

Volume 13 Number 1 Winter 1998



Activities in geriatrics and gerontology education and research

Virginia Center on Aging

Virginia Geriatric Education Center

Virginia Department for the Aging

Contents

<a href="#"><u>Case Study</u></a>	<a href="#"><u>From the Director, VGEC</u></a>	<a href="#"><u>From the Director, VCoA</u></a>	<a href="#"><u>From the Commissioner, VDA</u></a>	<a href="#"><u>Focus on VGEC</u></a>	<a href="#"><u>Focus on VCoA</u></a>	<a href="#"><u>Focus on VDA</u></a>	<a href="#"><u>Occupational Therapy Dept. at VCU</u></a>
<a href="#"><u>Waste, Fraud, &amp; Abuse in Medicare/Medicaid</u></a>	<a href="#"><u>Proposed VA Public Guardian &amp; Conservator Program</u></a>	<a href="#"><u>VCoA Recognizes Sen. Hunter B. Andrews</u></a>	<a href="#"><u>Comments by H.H. Newsome, VCU School of Medicine</u></a>	<a href="#"><u>Calendar of Events</u></a>	<a href="#"><u>New Films from the IRC</u></a>	<a href="#"><u>Request for Proposals - ARDRAF</u></a>	<a href="#"><u>Back to VCoA Home Page</u></a>

Case Study: Medications and Falls



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*Clinical Pharmacist*  
*Heritage Information Systems, Richmond, Virginia*

Dr. Patricia Slattum graduated with a B.S. and Pharm.D. in Pharmacy, a Ph.D. in Pharmaceutics, and a Certificate in Aging Studies from MCV/VCU. She received further training as a geriatric pharmacy fellow at McGuire Department of Veterans Affairs Medical Center in Richmond and as an NIH-funded postdoctoral fellow in aging and drug disposition at the University of North Carolina at Chapel Hill. Dr. Slattum joined the faculty at MCV/VCU School of Pharmacy in 1996, and serves as principal investigator for clinical studies of the effects of age and gender on drug disposition in the body and drug effects on the central nervous system. She also works as a clinical pharmacist with Heritage Information Systems, a health care technology company, on initiatives to improve drug therapy outcomes for the elderly.

### Educational Objectives:

1. To describe potential causes of falls and ways to prevent them.
2. To illustrate how medications can contribute to an increased risk of falls and recommend strategies for reducing this risk.

### Case Study

Jane Brown is an 83 year old woman who lives with her husband in her own home. She is active in her church and enjoys visiting with her grandchildren and great grandchildren. She suffers from several health problems including heart failure, arthritis, osteoporosis, occasional anxiety, insomnia, and cataracts. More recently she has begun to experience mild confusion, dizziness and depression. Jane Brown sees two doctors: a primary care doctor and a cardiologist. She takes the following medications: Digoxin (Lanoxin®) for heart failure  
Furosemide (Lasix®) for heart failure  
Flurazepam (Dalmane®) as needed for insomnia  
Lorazepam (Ativan®) as needed for anxiety  
Amitriptyline (Elavil®) for depression  
Meclizine (Antivert®) for dizziness.

She also takes acetaminophen or ibuprofen for aches and pains and calcium for her osteoporosis. She obtains her medications from two different pharmacies, depending on which is more convenient. She is enrolled in Medicare and a Medicare Supplemental Insurance program that pays for her prescription medications.

Last month, she fell against the bathroom sink, bruising her back and chest wall, but she did not feel that it was serious enough to consult her doctor. She has not attended church or been out of the house much since the fall.

### Are falls a significant problem?

Falls in the elderly result in significant medical, social, and financial consequences. About 30% of people age 65 and older living at home will fall each year (Tinetti, 1990). The number increases to 50% for those over age 80. More than half of ambulatory residents in long term care facilities fall each year. The majority of those who fall experience multiple episodes. Not only does the rate of falls increase with age, but the rate of injury from those falls increases as well. About 5% of people who fall fracture a bone, and 1% fracture a hip, resulting in 250,000 hip fractures each year in the U.S. Accidents, most of which are falls, are the sixth leading cause of death in persons over age 65. It has been estimated that the financial cost of caring for those who fall is \$12.4 billion per year (Tibbitts, 1996). Falls are cited as the reason for 40% of nursing home admissions. Falls often result in self-imposed activity restriction because of fear of falling, and may lead to withdrawal from normal activities and depression.

### What are the risk factors for falls?

Falls usually result from a combination of factors related to the individual, the environment, and/or medications. Characteristics of the individual that may contribute to an increased risk of falling include disabilities (e.g. muscle weakness or balance impairment), current diseases (e.g. cerebrovascular disease, cardiac arrhythmias, dementia, altered mental status, Parkinson's disease, seizure disorders, diabetic neuropathy, osteoporosis, cataracts, or a previous fracture), acute illnesses (e.g. infection, fever), or age-related changes in vision, hearing or reaction time. Environmental causes are believed to be responsible

for about 22% of falls (Tibbitts, 1996). These factors include poor lighting, obstacles on the floor, unstable furniture, low beds or toilets, or inadequate railings on stairs. Environmental factors are particularly significant in unfamiliar surroundings. Medications are also an important contributor to falls. The total number of medications is a significant factor, with increased risk associated with taking four or more drugs (Tibbitts, 1996). Specific drugs or drug classes which can increase risk of falls include (Tibbitts, 1996; Kay and Tideiksaar, 1990; Cooper, 1997):

*Drugs which act on the central nervous system:*

- \* tricyclic antidepressants
- \* trazadone
- \* monoamine oxidase inhibitor antidepressants
- \* antipsychotics
- \* barbiturates
- \* benzodiazepines
- \* drugs which can cause abnormal movements
- \* sedating antihistamines.

