcare team provide to ease the process? The following case studies illustrate the complexities of decision making.

Case study #1

Mr. Jackson is a 67-year-old man who has end-stage Alzheimer’s, is unable to eat, and recently had a feeding tube placed. He does not have an advance directive and never told his children what he would want done in circumstances he now faces. Unfortunately, his physician did not ask about his CPR wishes when Mr. Jackson was in the early stages of the disease. The physician is now asking, “Would he want CPR?” His adult children have been through much over the past years and are overwhelmed by the question. The

thoughts running their minds are, “Is it time?” “Are we giving up?” “I don’t want to make this choice but I can’t stand watching him suffer any longer.” “If I make this decision, does that mean I have lost my faith?”

How can we as aging professionals help those we serve, as they struggle with these difficult decisions? One of my roles as a bioethicist is to assist families, like Mr. Jackson’s, who are making the difficult decisions. I am not there to tell the family or healthcare team what to do, but to help those involved to think through the issues, so they can make a more informed decision. It is important during these conversations that we keep the patient’s wishes and needs at the forefront.

When working with Mr. Jackson’s son and daughter, I would make sure they are educated about CPR. Hopefully, Mr. Jackson’s doctors will not have eroded the trust and created a confrontational relationship by pushing for the DNR. I would need to be patient, as these end-of-life conversations are a process, not a one-time event.

I would make sure Mr. Jackson’s children understand the possible outcomes of CPR. He may survive CPR but never be able to leave the hospital or he may be hooked up to ventilators for the rest of his life. Research has found that, if CPR is able to bring a patient back to life, the chances of the survivor going home with good brain function is only about seven percent (Kaldjian, et al., 2009). In Mr. Jackson’s compromised condition, his prospects are even poorer. Typically, the suc-

cess rate of CPR will depend on the health of the patient, the patient's age, how quickly the CPR was begun, and other medical factors.

Next, I would make sure the family understood what can happen during CPR. Mr. Jackson may be brought back to life but in a worse condition than before, both mentally and physically. There is a chance of broken ribs, a collapsed lung, damage to the windpipe, and the longer he is unable to breathe, the greater the chance for brain damage.

Once the family understands the limits on CPR's working and what kind of outcomes might be expected, I would then point out that by their choosing CPR, Mr. Jackson may not have the opportunity for a peaceful and meaningful death experience. I would ask his children, "When your father pictured the last minutes of his life, did he see strangers straddling him on a bed, pushing on his chest, with his family waiting outside his door? Or would your father want his family and friends gathered around his bedside, with words of love being expressed, music being played or prayers being said?" By asking these important questions, I hope to contextualize the medical choices by explaining what it will be like for their father to experience CPR versus a more peaceful death.

Often it is necessary to address and to help relieve the guilt and angst of making these difficult decisions. One gift I may be able to give Mr. Jackson's children is to help them to understand that it is not really their decision. It is the patient's decision. I would explain that, as the decision makers, they are sup-

posed to consider all that they know about their dad, what he has told them in the past, his values, and what would be important to him. Using this information, they should do their best to make the decision they think their father would make, that is, substituted decision making.

I would gently ask, "What would your dad be telling us if he were able to speak right now? What would your dad say about wanting CPR?" Then I would be quiet and let them sit with the question. In most situations, the family will know the answer, but it will be painful for them to verbalize the choice. I would then acknowledge how loving and courageous they are to honor their father's wishes. No matter what decisions are made, it will be important that this family receive emotional and spiritual support as they struggle with these issues.

Case Study #2

Mrs. Garcia is an 83-year-old woman who has multiple sclerosis. Her Advance Directive states that she does not want CPR. Her multiple sclerosis has developed to the stage where she has lost capacity. Her husband is both her decision maker and caregiver and he knows her wishes. Last week, Mrs. Garcia suffered a heart attack and is in the ICU. This morning she coded and was brought back to life by CPR. Her husband has just been called to come to the hospital and was told that his wife survived CPR but her condition is deteriorating. What went wrong? Why wasn't her DNR honored? What is Mrs. Garcia's expected outcome after receiving CPR?

What went wrong? Unfortunately, this scenario happens more often than it should. When Mr. Garcia received the call about his wife, he was shocked and angered. How could this have happened?

There are a few possibilities. Some physicians will not agree to a DNR because of moral opposition and, therefore, will not write or respect a DNR. While physicians are certainly allowed to live by their morals and to refuse to participate in acts that go against their values, they are still obligated to inform patients about valid medical options and then to let the patient or decision maker decide. If the physician is unwilling to do this, then he or she should help the patient to find another doctor who is willing to talk about the DNR option. If the patient, family or someone from the healthcare team is worried about the patient's rights being violated, he or she should call for a bioethics consult from the hospital's bioethics committee.

Another possibility in Mrs. Garcia's case is that the DNR request from her Advance Directive was not transferred onto her hospital chart. If the DNR is not on the chart, it does not exist in practicality. Whether one is the patient, the loved one or someone working with the family, it is necessary to review the patient's Advance Directive and other healthcare wishes with the physician and to make sure that they are documented.

A final possibility is that medical miscommunication occurred. Perhaps the Advance Directive was not sent up from the emergency room, the team couldn't find the DNR, no

one took the time to look for it, the covering physician was unfamiliar with the patient or numerous other mishaps. As much as we would all wish for the practice of medicine to be perfect, healthcare is significantly flawed and human.

What should happen next in Mrs. Garcia's case? The first step will be to make sure the DNR order is written immediately. I would hope that apologies would come next. Administration, risk management, and other hospital staff will be involved in resolving this situation. This event will be evaluated to determine what caused this medical error and to take steps to make sure it does not happen again. (It will happen again, but usually not to the same patient.)

Ultimately, the physician will need to sit down with the family and talk about where to go from here. Since the CPR was performed, what is her condition? What options are available that would be respectful of Mrs. Garcia's wishes? Is it time for a hospice referral? Perhaps the physician who performed the CPR may not be the best person to handle the situation at this point because of broken trust. It may be necessary to bring in a different consultant to help bring peace to this situation. It will also be important to address Mr. Garcia's anger and frustration with the hospital and the healthcare team. He will probably be devastated that his wife's wishes were not honored and that she is still suffering. Appropriate social services should be brought in to help him with his grief.

