Volume 25 Number 1 Winter 2010

age in action

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

Case Study

Aging and the Behavioral Problems of Brain Injury

by Paul F. Aravich, Ph.D., and Marylin Copeland, M.S.W., C.B.IS.

Educational Objectives

1. List the various classes of brain injury.
2. Identify cognitive and emotional problems as among the most common and disabling complications of brain injury.
3. Assess challenges to successful aging with a brain injury.
4. Examine the consequences of inadequate systems of care for the challenging behaviors produced by brain injury.

Background

Within the global aging phenomenon there is a dramatic expansion of persons aging with disabilities, many of whom will live well past the age of 65. Unfortunately, the care of persons with disabilities often focuses on the disability itself, without an emphasis on other factors that promote successful aging, such as adequate social supports, environmental enrichment, wellness programs, and chronic disease screening (Aravich and McDonnell, 2005; Surgeon General, 2005). Consequently, the Surgeon General (2005) has sounded a call to action to address this unmet need for continuity of care, health disparities, and wellness programs. This call stresses replacing the "illness" model of disability with a more holistic person-centered approach that goes well beyond the disability and embraces a broader biopsychosocial view of the individual. This includes accommodations related to housing, transportation, assistive technologies, social supports, and more. Clearly, there are significant challenges in promoting successful aging in persons with disabilities. Just as clearly, there are significant consequences for failing to do so. Adults with brain injuries would greatly benefit from this more holistic approach.

Classes of Brain Injury

There are typically three main classes of brain injuries: developmental, acquired, and degenerative. Developmental brain injuries include cerebral palsy, Fragile X syndrome, and trisomy 21 (Down syndrome). Acquired brain injuries (ABI) include injuries secondary to, among other things, oxygen deficiency (e.g., cardiac arrest), metabolic insult (e.g., liver failure), infections (e.g., meningitis), and brain tumors. However, stroke and traumatic brain injury (TBI) are the most common causes of ABI, with more than 250,000 Virginians over the age of 18 living with their consequences. The third class of brain injuries is degenerative brain injuries, which include Alzheimer's disease and Parkinson's disease. Increasingly, two additional classes of brain injury are defined because of underlying biological pathologies: mental illness and substance-related disorders. Collectively these various classes of brain injury are a major cause of disability in non-institutionalized Americans over the age of 18.

Cognitive and Emotional Problems

Cognitive and emotional problems are among the most prevalent and disabling complications of any

Inside This Issue:

form of brain injury. Individuals who lack cognitive capacity require surrogate decision-makers. In Virginia, court-appointed public guardians are the guardians of last resort and serve over 600 incapacitated adults who are both indigent and have no one to take care of them; an estimated 1400 additional people are in need of public guardians. Most of the adults in the program (about 2/3) are under the age of 60 and diagnosed with developmental brain injuries. Many of these individuals will live well past the age of 65.

Challenging behaviors are the most problematic complications of the cognitive and emotional consequences of brain injury. While extremely challenging behaviors occur in a minority of persons, they are an immense source of suffering, caregiver stress, and institutional difficulties. One cannot overstate the implications for geriatrics and gerontology of the rapid expansion of persons aging with the behavioral complications of the various forms of brain injury. The issue of TBI provides a case in point. Because of advances in emergency medicine and surgical care, countless individuals are alive today who would have otherwise died. These include children who suffered accidents, as well as veterans returning from the war on terrorism. Indeed, the signature injuries from this war are TBI and post-traumatic stress disorder (PTSD). Mild TBI (also known as concussion) greatly increases the risk of PTSD, which can become a lifelong disability, impairing cognitive and emotional function. Contrary to popular belief, the problems of persons with TBI do not go away when discharged from the hospital; in many ways their problems are just beginning. A statewide survey of individuals living with an acquired brain injury (ABI) in Virginia found that their principal concern was the failure of health professionals to appreciate this fact.