*Drugs which act on the cardiovascular system:*

- \* beta blockers
- \* calcium channel blockers
- \* reserpine
- \* methyldopa
- \* vasodilators
- \* digoxin.

*Drugs which lower blood sugar:*

- \* oral hypoglycemics
- \* insulin.

The risk of a fall is increased when medications have been changed within the past two weeks (Tibbitts, 1996). Adverse drug effects, particularly sedation and dizziness, are usually greater at the initiation of treatment before the body begins to become tolerant to the side effects.

A clinical pharmacist, using a clinical rules system, designed an intervention to reduce the risk of falls in the elderly by identifying patients over age 75 who are at higher risk for falls. Claims data for patients enrolled in a Medicare Supplement plan (approximately 70,000 patients) were examined. Information from both insurance and drug claims was used to calculate a risk index. Each patient's risk factors were evaluated and combined into a risk index:

**Risk index =**

total number of high risk diagnoses +  
total number of high risk medications +

- 1 point for taking 4 or more medications +
- 1 point for taking 8 or more medications +
- 1 point for taking 12 or more medications +
- 1 point if being treated by more than one physician.

Patients with a risk index of 10 or greater were defined as "high risk" for a fall. Claims for 27,052 patients over age 75 (average age = 82.3 years) were reviewed. The average number of drugs per patient was 7.3, and the average number of high risk drugs per patient was 2.1. Patients were seen by an average of 2.3 physicians. A total of 2,211 patients (8%) were determined to be potentially at high risk for a fall.

*Jane Brown was one of these patients, with a risk index of 10. She has osteoporosis (1), cataracts (1) and confusion (1); uses 6 prescription medications (1); uses five high risk drugs [digoxin, imipramine, lorazepam, flurazepam and meclizine](5); and sees two physicians (1). The insurance company sent a letter to each of Jane Brown's physicians requesting that they review her drug regimen and consider any drug changes that would be appropriate to reduce her fall risk.*

### What can be done to reduce the risk of medication-related falls?

Prescribers can reduce fall risk due to medications by:

1. Determining through regular review the indication and ongoing need for each prescribed drug.
2. Discontinuing drugs of questionable benefit with appropriate clinical follow up.
3. Substituting a lower risk drug whenever possible.
4. Identifying patients who are at higher risk for drug adverse events (e.g. advanced age or presumed or documented renal impairment) because of an inability to effectively eliminate a drug effectively or compensate for the drug's effects, and adjusting dosages as needed.
5. Advising patients to be careful when ambulating whenever new drugs are begun.
6. Refraining from using a drug to treat an adverse event of another drug.
7. Adequately treating conditions such as osteoporosis to reduce the risk of injury after a fall.

Patients and their families can reduce fall risk due to medications by:

1. Informing each prescriber and pharmacist of all of the medications being taken, including nonprescription products.
2. Consulting the prescriber whenever an adverse drug reaction may be occurring, especially when confusion or loss of balance is noted. Problems attributed to normal aging may actually be medication side effects.
3. Consulting a doctor or pharmacist when choosing nonprescription products.
4. Exercising caution in the activities of daily living when starting a new medication, especially those that cause sedation, loss of balance, or low blood pressure.
5. Working with the prescriber to reduce the total number of prescription and nonprescription medications.

Another approach to reducing fall risk is a population-based one as described in this case. Using information technology, medical and pharmacy insurance claims data can be evaluated to identify patients at potential risk, and interventions can be designed to reduce that risk.

*Jane Brown visited her primary care doctor to discuss her medications and other health issues. Over the next 6 months, they worked together to reduce her fall risk.*

*\* The digoxin dose was decreased. She had been taking digoxin for more than 10 years. Digoxin is eliminated from the body by the kidneys. Her kidney function had been gradually declining over time. Her dose had become too high, resulting in confusion, dizziness, and drowsiness.*

*\* The prescription for flurazepam was discontinued. Flurazepam is a long-acting benzodiazepine that can accumulate in the elderly. Use should be discontinued gradually because dependence develops with chronic use. Flurazepam can also cause dizziness, confusion, and daytime drowsiness and has been associated with falls in the elderly. Non-medication strategies to alleviate insomnia were implemented.*

*\* Lorazepam was gradually discontinued. Lorazepam is also a benzodiazepine, and the use of two benzodiazepines simultaneously can result in additive toxicity. Lorazepam and flurazepam were prescribed by different doctors, who were unaware that Jane Brown was taking two benzodiazepines. Withdrawal of benzodiazepines can take months and requires a great deal of motivation from the patient and the prescriber.*

*\* Amitriptyline was switched to paroxetine (Paxil®). Amitriptyline has anticholinergic activity which can be associated with sedation, confusion, and impaired cognition in older persons. It may also lower blood pressure. Paroxetine and other SSRI antidepressants have a more favorable side effect profile in the elderly. An antidepressant may no longer be needed after benzodiazepines and anticholinergic drugs are discontinued.*

*\* Meclizine was discontinued. Meclizine was prescribed for dizziness that was probably a medication side effect. Meclizine is also an anticholinergic drug and often causes central nervous system side effects in the elderly.*

*\* Jane Brown was referred to a specialist to evaluate her osteoporosis and obtain appropriate treatment, including weight bearing exercise and strength training.*

*\* Strategies to reduce the risk of fall due to the environment were also discussed.*

## Summary

By working together, patients and their health care providers can reduce the risk of falls. Many factors associated with the individual, the environment, and medications contribute to fall risk. Drug therapy is a modifiable risk factor. A comprehensive review of a patient's drug history often reveals medications that were intended to be discontinued earlier, or were continued because of lack of coordination of care. Patients who appear to be "well controlled" on their current medication regimen may actually be placed

at unnecessarily high risk for adverse drug reactions and falls. Response to medication can change with age-associated changes in physiology. Ongoing monitoring of drug therapy may minimize fall risk.