Upon fuller evaluation of the event, it did appear that it was not that

Mrs. Garcia's wishes were disrespected, but that her wishes were not known (because no one had read her Advance Directive) and the CPR/DNR conversation never occurred. This, too, is also a common problem in healthcare. As mentioned, quite a few physicians are uncomfortable talking about end-of-life issues. Again, it is my hope that healthcare professionals do not simply talk about the medical choice of CPR but rather discuss what kind of life one would want after CPR and what kind of death one would desire. The following questions are just as important as, "Do you want CPR?"

- Where would the person want to die?
- With whom would the person want to be as he or she dies?
- What would bring peace and comfort during the dying process?
- For many people, CPR prolongs the dying process. Is this okay?

Conclusion

The conversation about CPR and other end-of-life decisions is a journey of informing, understanding, and helping to support the person who has the difficult choices to make. As professionals, we have to find the courage to walk with our critical patients as they move through their illness and toward death. As patients and family members, we have to recognize that it is important to have these conversations early, to ask for the answers and support we need. If the physician is unwilling to help in these tasks, find another who will. If, after talking with the physician, we realize that he or she will not respect or support the patient's

wishes, we should find one who will. Once the process has produced a decision, write it down and tell others. Don't make them guess.

A final thought: the intention of this review has not been to dismiss or preclude someone's choice to attempt CPR. Rather, it has been to help ensure that patients and their loved ones have a fuller understanding of the facts surrounding CPR, the chances of its working, the likely condition of the person after CPR, and the manner of death that is being chosen. May we all make wise and informed decisions for ourselves and for those in our care.

Study Questions

1. What are common misunderstandings about CPR?
2. When discussing DNR, what other issues should be raised?
3. What issues impede good decision-making for one's loved one?
4. What decision would you make personally regarding CPR/DNR and how might this affect how you interact with those you serve?

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About the Author



Viki Kind is a clinical bioethicist, medical educator, and hospice volunteer who practices in Los Angeles. She earned a master

degree in bioethics from the Medical College of Wisconsin. Viki is a member of the Los Angeles County Bar Association's Bioethics Committee and the Southern California Bioethics Committee Consortium. Her book, *The Caregiver's Path to Compassionate Decision Making: Making Choices for Those Who Can't*, guides families and healthcare professionals through the difficult process of making decisions for those who have lost capacity. She lectures nationally to healthcare professionals on improving integrity, compassion and end-of-life care through better communication.

From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

On Becoming Invisible

One of my best friends in college used to say that I had “an amazing grasp of the obvious.” So it is, with an almost thudding sense of “Duh!”, that I realize that people do judge a book by its cover. Whether literally (why else do so many covers feature “beautiful” women, irrespective of the book’s content, in order to induce sales?) or figuratively (hence the relentless promotion of desirable appearances, fashions, and first impressions), we often respond to the superficial. But what about those whose “book covers” are something less than the current societal ideal? For many of us, the answer is some degree of invisibility. We can become less visible to the larger society because of age or impairment. We are less “attractive” in the literal sense, attracting less notice or attention.

It is sometimes amazing, as an older man, to walk through a crowd of strangers and realize that no one has looked at me. I may have been prepared to smile or greet others. Instead, I notice that passers-by look at other people but not at me. I don't think that it's their rudeness so much as my irrelevance. Age or impairment tends to render us less *germane* to the popular core values, less likely to be noticed. On an individual basis, growing older can be a Cheshire cat-like experience of gradually disappearing.

Physical appearance is the cover of our personal book. As our bodies age, we distance ourselves, or rather we are distanced, from the physical ideal. As our appearance changes with age, we elicit less notice by others. They are indifferent. Somewhat, this can be a blessing. There's a certain freedom in it, not so great a pressure to compete for attention. When it comes to matters of need, however, not attracting attention can be a terrible impediment. If age or impairment may make us less visible or less relevant, age and impairment can combine to make us vanish.

Do we realize that there are tens of thousands of Virginians who are over age 60 and have survived to this point with lifelong disabilities such as cerebral palsy, autism, or Down syndrome? Moreover, the overwhelming majority have been living in the community all their lives. Have we noticed them? As a group or, more importantly, as individuals?

Acquiring a late-onset disability such as dementia creates another type of disappearing. Dr. Paul Raia, Vice President of the Alzheimer's Association of Massachusetts and New Hampshire, spoke in June in Richmond at the annual conference of the Area Planning and Services Committee (APSC) on Aging with Lifelong Disabilities. In his keynote address, Paul, who is blind, emphasized *Honoring the Person Within*. In his quietly passionate delivery, without the current “essential” of Power Point slides, Paul related case after case of individuals who had developed dementia in later life, and their gradual disappearance from

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those who loved them. But he offered a way of seeing them.

Paul contrasted rehabilitation and habilitation as meaningful interventions in their lives. In his view, rehabilitation has as its core value an effort to restore, to take the person to the greatest degree of independence and productive citizenship, through external control of services to the person with a disability. Restoration is unlikely with a progressive disease like Alzheimer's. Habilitation, he countered, would work on restoring capacity only after assessing what the person needs to develop emotionally; habilitation doesn't make one's self-definition dependent on function but on who the person is, how the person feels about himself or herself. Explaining that one part of the brain left relatively untouched by Alzheimer's disease is the amygdala, where the person is able to hold and to recognize emotions, Paul related changes to the physical environment and to the ways we communicate with someone with dementia that foster positive emotions in that person. For example, someone with advanced dementia may not understand cognitively when a caregiver says "no," and this sets up an adversarial situation where the person with dementia picks up on the emotional cues. Agreeing with and then guiding the person to another activity are more likely to create a positive emotional climate. Paul explained that activities programming is the motor that drives habilitation, offering opportunities to experience the joy of learning, even if there is no chance that what's learned will be retained.

In his conclusion, Paul discussed reciprocity, noting that by readjusting how we see the person "we can learn to train our hearts and spirits to see that the person with the disease is giving us a gift, an opportunity to honor the person within."

A few days later I met a man in Cleveland at a conference on aging and lifelong disabilities. He has cerebral palsy, uses a motorized wheelchair, and wants to be a country singer. He calls himself Cowboy Tim and has been singing at small gigs here and there. For his day job, he works at an independent living center, getting up each day at 4 a.m. for all the necessary preparations so that he can be at his job by 7:30. He is articulate and has a nice singing voice. But to hear him, people have to look beyond appearances. At our table over lunch he asked me if I knew who Charley Pride is. I replied that he was one of my father's favorite singers. He then asked me if I knew one of Charley's songs called "I'm Just Me." When I answered that I did not, Tim said that it was his favorite song and proceeded to sing a verse to me:

Oh I was just born to be
Exactly what you see
Nothing more or less
I'm not the worst or the best
I just try to be
Exactly what you see
Today and every day
I'm just me.