Traumatic brain injury can produce a variety of physical complications, including those related to mobility problems and risk of falling. But TBI can produce a variety of "hidden" cognitive and emotional complications, which are called neurobehavioral problems in the ABI field (a term that we think should be replaced with the more empirical description of "behavioral complications"). A recent position paper for the Virginia Brain Injury Council concluded that there is effectively no system of care for the cognitive and emotional consequences of ABI. Individuals with these problems are often shuffled between neurologists who believe these problems are best treated by psychiatrists, and psychiatrists who believe these problems have an organic basis and are best treated by neurologists. This brain-behavior dualism relates to what others have called "a mindless neurology and a brainless psychiatry," resulting in a tragic array: treatment providers who are not properly trained in the unique issues of ABI; institutional settings that are not designed to treat these problems and may exacerbate them; and overly restrictive pharmacological or physical environments. Persons with challenging behaviors due to the other kinds of brain injury, including Alzheimer's disease, suffer from the same lack of expertise and care. Virginia has a number of dedicated neurobehavioral facilities with nationally recognized experts and vacant beds. However, there is no Virginia Medicaid waiver to follow indigent people into these facilities. Instead, the person must first be rejected from all of the several hundred long-term care facilities in the Commonwealth before Medicaid will support treatment in an out-of-state neurobehavioral facility.

Shortage of Expertise

It is clear that we need more experts and facilities specifically dedicated to the cognitive and emotional complications of all forms of brain injury, including the behavioral complications of Alzheimer's disease. Needs include more physicians trained in the new field of neuropsychiatry; more experts in so-called positive behavioral controls to identify the environmental triggers for challenging behaviors; better training in the unique pharmacotherapeutic approaches necessary to deal with challenging behaviors produced by the classically defined forms of brain injuries; and specialized treatment facilities, which differ significantly from skilled-nursing facilities and psychiatric hospitals.

Implications for Successful Aging

The lack of training in the post-acute complications of TBI, in particular, has a number of implications for successful aging. For instance, the single largest cause of TBI across all age groups is falls, with the number one cause of TBI deaths in older people also being falls. Older frail people as well as younger persons with disabilities are at increased risk of falls and,

therefore, at increased risk for TBI. Consequently, fall risk assessment and fall prevention strategies go well beyond the issue of fractures and are a major concern for the promotion of brain fitness and successful aging. Furthermore, it is not infrequent that an older person with cognitive impairment secondary to an undiagnosed TBI is misdiagnosed as having Alzheimer's disease. Finally, the lack of a behavioral system of care for challenging behaviors frequently results in overly restrictive interventions, the lack of transitional care, and significant caregiver and institutional stress.

Based on these considerations, it would be expected that there is a major research emphasis on the promotion of successful aging in persons with TBI and in the long-term outcomes for this population. Surprisingly, the literature shows a paucity of truly long-term studies. Those that do exist frequently define long-term as five or 10 years post-injury despite the fact that many people live multiple decades with these injuries. The issues of seizure disorders and choking hazards are clearly important in this population, but so, too, are the issues of heart disease, diabetes, Alzheimer's disease, Parkinson's disease, and depression (see Aravich and McDonnell, 2005).

For instance, a focus on the TBI at the expense of healthy eating or regular physical examinations increases the risk of various chronic diseases. There is a substantial increased risk for Parkinson's disease and Alzheimer's disease in younger people who age with moderate to severe TBI. Repeated mild TBI in younger people is correlated with cognitive impairment in later life. Nearly half of all TBI is associated with alcohol abuse, either by the person who is injured or by the person who caused the injury. Alcohol abuse and depression are risk factors for Alzheimer's disease, as well as for TBI. Traumatic brain injury secondary to a failed suicide is highly correlated with depression. And, nearly half of all persons with Parkinson's disease suffer significant cognitive and emotional problems. The interrelationships and co-morbidities among these various forms of brain injuries demonstrate the complexity of promoting successful aging in this population and the need for multidisciplinary biopsychosocial approaches.

Case Study #1

Mr. Z, a frail, 84 year-old man living with his wife of 58 years, had mild cognitive impairment, unipolar depression, and end-stage congestive heart failure. He was diagnosed with emphysema five years ago and has PTSD related to his service in World War II. On the day before he was scheduled to have cataract surgery, he fell down the stairs. His wife did not remember how seriously he was injured but no 911 call was placed. Shortly thereafter, he began exhibiting cognitive problems and challenging behaviors, at which time he was misdiagnosed with Alzheimer's disease. The diagnosing physician did not refer the couple to the support services of the local Alzheimer's Association and of the Area Agency of Aging. Mr. Z. eventually tried to kill his wife, who called local law enforcement officials. He was handcuffed and detained in a local mental health facility for a few weeks, after which time he was returned back to his wife. Tragically, two days later he killed her.