## Study Questions

1. What risk factors contribute to falls?
2. What types of medications are particularly problematic when it comes to falls?
3. What strategies can be implemented to reduce medication-related fall risk?

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[back to table of contents](#)

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## From the Executive Director, *Virginia Geriatric Education Center*

*Iris A. Parham, Ph.D.*

Since the last issue, the VGEC has been gearing up for the newly funded Geriatric Interdisciplinary Team Training project. On November 20th, representatives from numerous disciplines from VCU and from Bon Secours, Sentara, and EVMS gathered together for a kick-off luncheon to introduce the project and the players to each other. Dr. Cecil Drain, Dean of the School of Allied Health Professions and Chairman of the Department of Nurse Anesthesia, welcomed the participants to the luncheon and to the initiation of the project. Welcomed were: Dr. Dolores Clement, Associate Dean and also representing Health Administration, School of Allied Health Professions; Dr. Victor Yanchick, Dean, School of Pharmacy; Dr. Connie Coogle, Virginia Center on Aging and project evaluator for this grant; Dr. Peter Boling and Dr. David Cifu, Medicine; Dr. Sandy Venegoni, Nursing; Dr. Linda Dougherty, Gerontology; Dr. Linda Baughan, Dentistry; Dr. Otto Payton, Physical Therapy; Dr. Jodi Teitelman and Dr. Al Copolillo, Occupational Therapy; Dr. Mary Ann Kirkpatrick, Pharmacy; Dr. Dick Luck and Dr. Margaret Glenn, Rehabilitation Counseling; Ms. Kathy Beall and Ms. Bonnie Jorde, Bon Secours; Mr. Bill Miller, Sentara; Ms. Madeline Dunston, EVMS; and VGEC staff, Dr. Joan Wood, Ms. Jen Worthington and myself.

On December 3rd, the next meeting was held in Williamsburg for a first set of core team trainers with

Mr. Bill Miller, Sentara; Ms. Paula Galvan, Bon Secours; Dr. Peter Boling, Medicine; Dr. Sandy Venegoni, Nursing; Dr. Ellen Netting, Social Work; Dr. Patti Slattum, Pharmacy; and VGEC staff, Dr. Wood, Jen Worthington and myself. This group took a first step in outlining a geriatrics overview staff training session for Sentara at Norfolk General in March and for Bon Secours (Richmond) in April. In May, the second training program will be a joint session for both facilities on interdisciplinary case management to be held in Williamsburg. The project is off to a good start with many great colleagues as collaborators.

*Ageing of the Baby Boomers*, was broadcast on local public television on January 14th. This is the culmination of three years of work on this project funded by the MCV Foundation of VCU. The VGEC, in conjunction with the Virginia Department of Social Services, has planned extensive statewide medication management training for the coming months. Please call the VGEC at (804) 828-9060 for details. We are looking forward to an exciting 1998.

[back to table of contents](#)

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## From the Director, *Virginia Center on Aging*

*Edward F. Ansello, Ph.D.*

The turning of the year always causes me to review the twelve months just ended. For the Virginia Center on Aging, 1997 was a productive year. Just a few examples: in education, we expanded our rich menu of Elderhostel course offerings and, in the Spring, added a new site, Mountain Lake in Giles County; in 1997 we drew about 2,500 non-Virginians to Virginia for our Elderhostel programs. At the same time, we broadened our lifelong learning activities locally with two multi-week non-credit courses at the Cedarfield retirement community. In research, the Alzheimer's and Related Diseases Research Award Fund (ARDRAF) stands out. VCoA has administered ARDRAF since its creation by the General Assembly in 1982. In its 1997 Session the General Assembly increased ARDRAF's appropriation so that we can now award four seed grants of \$16,500 each year to stimulate basic, clinical, psychosocial, and other research on dementing illnesses. ARDRAF has become such a productive agent for creative pilot research that, on average, grantees generate about \$6 in subsequent research awards for every \$1 they receive from ARDRAF. This is a remarkable rate of return. In training, VCoA completed its

2 1/2 year project on Home and Community Based Care. Funded by the U.S. Administration on Aging and ably directed by Michael Pyles and Shobha Shenoy, this project conducted many workshops across Virginia, from Tidewater to Lynchburg, for rural and minority Virginians on the keys to remaining in one's own home with advancing age and on advocacy. VCoA conducted two additional workshops out of its own resources after the federal support ended. In a related vein, we were pleased to learn late in the year that the Virginia Geriatric Education Center has been awarded three years of federal support for work on interdisciplinary geriatric team-building. VCoA is a partner in this initiative. Finally, on the home office front, we have grown intellectually and in project capacity with the addition of Paula Knapp

to our staff last January. Paula is an economist, completing her Ph.D. at Johns Hopkins, who brings a special expertise to our focus on the costs and benefits of family caregiving.

And now we look forward. To past and future friends, we wish a productive year ahead.

[back to table of contents](#)

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

*Ann Y. McGee, Ed.D.*

What a great pleasure it is for me to be able to "speak" to so many of you through the medium of this excellent newsletter. First of all, I want to let you know how excited I am to be working once more in the field of aging and how honored I am to be Virginia's new Commissioner of Aging. I will work hard to provide Virginia with a vision of aging in the 21st century that includes physical activity, a healthy lifestyle, spirituality, intergenerational sensitivity, and a commitment to the larger community.

Second of all, I want to tell you just a little about myself. I was born and raised in Richlands, Virginia, so I have some insight into the unique problems facing rural Virginians. As the executive director of the Council on Aging in Raleigh and Wake County, NC, I also dealt with the problems that impact the urban and suburban elderly. I am also familiar with the many issues surrounding the rising cost of health care from my years as the director of the Commonwealth's former Health Care Cost Review Council. In addition, I spent a short time as the president of the Virginia Association of Nonprofit Homes for the Aging. Finally, I will continue for an indefinite period as the acting director of the Governor's Employment and Training Department where we are working out the details of a multi-million dollar federal grant that will have a major impact on Virginia's welfare-to-work efforts. So you see, I have a wide variety of experiences that I can bring to my work here at the Department for the Aging.