When he finished, we quietly sang it again together.

From the Commissioner, Virginia Department for the Aging

Linda Nablo

It's All in a Name

In June I attended the annual meeting of the national association for state-level aging organizations. As a member of the board, I had the opportunity to discuss in-depth a proposed name change that was later presented to the full membership for approval. While this might seem trivial to some, it actually represents a very significant shift in the administration of aging services. The membership overwhelmingly supported changing the name from the National Association of State Units on Aging (NASUA) to the National Association of States United for Aging and Disability. Just adding a "D" to the acronym – NASUAD – may be small in print but should be viewed as a bright signpost pointing the way to the future. The press release announcing the name change explained it this way:

"When first established through the Older Americans Act (OAA), state units on aging were primarily responsible for the administration of OAA services within the aging network. Recently, federal legislation, increased reliance on additional funding sources, and the economic downturn have dramatically impacted and increased the scope of services states are called upon to provide, and their ability to do so. As the need for long-term services has expanded, so has the role of the state aging agency, with nearly 65

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percent of the states serving both seniors and individuals with disabilities as of October, 2009.”

Like most organizational name changes, adding the word “Disability” does not create a new direction but rather reflects what is already well underway. The nationwide movement to create Aging and Disability Resource Centers (ADRC) has been growing for several years and is known here in Virginia as *No Wrong Door*. This service delivery model is now embedded in the Affordable Care Act and is likely to be strengthened further when the Older Americans Act is reauthorized in 2011. It is important for those new to the aging services network to understand this change and maybe for some to refresh their understanding.

Developing ADRCs

The current trend to take a collaborative approach to serving older adults and individuals with disabilities began in 2003, when the Administration on Aging (AoA) and CMS offered grants to states to develop Aging and Disability Resource Centers. Initially, ADRCs were brick-and-mortar “one-stop” agencies, often combining several public providers under one roof. Over time, virtual “single point of entry” systems evolved, such as the one in Virginia, which takes a “No Wrong Door” approach to serving older adults and adults with disabilities. Regardless of the form, however, physical and virtual ADRCs have common goals: to empower consumers to make informed decisions about their long-term service and support options and to streamline their access to existing services

and supports. To-date, 45 states and territories have received ADRC grants and there are currently over 200 ADRC sites in operation nationally. Collectively, NWD/ADRC communities cover 73 counties/cities, or 54% of Virginia and will expand to an additional 31 cities/counties this fall, bringing the total coverage to nearly 78% of the Commonwealth.

As part of the NWD/ADRC initiative, Virginia is utilizing technology to improve coordination of care, provider efficiency, and the consumer’s experience through the sharing of continuously updated personal health/service information, assessments and electronic referrals among providers via a web-based system. The system is now fully integrated into 12 AAAs, leading NWD/ADRC in their communities.

Virginia’s NWD/ADRC network has grown considerably in size, diversity, strength, visibility, and credibility, but the primary barrier to further expansion is funding. Federal grants have been critical in providing funding to allow the Commonwealth to further this system change until state and local resources are more readily available. Like all recent grant opportunities from the AoA, the newest through the Affordable Care Act make it clear that ADRCs will play a key role in federally funded programs in the future.

While this collaborative service delivery model is still evolving, recognition that older adults and adults with disabilities share the desire for appropriate and accessible long term services and supports in their communities is driving sys-

tem change at the federal, state, local and organizational level.

VDA Needs Your Input

As reported in the last issue of *Age in Action*, VDA convened a comprehensive group of experts from diverse fields to produce the first Four-Year Plan for Aging Services, in December 2009. This Plan attempts to present a comprehensive picture of where we are now and where we need to go to meet effectively the needs and leverage the human resources of Virginia’s rapidly aging population. Prior to implementing a strategy, VDA wants your input. An online survey has been developed to solicit your feedback, ideas, and suggestions. Please review the plan at: <http://vda.virginia.gov/pdfdocs/FourYearPlanForAgingServices-RD461-2009.pdf>. The online survey is available at www.zoomerang.com/Survey/WEB22ARYNBNPAF.

Summer Sounds: The Staunton Music Festival

This August 20-28, the Staunton Music Festival hosts its “Summer Sounds” schedule of classical music events, with daily performances at some of the city’s most notable locations. Now in its 13th year, this acclaimed Festival hosts hundreds of musicians, composers, and performers, including some of Virginia’s leading and emerging composers. Founded by artistic director Carsten Schmidt, the Festival has become internationally known for its unusual breadth of

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Road Scholar Is the New Name for Elderhostel Learning Adventures

A letter from James Moses, President of the Elderhostel lifelong learning enterprise, announces a change in its name. The Virginia Center on Aging offers these programs at sites in Harrisonburg, Natural Bridge, Richmond, and Staunton. Here's some of that letter:

"To capture the vitality and excitement of our programs, Elderhostel has extended the Road Scholar name to all of our educational learning adventures.

Due to an extraordinary turn of events, we are discontinuing use of the Exploritas program name we launched last October. Soon after the first Exploritas publications were mailed last fall, Elderhostel was sued for trademark infringement by a commercial tour company for high school students that thought the name Exploritas was similar to theirs. Elderhostel had scrupulously followed federal law in registering the Exploritas trademark and was legally granted ownership of it by the United States Patent and Trademark Office and was shocked by the complaint. We were further surprised when it was decided in court that use of the name Exploritas created "confusion."

Beginning now, Elderhostel has extended the Road Scholar name, which was trademarked in 1992, to all of our learning adventures across the globe. We know that Road Scholar is a name that ener-

gizes all of our participants, from the new generation of 50-year-olds to our seasoned lifelong learners in their 80s.

"Road" connotes a journey and real-world experience, and "Scholar" reflects a deep appreciation for learning. Together, the words capture the heart of our program experience: learning from expert instructors enhanced by direct discovery of an idea, issue, subject or place. Our educational experiences range from snorkeling in the Great Barrier Reef with a marine biologist to immersion in the Oregon Shakespeare Festival with a noted professor.

Even though we are naming all of our programs Road Scholar, rest assured that the programs themselves will not change. Our programs will continue to be the same diverse collection of learning experiences, suitable to people of all activity levels and interests."