Case Study #2

Mr. M. is a 63 year-old Caucasian. At the age of 18 he fell asleep while driving home from his prom, suffered a severe TBI, and was in a coma for three weeks. Currently, he has a right-sided stiff knee with foot drop (commonly called a right-sided spastic gait), severe short-term memory problems, and challenging behaviors. Until six months ago, he lived with his parents, smoking two packs of cigarettes daily and sitting in front of the television. They died tragically in an automobile accident, leaving him indigent and un-befriended. He now has a court-appointed public guardian who has placed him in a long-term-care facility. Unfortunately, his challenging behaviors are so disruptive that the facility can no longer handle him. The guardianship program sought treatment in one of several specialized "neurobehavioral" treatment facilities in Virginia where there are numerous vacant beds. Unfortunately, Medicaid does not support such in-state "neurobehavioral" treatment. Following current Medicaid guidelines, the public guardian then documented that none of the nearly 300 long-term care facilities in the Commonwealth will accept him, at which time Medicaid supported his placement in a dedicated "neurobehavioral" facility in Massachusetts. That facility's neuropsychiatrist reviewed and then significantly altered his medications, for some

were actually exacerbating his problems; a psychologist specializing in the behavioral complications of ABI instituted positive behavioral controls, including a systematic identification of underlying environmental triggers. Mr. M's behavior has improved dramatically.

Case Study #3

Ms. K. is a 55 year-old African-American woman who was diagnosed with schizoaffective disorder when she was 25 years old. Two years later, she was beaten by her husband and sustained a moderate TBI. She is a highly social person who has lived alone since that time. Unfortunately, she has long struggled with serious mood swings and cognitive issues, which have put her at risk of losing her independence. Not long ago, while her out-of-state family members were considering placing her in an adult facility, Ms. K happened upon a notice in her local library announcing a meeting of a support group for brain injury survivors which was organized by the Brain Injury Association of Virginia. She reached out for help and obtained a case manager from the Association who now helps manage her life. The case manager also got her involved with a clubhouse program known as the Beacon House, which is part of the non-profit Mary Buckley Foundation and receives partial support from the Virginia Department of Rehabilitative Services. Clubhouses focus on abilities not disabilities and promote social support, skills building, and community re-integration. Virginia is a national leader in clubhouses for persons with ABI. The quality of Ms. D's life has improved dramatically. Her out-of-state relatives are working closely with the case manager to build even more services to meet her needs. Recently, the case manager persuaded her to get her first physical examination in nearly 20 years. Breast examination revealed a lump, which was proven negative when biopsied. She was subsequently diagnosed with osteoporosis but is in otherwise excellent health and says that she is the happiest she has been in twenty years.

Conclusion

These three cases, all factual, reflect much about the current status of aging with a brain injury. While the third case is evolving positively because of appropriate case management and use of an available resource in the community, far too frequently older adults with brain injuries, whether they age with an earlier injury or suffer the injury later in life, are not so fortunate. Happy endings are few and far between. While the behavioral complications of brain injury are among its most prevalent and disabling features, there is no system of care for these complications. Because of the current healthcare reform debate and because of the Federal 2008 Mental Health Parity and Addiction Equity Act, the climate is now ripe for behavioral health reform. Neurological and psychiatric disorders account for "…more hospitalization, more long-term care, and more chronic suffering than nearly all other disorders combined" (Cowan and Kandel, 2001). Larger numbers of people aging with various forms of brain injuries will only exacerbate the complexity of these problems, posing ever more serious challenges for policy-makers, service- and health care- providers, families, and advocates.

As argued elsewhere, the lessons learned from the promotion of successful aging with one form of brain injury may be applicable to other forms of brain injury (Aravich and McDonnell, 2005). For instance, does the clubhouse model of psychosocial enrichment for persons with mental illness and ABI have applications for community dwelling persons with degenerative brain injuries? Are the lessons learned from PACE programs (Program of All Inclusive Care of the Elderly) for continuity of care in older people applicable to younger people aging with disabilities? Sadly, providers and advocacy groups for the various classes of brain injury frequently "travel in largely parallel, non-intersecting universes" and often compete with each other (Aravich and McDonnell, 2005). Successful aging of persons with brain injuries requires a genuine paradigm shift to promote more interdisciplinary training and cooperation, address the behavioral problems of brain injury, and look beyond the disability to see the whole person.

Study Questions

1. What are the various classes of brain injury that affect cognition and emotion?
2. How can successful aging be promoted in persons with brain injury?
3. Which behavioral problems are among the most common and disabling complications of brain injury and is there a system of care?

References

Aravich, P.F. & McDonnell, A. (2005). Successful aging of individuals with brain injury. *Brain Injury Professional. 2*(2), 10-14.