Last of all, I want to assure you that I am committed to bringing my best efforts to bear in providing leadership on the issues before us. I will work with you to strengthen our network and serve our constituents in the best possible ways. I hope to travel around our Commonwealth this coming Spring and Summer to meet you, hear directly from older Virginians and their families, and observe programs in operation. In the meantime, please do not hesitate to share your ideas with me. Although I am extremely busy with the business of two agencies, I will make the time to read your letters and memos.

[back to table of contents](#)

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## Focus on the Virginia Geriatric Education Center

*Michelle Utterback*



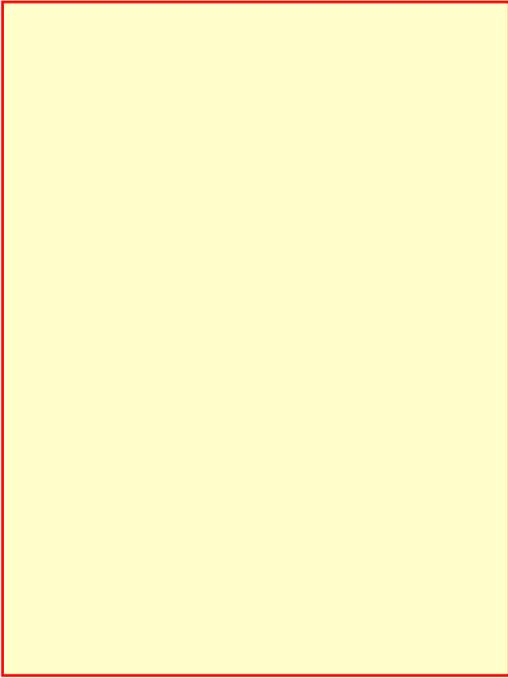
Michelle Utterback is the Office Services Specialist for the Virginia Geriatric Education Center. She has been with the Center since mid-1994. She came to Richmond from her home in Fairfax, Virginia in 1989 to pursue a psychology degree at Virginia Commonwealth University. Serendipity brought her to the VGEC in a part-time position. She steadily assumed more responsibility becoming an integral part of the Center. Her major duties pertain to the Center's contract with the Virginia Department of Social Services. She manages the statewide database for Medication Aides at adult care residences, and Facility and Master Trainers. The database is intended to ensure quality control over persons certified to dispense medications at adult care residences. She also provides logistical support for all of the other programs administered by the VGEC for professionals in the field of aging. These include such programs as training for all staff at adult care residences and the distance learning program for the Certificate in Aging Studies.

[back to table of contents](#)

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**Focus on the Virginia Center on Aging**

*William F. Egelhoff*



Bill Egelhoff has a distinguished record of service to Virginia's older adults. After graduating with a bachelor's degree from Williams College in 1940, and an MBA from Harvard University in 1943, he spent three years on active duty with the U.S. Navy. After his tour of duty, he pursued a career in insurance for seven years. Finding his calling to be elsewhere, he attended Virginia Theological Seminary in Alexandria and became an Episcopal minister. Completing seminary with an M.Div., he served for 15 years in parish ministry, eight years of which were in Williamsburg. In 1971, he joined the staff in the Gerontology Section of the Division of State Planning and Community Affairs (the agency precursor of the Virginia Department for the Aging), just as gerontology was beginning to be recognized as a professional field and discipline. He was responsible for implementing in Virginia the 1969 amendments to the Older Americans Act, establishing SEVAMP, one of the first area-wide model projects in the country. He coordinated services for the aging with other agencies at the state level and developed plans for the Virginia network of area agencies on aging.

In 1974, he joined the faculty at Virginia Commonwealth University to help start the M.S. program in Gerontology, the first such program in the eastern United States. The program was up and running by 1976. He taught graduate classes on problems, issues, and trends and on aging, ethics, and human values. In 1978, he started the first Elderhostel programs in Virginia. Elderhostel had only started three years prior to this, but Bill recognized the great potential for educational opportunities which Elderhostel afforded to older learners. From only two Virginia sites in 1979, the Commonwealth now boasts 70 Elderhostel sites. Bill served as the Virginia state director for Elderhostel through the Virginia Center on Aging while maintaining a joint appointment with the Department of Gerontology. In addition to these duties, he assumed the directorship of the Virginia Center on Aging in 1986. He phased out of these three roles over the next few years, until he was fully retired from state service by mid-1990.

Since retiring, he has attended numerous Elderhostels, showing a strong loyalty to our Virginia programs. He continues to volunteer his services as an Episcopal minister at St. Michael's in Bon Air,

and even finds occasional opportunities to serve as a chaplain on cruise ships. Fortunately for us, he continues to serve on the VCoA Advisory Committee and maintains his interest in issues of concern to older Virginians. He and Dot, his wife of 23 years, are enjoying their time and lives together.

[back to table of contents](#)

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## Focus on the Virginia Department for the Aging

*Robert D. Biggs*

When the dreaded error messages appear on the computer screens of Department for the Aging staff, the first person they call is Robert "Robbie" Biggs. Robbie is a Management Analyst and the resident computer guru with the Virginia Department for the Aging. This native of Martinsville grew up in Patrick County. He started his university student career at Virginia Tech, but soon switched to the Commonwealth's urban university - VCU. He received a bachelor's degree in Finance in 1993 and is continuing his education by working towards a Certificate in Information Systems.

At the VDA, Robbie is a fitness nut in an agency of mostly couch potatoes. He runs, lifts weights, plays tennis, and bowls. He recently ran in the Richmond Times-Dispatch Marathon as part of a relay team. His team finished 16th out of 32 teams that participated. "It was only the second time I had ever competed in any organized race and my excitement and nervousness got me to the finish line," he told colleagues the next day as he limped down the hall.