AAAG Offers Online Training Courses

The Alcohol and Aging Awareness Group (AAAG), in partnership with Virginia Association of Community Service Boards, has launched complimentary online training courses for service providers that address alcohol, medications, and aging. The web based training is available at <http://vacsb.elearning.networkofcare.org/>. Click on View by Provider, click on Alcohol and Aging Awareness Group, to access the three one-hour complimentary courses. Users will then need to log in to complete the courses that include pre/post tests, videos, power points, and certificates of completion. The three highlighted sessions include presentations by Dr. Paul Aravich from Eastern Virginia Medical School and Debra Jay and Dr. Frederic C. Blow from the University of Michigan at the 2008 and 2009 AAAG conferences.

If you would like to order *The Hidden Epidemic, Alcohol, Medications and the Older Adult Best Practices 2009 Conference DVD*, visit the Virginia ABC web site link at www.abc.state.va.us/Education/olderadults/aging_dvd.html.



VCoA Receives SGS Media Award

Ed Ansello, on behalf of VCoA and *Age in Action*, gratefully accepts from its President Jim Mitchell the Media Award of the Southern Gerontological Society, given at its 31st annual meeting in April to the overall best aging-related media product (print, video or broadcast) in the South.

Refreshed Medicare.Gov – Bright and Friendly

The U.S. Health and Human Services Department recently upgraded its website, Medicare.Gov. The people at HHS did a masterful job of making the site readable and user friendly. Visitors encounter a bright, welcoming home page, from which one can link to the most frequently used services. Only five drop down menus lead to most everything one needs to know from Medicare, all clearly labeled and unambiguous. These are: Home, Manage Your Health, Medicare Basics, Resource Locator, and Help & Support.

The Manage Your Health tab includes information on Preventive Services; Flu Shots; the Welcome to Medicare Preventive Physical Exam that newly eligible older Americans may have one-time within the first 12 months of having Medicare Part B; and the MyMedicare.Gov site, “Medicare’s free, secure online service for accessing personalized information regarding your Medicare benefits and services.”

The Resource Locator tab lists Drug and Health Plans, Medigap Policies, Doctors (searchable by specialty and zip code), Hospitals, Home Health Agencies, Nursing Homes (every Medicare- and Medicaid-certified facility in the country), and much more. This website is helpful to Medicare beneficiaries, family members, and a range of service providers. There’s a tremendous amount of information here but it’s navigable and clearly presented. Kudos to the folks at HHS!

It’s “Back to School” Season

by Monica Hughes

We’re listening to heat wave warnings and watching the thermometers soar as we turn the pages of our summer calendar. We anticipate, with the turning of the page, the falling of the temperature and of the leaves. As we enjoy our final summer travels and the fruits of our gardening labors, we pay little attention to the “Back to School” exhilaration of the fall season that beckons younger families. Or is that true? These days, for a growing number of adults ages 50 and older, fall brings them back to school. Some return to improve their promotability or to move from one career into another. But, for many in this group, the door also opens to the freedom of learning for its own sake.

Fortunately, there are many options available for today’s older adult. University and community college courses remain viable options, for credit or for audit. Elderhostel Road Scholar programs offer learning with travel. Another affordable option that offers a wealth of choices is the Lifelong Learning Institute in Chesterfield. This coming fall (along with a cornucopia of other opportunities at LLI) you will be able to discover your talents in a painting or a sculpting class, explore the Italian language or examine the Rise and Fall of the Roman Republic. You can learn about Healing Touch or cyclotron (molecular imaging). Dig into anthropology to find out the what, why, and how of civilization or try

your pen at creative writing. Stretch beyond your mind and experience the relaxation and exercise of yoga.

This is just a sampling of the many opportunities available. So whether you are seeking to improve your quality of life, to open new horizons, to find adventure and joy or simply an excuse to open a new book, ... whether you love the idea of engaging new ideas or are in quest of new friendships, consider going “Back to School” this fall.

For more information on the Lifelong Learning Institute in Chesterfield or the upcoming fall program, you can call (804) 378-2527 or visit www.llichesterfield.org.

Summer Sounds, *continued*

repertoire and high quality musicians and performances.

See the full schedule of events at www.stauntonmusicfestival.com or make plans to attend the VCU Elderhostel/Road Scholar program August 23-27 that includes the Staunton Music Festival, a performance of Shakespeare’s “The Taming of the Shrew” at the Blackfriars Playhouse, exciting classes, and upscale accommodations at the Stonewall Jackson Hotel. For details on this program, visit www.roadscholar.org (enter search for program #17692) or call the Virginia Center on Aging at (804) 828-1525.

COMMONWEALTH OF VIRGINIA

Alzheimer's and Related Diseases Research Award Fund

2010-2011 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 (AD) and related disorders 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. The grant awards for 2010-2011 are as follows:

VCU Severn B. Churn, Ph.D. "Neuronal Mechanisms of Trauma-Induced Alzheimer's Disease"

This study will elucidate the neuronal mechanisms through which traumatic brain injury (TBI) results in an increased probability of developing Alzheimer's disease. Not only is aging associated with an increased risk of, but also an increased sensitivity to, the secondary effects of TBI. In addition, among the secondary effects of TBI is an increased incidence of AD. The association is particularly noticeable among males and when the time differential is within 10 years. This proposal will characterize the overlapping neuronal mechanism shared by both TBI and AD to elucidate a common mechanism that can be clinically treated. More specifically, the experiments will examine how TBI and AD induce a common, calcineurin-dependent mechanism of synapse elimination. Identifying the cellular mechanisms underlying this association will enable the development of prophylactic measures to prevent AD. *(Dr. Churn may be contacted at 804/828-0290)*

GMU Vasiliki N. Ikonomidou, Ph.D. and Pamela Greenwood, Ph.D. "Detection of ApoE-related White Matter Degeneration Using Tissue Specific MRI: Sensitivity and Implications for Cognitive Function"

Early detection of AD in the preclinical stage before neuron loss occurs is the preeminent goal of much AD research. Brain damage associated with the development of AD starts accumulating in the brain possibly for decades before the onset of clinical symptoms. Even though we can detect some of these changes, there are transitional steps that remain unclear, resulting in our inability to distinguish what may be a benign state from a dynamic process resulting in AD. The investigators hypothesize that one of these intermediate processes is the development of white matter inflammation and injury. In order to better detect and characterize this, the studies will use Tissue Specific Imaging, a novel, non-invasive Magnetic Resonance Imaging (MRI) technique, as a biomarker for white matter degeneration in neurologically healthy adults. Specifically, the research team wants to determine (a) if individuals at increased genetic risk to AD, due to their inheritance of the APoE-ε4 allele, show a larger burden of white matter integrity loss than the general population, and (b) the relationships of such changes, expressed both as affected volume and as severity of changes in cognitive function. If successful, this technique will serve as a tool to detect and monitor dementia-related processes in the brain, thereby increasing both the possibility of diagnosis before the onset of neuron loss and symptoms, as well as the ability to monitor drug efficacy. *(Dr. Ikonomidou may be contacted at 703/993-9354; Dr. Greenwood may be contacted at 703/993-4268)*