Cowan, W.M. & Kandel, E.R. (2001). Prospects for neurology and psychiatry. *Journal of the American Medical Association, 285*(5), 594-600.

Surgeon General. (2005). The Surgeon General's call to action to improve the health and wellness of persons with disabilities. Accessed December 2009 at www.surgeongeneral.gov/library/disabilities.

Resources

Brain Injury Association of America: www.biausa.org.

HHS. Centers for Medicare and Medicaid Services. Program of All Inclusive Care for the Elderly (PACE): www.cms.hhs.gov/PACE.

IBICA. International Brain Injury Clubhouse Alliance: www.braininjuryclubhouses.net.

ICCD. International Center for Clubhouse Development: www.iccd.org.

National Alliance on Mental Illness: www.nami.org.

Office on Disability. Department of Health and Human Services: www.hhs.gov/od/topics/healthandhumanservices/healthandhumanservices.html.

About the Authors

Paul F. Aravich, Ph.D., is a Professor at Eastern Virginia Medical School, Norfolk, and chair of the Virginia Public Guardian and Conservator Advisory Board, former chair of the Virginia Brain Injury Council and its neurobehavioral committee. He works with the Commonwealth's Alzheimer's and Related Diseases Research Award Fund, the I Need a LightHouse Foundation for suicide awareness, the Mary Buckley Foundation for brain injury survivors, and the Southeastern Virginia Chapter of the Alzheimer's Association

Marylin Copeland, M.S.W., C.B.I.S., is the South Hampton Roads Regional Resource Coordinator for the Brain Injury Association of Virginia. She is a member of a Human Rights Committee for the Virginia Department of Behavioral Health and is Co-Chair of the Norfolk Commission for Persons with Disabilities.

SGS Annual Meeting in Richmond

April 7-10, 2010

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

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

Dozens of sessions. Exceptional lodging rate of $138/night for single or double. For more information about the conference visit www.southerngerontologicalsociety.org.

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

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

Edward F. Ansello, Ph.D.

Aging as an Option

An efficiency expert from the home office visits a plant in Maine. He sees the manager, an older New Englander, and asks him, "How many workers do you have approaching retirement?" The man answers, "Don't have any goin' the other way."

Sometimes people treat aging as if it were an option or a discretionary exercise. "Grow older?" "No, thanks. I think I'll do something else." We see this in public policy much too frequently. Policy makers, whether local, state, or federal, defer focus on the matters of aging, even when the economy is robust. Add serious economic stress to the picture and aging as a subject disappears from consideration, in plans, priorities, and budgets. Except for Social Security and Medicare. These two topics have so many proponents and opponents that they seem always in someone's cross hairs. But even here, the discussions tend to be framed in economic terms rather than those of human development.

The reality is that the citizens of Virginia, like those of most of the world, are growing older ---steadily and across all sub-groups. Growing up may be of one's own choice, but growing older is not. This imperative makes older adults an enormous resource of time and talents. Older adults present, as well, perhaps the greatest heterogeneity in human development of any age group in the life course.

Aging is neither a fad nor an option but a bedrock reality that should be constantly under consideration, especially by those charged with protecting the common good. Two positive examples of such consideration, among many, present themselves. The first is a recent, inspired initiative conceived and being launched, with the aid of dozens of others, by the Virginia Department for the Aging: the Commonwealth's *Four-Year Plan for Aging Services*. VDA Commissioner Nablo discusses it in her editorial in this issue. The second is the work of colleagues at the Virginia Center on Aging, which I had cause to review recently and for which I gained a new appreciation.

The Four-Year Plan just launched by the Virginia Department for the Aging opens by recognizing that it no longer makes sense to talk about older Virginians as "them" but rather as "us." (The same insight would be true in Texas or New York or most anywhere in the developed world.) The Plan puts into operation an awareness that we all will likely grow older, that we do so in idiosyncratic fashion and become more ourselves and less like our agemates in many ways, that older adults present a continuum of skills, capacities, knowledge, and needs; and that response to this wondrous array of us should take the form of assisted autonomy, helping each to make the most of his or her "self."