Robbie also has a soft spot in his heart for hurt or abandoned animals. He recently rescued a cold, frightened black lab mix puppy that he found shivering at a local tennis court. He took the 15 week old pup to the vet and then home to become a temporary member of his growing family of canines which already included a 2 year old Akita and an 18 month old chocolate lab and coon hound mix. Robbie successfully placed the pup in an adoptive home in his East End neighborhood.

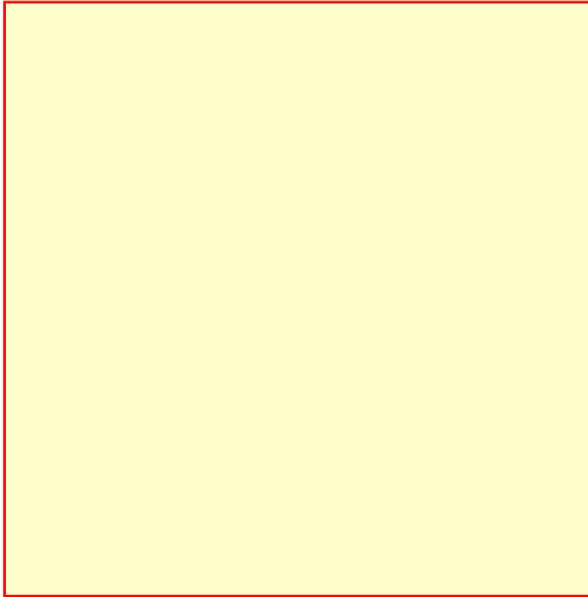
Robbie first came to work for the department in January of 1991 as a VCU work-study student. The department subsequently brought him on board as a full time employee a year later.

Robbie brings a quiet confidence to his work at the department. Whether he is updating the department's web page or analyzing service utilization data provided by local Area Agencies on Aging, he is always eager to provide assistance to the "computer impaired" among his coworkers.

[back to table of contents](#)

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## Profile of: The Department of Occupational Therapy, Virginia Commonwealth University, Medical College of Virginia Campus



left to right: Al Copolillo, OTR, Ph.D., Jodi Teitelman, Ph.D., Janet Watts, OTR, Ph.D.

The current involvement of three full-time and two adjunct faculty from the Department of Occupational Therapy at Virginia Commonwealth University in gerontological issues reflects the Department's long-standing interest in the field of aging. Two faculty members, Janet Watts, OTR, Ph.D. and Jodi Teitelman, Ph.D. earned Certificates in Aging Studies from the Department of Gerontology at VCU. Al Copolillo, OTR, Ph.D. joined the faculty this academic year as an Assistant Professor. Lori Shiffman, OTR, an Adjunct Faculty member also completed the Certificate program. Additionally, Carolyn Velletri, OTR, another Adjunct Faculty member has a private practice treating primarily older adults and is a board member of Stuart Circle Day Services.

Janet Watts, now an Associate Professor and member of the OT faculty since 1977 has published articles on assistive device use and volition, activity patterns, and life satisfaction in older adults in the American Journal of Occupational Therapy and Physical and Occupational Therapy in Geriatrics. She also wrote and edited cases for Motivational Strategies in Geriatric Rehabilitation, published by the American Occupational Therapy Association (AOTA) in 1997.

Jodi Teitelman, who joined the OT faculty as an Associate Professor in 1995 taught in the VCU Department of Gerontology from 1983-1991. She and Dr. Iris Parham edited a series of curriculum resource guides in geriatrics, two of which were later published and distributed by AOTA. Jodi and Janet are currently working with three graduate students to conduct focus group studies under the auspices of the Alzheimer's Association to determine caregivers' perceptions of gaps in service coverage and the impact of this on occupational functioning. Jodi is a Board Member of the Alzheimer's Association of Greater Richmond and chairs the Patient and Family Services and Medical And Scientific

## Review Committees.

Al Copolillo, who joined the faculty this year as an Assistant Professor, also has a strong identification with gerontology. Al is currently extending his doctoral dissertation research which looked at patterns of assistive device use in the gerontological population. His current focus is on qualitative approaches to studying use of mobility devices in community-dwelling African-American older adults. This project was recently awarded funding by the A.D. Williams Foundation.

Currently, undergraduate and graduate students in occupational therapy receive exposure to gerontology content throughout the curriculum. All students are required to complete a two-credit hour course in normal adult development and aging, and their impact on occupational functioning. The in-depth courses on adult psychosocial dysfunction and physical disabilities also have a strong adult/older adult focus. Before graduating, all students also learn about the health and long-term care systems and the potential role of occupational therapy in various practice sites along those continua.

The Department is currently in the process of reevaluating and restructuring its educational program. One of the goals of this process is to re-establish a post-professional Master's degree program to include a specific gerontological consultation and education track, as well as one in pediatrics. It is hoped that this specialized program will accept its first applicants in 1999. Faculty are also preparing curricula in aging for the proposed interdisciplinary doctoral program for the School of Allied Health Professions.

The OT Department has continually maintained a commitment to and involvement in gerontological issues in response to the "demographic imperative" of most rehabilitation settings. To that end, faculty have enjoyed a long-standing association with the VCU Department of Gerontology, the Virginia Center on Aging, and the Virginia Geriatric Education Center, and look forward to continuing these collaborations.

[back to table of contents](#)

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## Are You Aware of Possible Instances of Waste, Fraud, and Abuse in the Medicaid or Medicare Programs?