**Alzheimer's Association
Southeastern Virginia**

**Patricia Lacey, M.B.A., Sonya Barsness, M.S.G. and Scott Sautter, Ph.D.
“The Impact of Early Alzheimer’s Support and Education Programs on
Both Diagnosed Participants and Their Care Partners”**

This study will investigate the social and psychological impact of EASE (Early Alzheimer’s Support and Education), a program offered by the Alzheimer’s Association for individuals diagnosed in the early stages of AD and their care partners. EASE strives to empower individuals to become active participants in their care by educating them about the disease, as well as care and treatment options. To date, there is scarce research on the impact of early stage programs. Program evaluation results from similar interventions indicate that they are well-received and have a positive influence on how affected individuals understand the disease, cope with it, and plan for the future. This study seeks to strengthen the evidence by conducting a more rigorously-designed investigation. It is hypothesized that EASE participants will report a change for the better compared to individuals assigned to a delayed-intervention control group in areas of self-efficacy, quality of life, and health outcomes. It is expected that this research will contribute to the body of knowledge of dementia care by filling a gap in the evaluation of psychosocial interventions for people in the early stages of dementia. *(Ms. Lacey may be contacted at 757/ 459-2405; Ms. Barsness may be contacted at 757/773-7841; Dr. Sautter may be contact at 757/498-9585)*

VCU

**Kate Lapane, Ph.D. “Assessment of Factors Which Influence Physician Decision-Making
Regarding Medication Use in Patients with Dementia at the End of Life”**

There is little information regarding how doctors decide which medications should be started, which should be continued, and which should be stopped in patients with advanced dementia who are near death. Current evidence suggests that these patients are the “disadvantaged dying,” and are likely to be subject to the prevalence of suboptimal and inappropriate medication use seen in more general populations with reduced life expectancy. This study will examine a number of factors that may influence how doctors make decisions regarding drug treatment in AD patients at the end of life. Descriptions (or “vignettes”) of patients who have dementia and their conditions have been developed. These will be sent to doctors in hospital and community settings, who will be asked to describe how they would make decisions about medication for these patients. The investigators will consider where the patient lives (hospital, nursing home or in their home), whether the patient has an advance directive (a statement giving directions for the patient’s future medical care, written before illness is so severe that they are unable to make decisions), and the wishes of the patient’s family. The goal is to understand which factors influence the decisions that doctors make. The findings will inform future interventions and discussions regarding public policy. *(Dr. Lapane may be contacted at 804/628-2506)*

EVMS

**Serina A. Neumann, Ph.D. and colleagues. “Donepezil’s Effect on Cardiac Function in
Patients with Alzheimer’s Disease through an In Vivo, Non Invasive Measure of Peripheral
Neuro-Cholinergic Function: Relation to Therapeutic Efficacy”**

AD is known to affect the nervous system in ways that influence heart function, which may place AD patients at increased risk for cardiovascular-related death. One of the very probable mechanisms of the subtle cardiac autonomic dysfunction in AD is degenerative damage of central nervous structures related to the autonomic nervous system and the influence of these neurodegenerative changes on higher cerebral functions. Involvement of peripheral nervous structures may also play a role. The characterization of changes in cardiac autonomic function in AD patients, however, has been scarcely evaluated. Furthermore, the effectiveness of treatment for AD with standard FDA-approved drugs like donepezil (Aricept®) may be related to the protection of heart function. This investigation will measure both cardiac autonomic function (measured by heart rate variability) and mental abilities in 26 elderly men and women before and after they begin taking donepezil for suspected mild AD. These measures will be compared with measures taken from 26 apparently health men and women of similar age. This study will help to characterize cardiac autonomic function and potential relations to neuropsychological function in newly diagnosed AD patients, and add to the understanding of donepezil’s effect on cardiac autonomic function in these patients. *(Dr. Neumann may be contacted at 757/446-5888)*

2010-2011 ARDRAF Awards Committee

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The ARDRAF Awards Committee in Deliberation, June 2010



The Alzheimer's and Related Diseases Research Award Fund (ARDRAF) benefits from scrupulous attention to proposals submitted for consideration, and from the gifts of time so generously given by its Awards Committee and others. Each application is assessed by three referees before being reviewed by the ARDRAF review team meeting as a committee of the whole. First, applicants must identify peer reviewers, that is, researchers not at their own institution who understand the complexities of the research being proposed. Next, Dr. Coogle, as ARDRAF administrator, identifies individuals with a related research history, anywhere in the world, and she requests their assistance gratis as outside reviewers. Most often, they agree. Third, every proposal is

assigned to two ADRAF review committee members, one of whom, with expertise related to the thrust of the proposal, acts as primary reviewer who completes an independent review and summarizes the assessments of all three reviewers for the whole committee. The full committee, excepting those who recuse themselves for conflict of interest, then discusses and rates every proposal being considered. The process is lengthy but results in outstanding analyses of proposals. As a result, ARDRAF awardees have a high likelihood of turning their pilot funding into larger federal or foundation grants, returning to Virginia \$9-\$11 on average for every \$1 awarded.

Focus on the Virginia Center on Aging

Kimberly Spruill Ivey, M.S.



Kim Ivey is no stranger to the Virginia Center on Aging or to *Age in Action*. Kim first began working for VCoA in 1994 while she was an undergraduate student. She had told the job counselors at VCU's cooperative education program that she might be interested in a career in hospital administration. VCoA is located physically on the Medical Campus of VCU, so they declared it a "match." So she began a relationship with VCoA that has seen her involved in project staffing, marketing, outreach, management of audio-visual materials, and most everything that VCoA does. She has been working part-time as the Editor of *Age in Action* since 2005.