So, in practice, we Virginians should focus on stimulating mental growth among elders through lifelong learning; community, continuing, and adult education; higher education; and other opportunities, formal and informal, that cultivate such growth. We should recognize and redress the staggering shortfall in geriatric training, a dilemma recently examined by Dr. Dick Lindsay in these pages. The numbers of health care providers trained in geriatrics is actually decreasing around us as we age in unprecedented numbers. We should be more aware of the shortage of home care providers whose visits prolong living in the community for older Virginians and adults with disabilities. Relatedly, we should develop "livable communities" that reinforce and encourage safety, health, social interactions, learning, service, work, leisure and more across the life span. Such communities would be not only "aging friendly" but also "all people friendly," for community improvements in safety and access, for example, would benefit everyone in that community. Blueprints already exist in the Thomas Jefferson Planning District in and around Charlottesville, in Fairfax County, and elsewhere. These and like-minded actions should not fade in and out of attention as if growing older were an option.

The second positive example demonstrating a recognition that aging is here to stay is the work of colleagues at the Virginia Center on Aging. The small staff here has excelled in projects whose variety, enterprise, and accomplishments would do credit to a much larger operation. This includes funded projects on: research into mindfulness-based stress reduction for caregivers who daily cope with the

challenges of caring for a loved one with dementia; identifying and strengthening the abilities of trusted members of local communities, such as clergy and lay leaders, to help those who are victims of domestic violence; confronting elder abuse, neglect, and exploitation by training law enforcement, prosecutors, and judges in proven practices; and helping to build the minds and bodies of mid-life and older adults through sustained brick-and-mortar programs in lifelong learning in several geographic locations in Virginia, and through educational outreach across the Commonwealth.

VCoA maintains partnerships with hundreds of agencies, groups, and individuals in every region of Virginia. These have helped in creative work to overcome barriers to fuller community life for older adults with lifelong, developmental disabilities. Scholars, researchers, and practitioners from Virginia's many colleges and universities have served as volunteer reviewers, helping to secure the reputation of the Alzheimer's and Related Diseases Research Award Fund (ARDRAF) as the nation's most productive and cost-effective stimulus for pilot research into the causes, consequences, and treatment of dementing illnesses.

At the same time, I have discovered, in a retrospective prompted by funding cutbacks, that over the past 10 years the General Assembly has appropriated $4.2 million cumulatively for the Virginia Center on Aging and the programs it administers, while VCoA has returned to Virginia $19.2 million through competitive grants we have obtained, Elderhostel tuitions and discretionary spending by non-Virginia attendees, subsequent awards obtained by ARDRAF awardees made possible by the findings of their pilot research studies, and other initiatives. This translates to a stunning return on investment, by any standard.

This is a good time to remind policy makers of the ever-present reality of growing older. For the Commonwealth. For themselves. Actually, every day is a good time to remember and to act responsibly.

When I visit the primary grades to read to children from picture books containing older characters, one of the themes that I share with the children is "If You're Lucky, You Get to Be Old." We are and we have. We need to remember that we should not treat aging and aging-related research, training, and services as an option.

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

Linda Nablo

A New Four-Year Plan for Aging

In recent years, Virginia's citizens and leaders have taken great pride in the recognition the Commonwealth has received, such as the "Best Managed State," the "Best State for Business," and as a great place to raise children. The time has come to ensure that Virginia is also known as a great place to grow old. Virginia's *Four-Year Plan for Aging Services* is an important step toward that end.

We've seen the numbers. As the Baby Boom generation races toward traditional retirement age, Virginia's population of older adults will reach 1.8 million by 2030; more than double that population in 2000. The question is, What is Virginia doing to prepare? In direct response, the 2008 Virginia General Assembly expanded the duties of the Virginia Department for the Aging by mandating a four-year planning process for aging services. Recognizing the magnitude of this task and understanding the devastating consequences if our planning efforts are not successful, VDA convened a comprehensive group of experts from diverse fields: physical, mental, and cognitive health; housing; transportation; home and community-based services; Medicare; civic engagement; advocacy; and community preparedness. VDA's four-year plan workgroup met regularly for the past six months to ensure that every

aspect of aging was considered. Government partners included: key state health and human service agencies and the Department of Corrections, Department of Housing and Community Development, Department of Planning and Budget, and the Department of Rail and Public Transportation, plus the Virginia Center on Aging and the Department of Gerontology at VCU. The private sector was represented by AARP, the Alzheimer's Association, Area Agencies on Aging, the Council on Virginia's Future, the Older Dominion Partnership, SeniorNavigator, the Virginia Health Care Association, the Virginia Association of Nonprofit Homes for the Aging, and more.