*Bill Peterson*

Although Mrs. Jones (not her actual name) had no problems walking or riding the bus, a fully equipped emergency-response ambulance provided transportation to a routine medical appointment. Medicaid was subsequently billed several hundred dollars by the ambulance company for the trip. Mrs. Jones' care manager became alarmed when she discovered that the same company was providing for all of Mrs. Jones' transportation needs and that each trip was in a fully equipped ambulance. The care manager called the state Operation Restore Trust coordinator to share her concerns. The state coordinator linked

the care manager with the state's Attorney General. The Attorney General, in cooperation with the federal Office of the Inspector General, investigated the billing practices of the ambulance company and an out-of-court settlement resulted in several hundred thousand dollars being returned to the Medicaid program.

Mr. Smith (not his actual name) was told that Medicare would purchase a sophisticated air mattress for his mother's nursing home bed and that the mattress would prevent bed sores. Soon after this, he was reviewing his mother's Medicare paperwork and noticed that the Medicare program had been billed for several thousand dollars. Yet his mother had received only a thin foam "egg crate" pad for her bed. Angered by what he felt was an obvious case of abuse, he contacted his state's *Operation Restore Trust* coordinator. The coordinator helped him convey his story to the Attorney General's office which was able to recoup nearly a million dollars from the durable medical equipment supplier who had provided the cheap foam pad.

These instances of questionable billing practices by health care service providers may be the just the tip of the iceberg according to the Inspector General's office in Washington, DC. Fraudulent billing practices in both the Medicare and Medicaid programs cost taxpayers \$40 billion every year. The President, Congress, and the Secretary of Health and Human Services have all made health care fraud a national priority. The President announced his campaign to stop waste, fraud, and abuse during the 1995 White House Conference on Aging. The president has called his anti-fraud initiative **Operation Restore Trust (ORT)**. A critical component of the ORT initiative is the active involvement of those of you who work in the aging, health care, and human services networks and other organizations that focus primarily on providing services to older citizens. Virginia has recently received a grant from the Administration on Aging to educate the aging network about health care fraud. Through your daily contacts with older individuals, you and your staff can, in turn, educate hundreds of consumers and their families about how to recognize and report suspected Medicare and Medicaid fraud.

The Virginia Department for the Aging and the Virginia Association of Area Agencies on Aging are working together to make information about health care fraud, waste, and abuse available to health and human services staffs as well as to older consumers and their families. The statewide coordinator for these activities is **Marian Dolliver**. Ms. Dolliver is a licensed social worker with many years experience in aging and long-term care. Under her direction, a number of regional training events targeted to ombudsmen, health insurance counselors, case managers, outreach workers, and other staff are being planned. In addition to providing training, Ms. Dolliver will also act as the statewide coordinator for referring suspected instances of fraud or abuse to the Office of the Attorney General.

Over the coming months, Ms. Dolliver will be providing you with additional information about Virginia's ORT project. She will be sharing specific material about health care fraud and scheduling training sessions to educate staff about how to spot suspected cases of fraud or abuse. In the meantime, you should feel free to contact Ms. Dolliver at **(804) 644-2804** if you suspect waste, fraud, or abuse in Medicare or Medicaid, or if you want additional information about this issue.

[back to table of contents](#)

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## The Proposed Virginia Public Guardian and Conservator Program

*Bill Peterson*

What do the homeless woman rummaging through the restaurant dumpster and your local Sheriff have in common? Both may have been subject to a decision by their local Circuit Court judge. A decision which may have found the homeless woman to be incompetent and the Sheriff to be her "guardian of last resort." After years of study, however, the 1998 session of the General Assembly will consider legislation to implement a public guardianship program in Virginia. This program will provide a public guardian or conservator for those persons incapable of making decisions, whose finances are insufficient to compensate a private guardian, and for whom there is no willing and responsible person to serve as their guardian. The public guardian/conservator program will replace the Sheriff as the guardian of last resort.

Senate Document #23 verified the need for public guardians in Virginia in 1990. Traditionally, however, local Sheriffs have served as the Commonwealth's guardian of last resort. Recent Code changes will terminate the statutory authority of the courts to appoint the Sheriff after January 1, 1999. Also, data gathered from January through August of 1997 by researchers from Virginia Tech found that 1,425 persons needed a public guardian and another 1,414 persons needed some other type of surrogate decision making services such as power of attorney.

Through a bipartisan effort in cooperation with the Virginia Guardianship Association, the 1995 General Assembly approved funding for two demonstration projects that attempt to develop a system of public guardianship for persons in need of guardianship but for whom no guardians were available. These projects were a response to the growing concern over the appointment of the local Sheriff as the guardian of last resort for many low-income Virginians in need of guardianship. Both projects began receiving funding in July of 1995 and have received additional funding to operate through June of 1998. A third project also began receiving funding in 1997. These projects have demonstrated that there are alternative ways to meet the needs of incapacitated individuals other than by having the Sheriff appointed as the guardian of last resort.

The proposed public guardianship program will provide general funds to the Virginia Department for the Aging (VDA) to develop a statewide system of local or regional public guardian/ conservator programs to serve eligible adults of all ages. The statewide program will have the following characteristics:

- \* A fifteen member statewide Advisory Board will assist in the coordination and management of Virginia's new public guardianship program.
- \* The VDA will have the option of entering into a contract with either a public or private nonprofit organization for the administration and day-to-day operation of the program.

- \* Funding will be provided to local/regional programs based upon an RFP process - as many as 7 new local/regional programs may receive grants.
- \* Local/regional public guardianship programs funded under this initiative will be required to have a maximum staff to client ratio of 1:20 (not including volunteers).
- \* Local/regional public guardianship programs will have all the powers and duties specified in the adult guardianship sections of the Code (Chapter 4 - Sections 37.1-134 et seq.).

Support for the Public Guardian and Conservator Program comes from the Virginia Bar Association, the Virginia Guardianship Association, the Virginia Coalition for the Aging, and the Virginia Association of Area Agencies on Aging. For more information about this legislation, call Bill Peterson at the Virginia Department for the Aging: (804) 662-9325.