Prior to joining VCoA, she had never heard of gerontology, nor had any idea that there was a whole field of work dedicated to matters related to aging and older adults. Gerontology quickly became her own passion. She joined VCoA as a full time employee after graduating from VCU in 1995, and entered the Department of Gerontology's graduate program in 1997. She graduated in 2000 with a Master Degree in Gerontology, with a focus in adult education. While working at VCoA, she had many great experiences and was involved in a variety of projects. She did everything from helping with the Elderhostel program and the

Alzheimer's and Related Diseases Research Award Fund (ARDRAF) to planning conferences and developing VCoA's first web page. During this time, she also joined the Board of the Virginia Association on Aging, eventually serving as President, and the Board of the Alzheimer's Association Greater Richmond Chapter.

Kim left VCoA in 2000 to work more directly with older adults and has accumulated a resume of positive experiences. As a marketing counselor for The Hermitage, a retirement community of the Virginia United Methodist Homes, she helped older adults and their families to assess their housing options and make decisions about moving in. As the Helpline Coordinator for the Alzheimer's Association Greater Richmond Chapter, she helped caregivers better understand dementia and find much-needed resources, such as physicians, elder law attorneys, and long-term care facilities. As Director of Foundation Programs for the Virginia Pharmacists Association, she began a capital campaign and managed immunization education programs for the pharmacists of Virginia. She also worked in admissions for ManorCare and as the manager of an Alzheimer's neighborhood for Sunrise, a continuing care community. These experiences have broadened Kim's perspective, providing invaluable insights into the complex but invigorating field of aging; she has gained an appreciation of both non-profit and for-profit long-term care facilities; both short-term rehabilitation stays and long-term care placements; Medicare, Medicaid, and private-pay options; managing and schedul-

ing certified nursing assistant (CNA) staff; fundraising; conference/program planning; and activity planning.

Kim currently works part-time planning and running activities in the memory care unit of The Crossings at Bon Air, a new retirement community in Chesterfield County. She finds this a "fun" job, one where she spends her days with 11 memory-impaired residents doing everything from baking to bingo, including her driving the van for scenic excursions around town.

She also volunteers for Young Adults for Alzheimer's Awareness (YAAA!), serving as Secretary. YAAA!'s vision is to educate and engage young adults about the impact of Alzheimer's disease in our community. They also raise money for the Alzheimer's Association Greater Richmond Chapter.

Kim and her husband, John, recently celebrated their third wedding anniversary. They enjoy playing volleyball together, playing on leagues through Henrico County and the Richmond Volleyball Club. They have a 17-month-old daughter and are expecting their second child this December. To help keep her sanity as a new mother, Kim became involved in Richmond-Mommies.com, an on-line forum for area mothers.

Kim is also an animal lover, being the adoptive mother of a rescued Shih-Tzu named Katie and two cats – Gomez and Turtle. She enjoys spending time with her family, reading (especially suspense and vampire novels), movies, and relaxing with friends.

Living Too Long Revisited

By Saul Friedman

The following contains excerpts from an essay written by Pulitzer Prize-winning journalist Saul Friedman appearing June 2, 2010 on the website Time Goes By. It is reproduced with the author's permission.

This began as an essay on longevity, the advances the United States and much of the world have made in increasing life expectancy. Then I came across this piece from *The New York Times* of October 24, 1880. The story, entitled *Living Too Long*, began:

“Generally speaking, one of the last and least of our anxieties is that we may live too long. Throughout youth and maturity, the prospect of longevity is very apt to be pleasant, for the thing itself seems desirable – far more so in the distance than if at hand.”

As usual, *The Times* came to no conclusion, although the article made a strong case against growing too old without telling us how long is too long. In 1880, the life expectancy in the U.S. for white males was 40. Today it's 78.2, somewhat less than Japan (82.6) and most of Europe (in the 80s), all of which provide universal health care.

But it's not my aim to promote access to good health care, but to examine a strange phenomenon. The world has had great success since 1880 in achieving a longer,

healthier life for people almost everywhere. Indeed, life expectancy in most of the world has grown by 10 years just since 1960. And yet, too many Americans, politicians, and ordinary people seem to fear longevity, and some are questioning whether we're living too long.

A woman I met years ago who was the subject of my column on the problems of older Americans, had just placed her husband, suffering from Parkinson's disease, in a nursing home and she didn't know how to pay for it and continue to keep up her own home and living standards. “Who knew I would live this long?” she said. She was only 70. A few weeks ago, a reader told me quite candidly that people on Medicare or Social Security were selfish and should forgo these programs “that will keep you alive for a few more years; better to use the money to send your grandchildren to college.”

That we on Medicare and Social Security are living too long and are a drain on the rest of society is not a new idea. Twenty five years ago, the *Atlantic Monthly*, with the help of an ugly caricature, depicted older Americans as “Greedy Geezers.” And about that time, then Gov. Richard Lamm of Colorado told a meeting of lawyers that elderly people who are terminally ill “have a duty to die and get out of the way” rather than try to survive by artificial means. People who allowed themselves to die, he said, are like “leaves falling off a tree and forming humus for other plants to grow...Let the other society, our kids, build a reasonable life.” He figured it's better to be humus than to watch your grandchildren grow up.

In 1996, as a former governor, Lamm was at it again calling for Medicare to be cut tenfold because it was spending too much prolonging lives. And he predicted that, as the society ages, “we have to learn to run a nation of 50 Floridas.” As we shall see, that sour vision of the future has cropped up more recently.

But the criticism that Medicare spent too much money on the last years of the lives of beneficiaries, along with efforts by Newt Gingrich's Republican Congress to privatize Medicare and cut its funding, prompted Medicare in 1995 to begin its hospice program. Medicare paid fully to care for patients whose doctors attested that they had less than six months to live. Patients who volunteered to enter hospice had to agree that they could receive only palliative care – pain killers and bedside help – to make them comfortable. But they were denied curative treatment, including their own routine medicines, even if there was a chance it would prolong their lives.

But the hospice program gave lie to the notion that death is the answer to saving money. Fortunately, as medical advances such as chemotherapy, open heart surgery, and more sophisticated diagnostic techniques like the CT-Scan and PET-Scan became available and common, it was no longer as easy as Lamm suggested to call patients terminally ill, or to predict how much longer they had to live. Few doctors will tell a patient how long he or she has to live, for the course of an illness is not predictable for everyone. Cancer patients today may survive into

their eighties. And the severely disabled, like Stephen Hawking, may contribute handsomely to the living. As a result, Medicare now recognizes that the six-month prediction of a doctor, which is still required, may be extended indefinitely under current Medicare rules. Indeed, some patients get well enough to opt out of hospice care. In addition, Medicare dropped its prohibition on curative care and now permits a cancer patient to continue chemotherapy while in hospice. Nevertheless, Medicare hospice will take over the care of a patient and is there to provide care for the patient (and comfort for the family) at the end of life.