[back to table of contents](#)

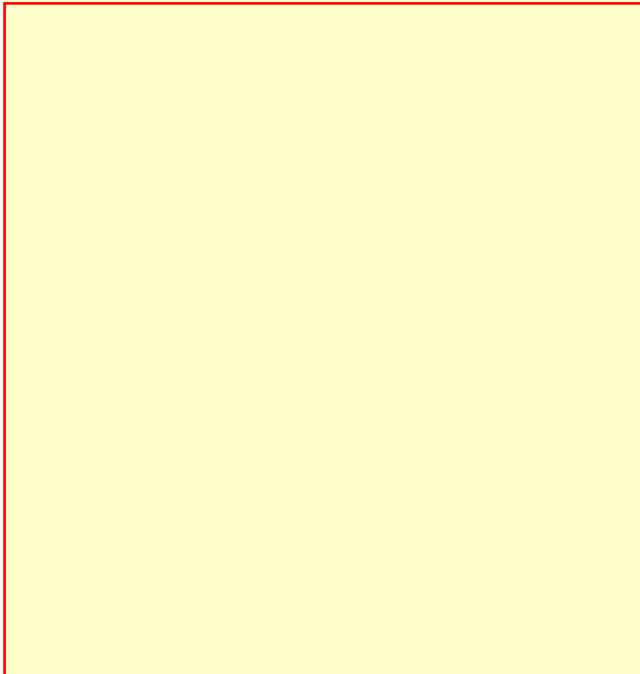
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## The Virginia Center on Aging Recognition of The Honorable Hunter B. Andrews for his service to benefit older Virginians

The Virginia Center on Aging had the pleasure of honoring former Senator Hunter Andrews on October 16, 1997 in a luncheon reception at the Chamberlin Hotel attended by former colleagues in the General Assembly, VCU officials, VCoA's Advisory Committee and University Council, and many others. Senator Andrews was for 32 years a friend of older Virginians and aging-related issues when they came before the General Assembly. As chairman of the Senate Finance Committee, Senator Andrews kept a keen eye on matters related to the well-being of Virginia's elders and their families. He encouraged the work of the Virginia Center on Aging, itself a creation of the General Assembly, and championed its initiatives in lifelong learning, research on aging, and aging-related information dissemination. He saw the contributions to science and to everyday life of the Alzheimer's and Related Diseases Research Award Fund which our Center has administered for the Commonwealth since 1978. More than once he defended the continuation of the Virginia Center on Aging's diverse undertakings during the budgetary process.



Guests at the ceremony: (l to r): Del. Vincent Behm, Sen. Henry Maxwell, Former Del. Pete Giesen, Del. Flora Crittenden, Former Sen. Hunter Andrews, Del. Mary Christian, U.S. Rep. Robert Scott, Dr. Edward Ansello, Sen. Yvonne Miller, Del. Phillip Hamilton



Right: Dr. H.H. Newsome (left) presents the plaque to Senator Hunter Andrews in honor of his long-time support for aging issues. The plaque reads:

Virginia Commonwealth University  
and

The Virginia Center on Aging  
Recognize  
The Honorable Hunter B. Andrews  
Senator, Virginia General Assembly  
(1964-1996)  
for  
his leadership in and contributions to  
aging-related research, education,  
and service to benefit older Virginians  
and their families, and his defense  
of their quality of life  
October 1997

Comments by H.H. Newsome, M.D.  
Senior Associate Dean, School of Medicine  
Virginia Commonwealth University

We are gathered to recognize the Honorable Hunter B. Andrews and to celebrate his public career of 32 years in the Senate of Virginia. We honor Senator Andrews for his significant contributions to older Virginians and to aging-related research, education, and service. At the same time, however, we acknowledge that his concern for the well-being of Virginians extends to the whole course of life. His commitment to excellence in education - from elementary school level through postgraduate to lifelong learning - exemplifies this concern.

Senator Hunter Andrews was first elected to the General Assembly from Hampton in 1964. During his noteworthy tenure in the Senate of Virginia, he made his impression on the scope and direction of legislation and helped to forge Virginia's General Assembly into one which consistently has earned one of the highest levels of public confidence of any state assembly in the country. In the Senate, he has served as Chairman of the Finance Committee, Education and Health Committee, Privilege and Elections Committee, and Courts of Justice Committee. He was Majority Leader of the Senate from 1980 to 1996.

From the beginning of his public life, Senator Andrews has been dedicated to education. Indeed, his first election to the Senate closely followed ten years of service as a member and chairman of the City of Hampton School Board. In addition to his leadership on the Senate Education and Health Committee, he has served on the Executive Committee of the Southern Regional Education Board and was Vice Chairman of the Education Commission of the States.

Closer to home, his well-established concern for education and for older Virginians expressed itself in 1987 when the Virginia Center on Aging faced the prospect of no funding for its operations at the close

of ten years of support by Virginia Commonwealth University through its internal overhead accounts. Senator Andrews stepped forward and secured a line item budget for the Virginia Center on Aging in the 1988-90 biennium. During the fiscal crisis of the early 1990s, Senator Andrews saw the overriding need for the work that the Virginia Center on Aging accomplishes. As Chairman of the Senate Finance Committee, Senator Andrews kept a keen eye on matters related to the well-being of Virginia's elders and their families. He encouraged the work of the Virginia Center on Aging, and championed its initiatives in lifelong learning, research on aging, and aging-related information dissemination. He saw the contributions to science and to everyday life of the Alzheimer's and Related Diseases Research Award Fund which the Center has administered for the Commonwealth since 1978. More than once he defended the continuation of the Virginia Center on Aging's diverse undertakings during the budgetary process. Similarly, he defended the operation of the Virginia Department for the Aging against those who sought to achieve short-term savings at the expense of our longest lived citizens.