Thus, it has become obvious that there is nothing predictable about aging except that it will end. Everything else is a matter of luck, background, chance, environment, genes, and perception. We are not as old as our parents were at our age. And likely they didn't live to be our age.

One of the first writers to call for a celebration of longevity was social historian Theodore Roszak, who wrote the classic study of the Sixties and thereby coined a new phrase, in *The Making of A Counter Culture* (1968). In his 1998 book, *America the Wise: The Longevity Revolution and the True Wealth of Nations*, he called on the nation to celebrate and welcome the wisdom of America's booming population of older Americans.

"The future belongs to maturity," he wrote. "Never before has an older generation (more than 80 million Americans in their sixties, seventies, eighties and even nineties)

been so conversant with so many divergent ideas and dissenting values."

His book was published before the full force of the digital explosion, but the older generation, the aging boomers, and even those who may be called elderly, are not lagging behind younger Americans in their skills with computers and accompanying gadgets. Indeed, the geniuses at Apple, Google, IBM, Microsoft and Amazon are beyond their boomer years.

Roszak's 2001 update of *America the Wise*, entitled *The Longevity Revolution*, says of longevity, "It is inevitable. It is good." His optimism is shared by the godfather of the study of aging, Dr. Robert N. Butler, a geriatrician and founder of the New York-based International Longevity Center, a think tank on issues facing older America. Butler won a Pulitzer Prize for his 1975 book, *Why Survive*, a pioneering study of what it's like to grow old in America. His was not an encouraging picture of "old age." He became the first director of the National Institute on Aging, and has done more than any one to call attention to the potential and problems of longevity. And despite the longevity alarmists, much has changed for the better. His latest book, in contrast to his first, celebrates the rewards and possibilities of aging in America. Entitled *The Longevity Prescription*, Butler, who is active in his eighties, begins with a chapter on "Embracing longevity." He notes that in the beginning of the 19th Century, life expectancy was 35. "In round numbers we can anticipate living ten thousand days longer than our ancestors could a

century ago." Butler says, "The average American does not need to resign himself or herself to spending these added decades descending slowly and unhappily into disease and disability...You are not your parents' genes."

And he proceeds to dispel some of the myths of aging and he prescribes some reasonable things all of us can do to prevent illness and remain active and mentally alert. "No matter what your age, there are ways to enhance your longevity." They seem as obvious as his admonition to quit smoking (Butler was a smoker), but they are too often overlooked.

His advice includes: how to maintain mental vitality; why you should nurture old and new relationships; and how to get effective medical care.

I have interviewed Butler, was a participant at his first Age Boom Academy at his longevity center and I know that he and Roszak are ardent defenders of Social Security and Medicare and advocates for single-payer, universal health insurance. To these ends, the new version of Roszak's book exposes the rich predators who see longevity as "the Gray Peril," driving America into bankruptcy because of the increasing costs of Medicare and Social Security.

Because of the recession and high unemployment, the Social Security system will pay out more in benefits this year and next than it takes in payroll taxes, but that happened in the recession of 1981-2 and in 1983, when Ronald Reagan approved a fix that saved Social

Security for 75 years.

Thus, economist Dean Baker chastised the *Wall Street Journal* for saying the Social Security trust fund will show a deficit; the trust fund earns interest on the bonds it sells to the Treasury and will show a surplus of \$100 billion this year. But on the larger issue of entitlement spending, Princeton's Uwe Reinhardt, the nation's leading health economist put the hysteria about the cost of entitlements in perspective. In a lecture for the Woodrow Wilson School in Washington, he noted that outlays for all Social Security programs, though not part of the budget, will remain flat at six percent of the Gross Domestic Product for the next 60 years, while Medicare spending will rise from the current 3.59 percent to 8.74 percent in 2050. But not to worry, Reinhardt said. By 2050, even at an annual growth rate of 1.5 percent, the GDP per capita will grow from the current \$40,000 to \$78,200. "Why should I worry about who will be running the world in 2050," said Reinhardt, "when they will have so much real GDP to play with?"

Saul Friedman writes the twice-monthly *Reflections* column for *Time Goes By* (www.timegoesby.net) in which he comments on news, politics and social issues from his perspective as one of the younger members of the greatest generation. His other column, *Gray Matters*, formerly published in *Newsday*, appears each Saturday.

Food Labeling: Recipe for Confusion

The Food and Drug Administration (FDA) has been examining nutrition labeling as it prepares to push for front-of-the package information for consumers. What it has been finding is eye-opening and may help explain why some of us get frustrated trying to lose weight. It seems that serving sizes, set by the FDA after surveys in the 1970s and 1980s, have not kept pace with changes in the way Americans eat. The portion sizes tend to bear little resemblance to the way we now eat, nor are they standardized from one product to another within the same category, say, breakfast cereal or ice cream. Add to this the manufacturers' practice of printing nutritional information in type sizes that many older adults have difficulty reading, and we have a recipe for confusion.

So, if the serving size listed is smaller than what we really eat (it's never larger), we think that we are getting fewer calories, less salt, or other nutrients than we actually are, unless, of course, we read every label carefully and who can or does?

Misleading portion size information is important because the standard serving size shown on a package determines all the other nutritional values on the label, including calorie counts. At the same time, manufacturers tout key nutrition facts on the front of packages; so if these are based on unrealistic portion sizes, the problem can be magnified. Rather than helping to fight obesity, such practices may simply add to the confusion over what makes a

healthy diet.

William Neumann of the *New York Times* earlier this year provided some stomach-tightening details. Consider the humble chip: most potato or corn chip bags today show a one-ounce serving size, containing a tolerable 150 calories, or thereabouts. But only the most disciplined snacker will stop at an ounce. For some brands, like Tostitos Hint of Lime, that can be just six chips. In the real world, many people might eat two or three times that, or more. Munch half a bag of Tostitos while watching the Super Bowl and you could take in about half the 2,000 calories an average person needs in a day.

"We are actively looking at serving size and evaluating what steps we need to take," said Barbara O. Schneeman, director of the F.D.A. office that oversees nutrition labels. "Ultimately, the purpose of nutrition labeling is to help consumers make healthier choices, make improvements in their diet, and we want to make sure we achieve that goal."