It is no exaggeration to say that Senator Andrews has always had the vision to see clearly how well programs like the Virginia Center on Aging and the Virginia Department for the Aging serve the Commonwealth's families and elders. In the case of the Virginia Center on Aging, his vision and commitment have meant the continuation of a robust research agenda, an expansive array of opportunities for lifelong learning across Virginia, and pioneering initiatives in the areas of aging with disabilities, and family caregiving of relatives with impairments. These have been accomplished with a special emphasis on Virginians whose needs historically have been the least likely attended to, namely, rural and minority Virginians. It is reasonable to conclude that the work that we do **now** to benefit older Virginians and their families would not be possible without the work that he did **then** during his tenure in the Senate.

[back to table of contents](#)

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## Calendar of Events

### January 27, 1998

Older Virginians Day at the General Assembly. For more information, contact Bill Peterson, Virginia Department for the Aging, (804) 662-9325.

### March 20-22, 1998

*Recent Advances in Geriatrics*. The Ninth Annual Williamsburg Geriatrics Conference. The American Geriatrics Society. Contact Janis Todd, at McGuire Research Institute, (804) 675-5365.

### March 25-28, 1998

*Critical Choices: Charting a Course for the Age Boom*. 44th Annual Meeting of the American Society on Aging, in San Francisco. Contact the American Society on Aging at (415) 974-9600.

### March 29-April 2, 1998

*Partnering for the Future: Vital Aging.* 48th Annual Conference of the National Council on the Aging. Held in Washington, D.C. Contact the NCOA at (202) 479-6991.

### April 6-7, 1998

*The New Guardianship Code: Making it Work.* The 7th Annual Conference of the Virginia Guardianship Association Conference, in Richmond, VA. Contact the VGA at (804) 828-9622.

### April 15-18, 1998

*Fresh Approaches to Aging in the South: New Contexts, New Tools, and New Relationships.* 19th Annual Meeting of the Southern Gerontological Society, in Chattanooga, TN. Contact SGS at (850) 222-3524.

### June 11, 1998

The 4th Annual Virginia Coalition for the Prevention of Elder Abuse Conference, in Richmond, VA. Contact Joy Duke at (804) 692-1260.

### June 28-July 1, 1998

The 15th Annual Summer Series on Aging, sponsored by the Sanders-Brown Center on Aging, University of Kentucky, Lexington, KY. Contact Mattie Umscheid at (606) 257-8301, mumsch@pop.uky.edu.

[back to table of contents](#)

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## New Films Available from the Information Resources Center

The Virginia Center on Aging has added two new films to its lending library collection. The first is called *Caring...Sharing: The Alzheimer's Caregiver* (1987, 38 minutes). It investigates what it means to be a caregiver, to be the "second victim" of Alzheimer's Disease. Fears and frustrations as well as joyful moments and caregiver growth are examined. This film looks at the problems associated with caregiving for an Alzheimer's patient and offers solutions. The second new video in the collection is *My Mother, My Father: Seven Years Later* (1991, 42 minutes). The predecessor to this film, *My Mother, My Father* (1984, 33 minutes), is one of our most popular loaners. It is an examination of four families and their feelings as they deal with the stresses of caregiving. The new film looks at the same four families seven years later. Changes in family dynamics and caregiving needs as well as the aging of the caregivers are examined. This film shows a unique perspective of caregiving relationships and how they change over time.

To find out about borrowing these or any other films, or to get a copy of the most recent film list, contact Kimberly Smith at (804) 828-1525, or kspruill@hsc.vcu.edu.

[back to table of contents](#)

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## Request for Proposals: Alzheimer's and Related Diseases Research Award Fund

### Purpose:

The Award Fund has been established by the Commonwealth of Virginia to promote research into Alzheimer's and related diseases. Because of a commitment to program balance, scientifically rigorous applications from a variety of disciplines are desired. Studies may involve:

- the underlying cause, epidemiology, diagnosis, or treatment of the disease
- state policies, programs, financing for care and support of those affected by the disease
- social and psychological impact upon the individual, family, and community

### Funding:

Awards are limited to \$16,500 each. Number of awards is contingent on available funds.

### Eligibility:

Applicants must be employed by colleges, universities, research institutes, or other not-for-profit organizations located in Virginia.

### Schedule:

A nonbinding letter of intent with tentative title and abstract is requested by March 4, 1998. Applications will be accepted through April 1, 1998. Applicants will be notified by June 19, 1998. Funding begins July 1, 1998; the project must be completed by June 30, 1999.

### Review:

Proposals will be reviewed for scientific merit by three qualified technical reviewers, one of whom is selected by the applicant. The Awards Committee will evaluate project significance and make the final funding decision.

### Application:

Application forms, guidelines, and further information can be obtained by contacting:

Constance L. Coogle, Ph.D.  
Alzheimer's and Related Diseases Research Award Fund  
Virginia Center on Aging Phone: (804) 828-1525  
P.O. Box 980229 FAX: (804) 828-7905  
Richmond, VA 23298-0229 e-mail: ccoogle@gems.vcu.edu

The forms and guidelines are also available on our web site at <http://views.vcu.edu/vcoa/ardraf.htm>.

[\*back to table of contents\*](#)

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Responses to case studies and comments on other newsletter features are invited and may be published in a future issue. Please include your name, title, institution, and signature. Mail comments to: Michael P. Hite, Age in Action, P.O. Box 980229, Richmond, VA 23298-0229, 804/828-1525, fax to 804/828-7905, or e-mail to [mhite@hsc.vcu.edu](mailto:mhite@hsc.vcu.edu).

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Virginia Commonwealth University is an equal opportunity/affirmative action institution and does not discriminate on the basis of race, gender, age, religion, ethnic origin, or disability. If special accommodations are needed, please contact Dr. Edward F. Ansello, VCoA, at 804/828-1525 or Dr. Iris A. Parham, VGEC, at 804/828-1565.

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