The push to re-evaluate serving size comes as the F.D.A. is considering ways to better convey nutrition facts to hurried consumers, in particular by posting key information on the front of packages. Officials say such labeling will be voluntary, but the agency may set rules to prevent companies from highlighting the good things about their products, like a lack of trans fats, while ignoring the bad, like a surfeit of unhealthy saturated fats.

On today's food packages, many of the serving sizes puzzle even the

experts. For ice cream, the serving size is half a cup. For packaged muffins, it is often half a muffin. For cookies it is generally one ounce, equal to two Double Stuf Oreos... (and for most) breakfast cereals, a serving is three-quarters of a cup. It is difficult to say exactly how much people eat, said Lisa R. Young, an adjunct professor of nutrition at New York University, but she said that research showed that the portions Americans serve themselves had been growing in recent years.

So, if we are trying slowly to drop some weight and we hit upon eating more of certain “healthy” breakfast cereals, we may actually be consuming two or three times the nutrients and calories in our bowl as we think, because the serving size (often given in grams!) is so unrealistically small.

The take-away lessons: take the time to read the label carefully, even if you have to squint; do not rely only on the calorie count touted but consider the size of the portion on which it is based. Simmer and stir slowly.

Blancato Honored

Robert Blancato, Chairman of the Commonwealth Council on Aging in Virginia, received the 2010 Arthur S. Flemming Award this June from the National Association of State Units on Aging (NASUA), in recognition of outstanding service in public policy and advocacy for older Americans. Named in honor of the U.S. Secretary of Health, Education, and Welfare during the Eisenhower administration who helped shape Social Security policy for more than four decades, the Flemming award recognizes notable leaders whose work has improved the lives of older Americans and people with disabilities.

Bob Blancato has been a tireless public servant, ardent advocate, and national expert on aging-related public policy for more than 30 years. He has served as both Staff Director and Senior Advisor of the U.S. House Select Committee on Aging’s Subcommittee on Human Services; was President Clinton’s appointee as Executive Director of the 1995 White House Conference on Aging; and President Bush’s on the Policy and Executive Committees of the 2005 Conference. Bob has committed himself to raising awareness of elder abuse and advancing public policy on elder justice; he has served as President and currently is an Executive Committee member of the National Committee for the Prevention on Elder Abuse. He was instrumental in ensuring the inclusion of the long-stalled Elder Justice Act in the recently passed Affordable Care Act (health reform). Bob’s is an honor richly deserved.

Virginia State Bar’s Resource On-Line

The *Senior Citizens Handbook*, published by the Virginia State Bar Association through the support of the Virginia Law Foundation, is available online at www.vsb.org/site/publications/senior-citizens-handbook. The Virginia State Bar is an agency of the Supreme Court of Virginia. The *Handbook* presents helpful information on a range of important topics for older Virginians, their caregivers, and anyone interested in aging-related matters. With over 100 pages of content, it reviews, with minimal *legalese*, such relevant matters as Social Security, Food Stamps, Federal Tax Relief, Medicare, Medicaid, Alzheimer’s Disease, Nursing Homes, Continuing Care Communities, Reverse Mortgages, Guardianship, Grandparent Rights, Planning for the Future, and Dispute Resolution. There are also 20 pages of “Helpful Contacts” that include listings of local Departments of Social Services, Area Agencies on Aging, aging-related legal services, information & referral services, and consumer protection agencies.

Calendar of Events

July 17-21, 2010

National Association of Area Agencies on Aging's 35th Annual Conference & Tradeshow. Hyatt Regency St. Louis at The Arch, St. Louis, MO. For information, visit www.n4a.org.

July 26-30, 2010

Culture Change Seminars for LTC Administrators and Leaders. (Same program offered on four dates).

Presented by the Virginia Culture Change Coalition. 10:00 a.m. - 4:00 p.m. each day. \$65 fee includes materials and lunch. For information or to register, call (804) 644-3424 or info@designsource.com.

26th: Harbor's Edge Retirement Community, Norfolk.

27th: Covenant Woods, Mechanicsville.

28th: Westminster at Lake Ridge, Lake Ridge.

30th: The Glebe, Daleville.

August 12, 2010

Central Virginia Regional Triad Meeting. 9:00 a.m. Richmond Better Business Bureau, 720 Moorefield Park Dr. Suite 300. For information, call Dave Sussan at (804) 780-2222.

September 21, 2010

Volunteer Opportunity Fair. Sponsored by the Chesterfield Senior Advocate. 9:00 a.m. - 2:00 p.m. at Chesterfield Towne Center, Midlothian. Adults of all ages can visit with local organizations that are in need of volunteers. For more information, call (804) 768-7878.

September 30, 2010

Chesterfield Aging Summit. Sponsored by the Senior Advocate. Bon Air Baptist Church, Chesterfield. 9:00 a.m. Part of a national movement to promote aging in place, this event is designed to engage the community in developing strategies to improve livability for older adults in Chesterfield. For more information, call (804) 768-7878.

October 18, 2010

Connecting with Your Elected Officials. Sponsored by the Chesterfield Council on Aging. Central Library, 9501 Lori Road, Chesterfield. Workshop on becoming an effective advocate for older adults and adults with disabilities. Learn to incorporate change at state, local, and national levels. RSVP to (804) 768-7878.

October 25-26, 2010

Virginia Association for Home Care and Hospice Annual Conference and Trade Show. Holiday Inn Koger Center, Richmond. For information, contact Debbie Blom at (804) 285-8636 or dblom@vahc.org.

November 5, 2010

Senior Centers – Let's Make the Connection. The Virginia Recreation & Park Society Senior Resource Group's 5th Annual Fall Conference on Senior Programming, Therapeutic Recreation & Aging. Deep Run Recreation Center, Henrico. 8:15 a.m. - 4:00 p.m. For information, call (804) 730-9447 or vrps@vrps.com.

November 6, 2010

Hearing Workshops. Sponsored by the Chesterfield Disability Services Board. Bon Air Methodist Church. 9:00 a.m. – 1:00 p.m. Coping with Hearing Loss, Buying a Hearing Aide, Equipment Available for Persons with Hearing Impairments. Free hearing screenings provided by appointment. RSVP to (804) 768-7878.

January 26, 2011

Virginia Center on Aging's 25th Annual Legislative Breakfast. St. Paul's Episcopal Church, Richmond. 7:30 a.m. - 9:00 a.m. For information, call (804) 828-1525.

Age in Action

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Editor

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

**Fall 2010 Issue Deadline:
September 15, 2010**

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www.vcu.edu/vcoa

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