As a result of this comprehensive and collaborative approach, the *Four-Year Plan for Aging Service*s is different from previous studies and reports. It recognizes the great variability among older Virginians and focuses on a continuum from those older persons who are most in need of assistance to those persons who represent a largely unrecognized and untapped resource for the Commonwealth. Numerous prior studies have already documented issues in serving Virginia's older adults. This Plan attempts to present a comprehensive picture of where we are now and where we need to go to effectively meet the needs and leverage the human resources of Virginia's rapidly aging population.

The Plan describes the current informal and formal array of supports and services used by older Virginians, and starts to lay out a plan for how the system must change in order to meet future demands. It begins by underscoring the value of older Virginians as vital resources to our families and communities, stressing the power and responsibility each of us has in shaping our later years, and introducing the concept of "Optimal Aging." It also recognizes that some of us require a level of assistance beyond what can be provided with informal supports or paid for with private means. The Plan goes on to discuss how the Commonwealth, its communities, and public and private services can be designed to help us all remain safe and autonomous to the greatest extent possible, enabling us to "Age in Place" through the development of "Livable Communities."

Recognizing models and resources available to help communities, this Plan goes beyond surviving the impending "Age Wave" and actually prompts Virginia to seize the opportunity to create aging-friendly or "Livable Communities" for all ages. Such communities address the needs of older adults for safety and security, accessible and affordable housing, mobility options, home and community-based services, and accessible health care and medical-related supports, promoting the idea that "Livable Communities" are not just better for older adults, but also support healthier lifestyles for people of all ages.

This Plan is the beginning of a comprehensive, inclusive, and proactive approach to the aging of our Commonwealth. It contains recommendations that are the collective voices of policy makers, service providers, researchers, planners, and advocates. Although many of the recommendations focus on the most vulnerable citizens, others are more universal in nature, with a goal to assist all older adults to remain as autonomous as possible given their unique circumstances.

Currently, the recommendations in the Plan are not prioritized but rather categorized by topics. Arguably, some, such as recommendations regarding health care workforce development, are particularly urgent because of the years it will take to educate and develop the number of professionals and direct service workers needed to support the coming wave of older Virginians. Some recommendations are detailed because the necessary research is available to guide and support specific strategies. Others are broad-based, acknowledging the need for additional information to determine the proper approach. Many recommendations will necessitate funding and must be addressed as the economic climate improves. Finally, many recommendations will only come to fruition through collaborative efforts. It will be necessary to break through historical silos and develop new creative partnerships, leveraging the strengths of both the public and private sectors. Wherever possible, the Plan recognizes and supports the recommendations of current successful collaborative efforts.

The primary goal of this first planning effort is to establish a structure and process that will serve as a solid foundation from which future efforts to assess Virginia's network of aging services can evolve.

- continued on page 16

2010 Commonwealth Council on Aging Best Practices Awards Program

The *Commonwealth Council on Aging Best Practices Awards* are designed to identify and recognize valuable programs serving older Virginians and their caregivers and to encourage the replication of model programs across the Commonwealth. Programs are judged for their innovation, cost-effectiveness, sustainability, ease of replication, and their impact on the quality of life of older adults, their families, and caregivers.

Although this is the fourth year of the *Best Practices Awards Program*, it is the first time that there will be monetary gifts presented with the top prizes. Thanks to the generosity of the Rotondaro Family Foundation, the Council will award six levels of recognition. First place will receive $5,000; second place, $2,500; third place, $1,000; and three honorable mentions will receive $500 each.

"We are grateful to the Rotondaro Family Foundation for their leadership as the first donor to this important recognition program. We hope that this will prompt other private sector donors to continue this practice for these awards in the future," said Bob Blancato, new Chair of the Commonwealth Council on Aging. "This is an exciting new expansion to a valuable program, which was created and sustained, thanks to past leadership of the Council."

Another change in the awards program this year is the elimination of specific categories. Instead, the awards will echo the Four-Year Plan's message to develop and support programs and services that assist older adults to "Age in Place." This invites a greater opportunity to recognize creativity in services that foster "Livable Communities," from transportation to housing, from caregiver support to intergenerational programming – the door is wide open. "It is important as we plan for the "Age Wave" that we are developing programs that encourage and support older adults to remain in their homes for as long as possible and to be active contributors to our communities, regardless of where they are on the continuum," said Commissioner Linda Nablo. "By attaching the "Aging in Place" theme to the *Best Practices Awards Program*, we can increase the focus on supporting individuals in their homes and foster a greater awareness of the importance of available home- and community-based supports."

Since its inception, replication has been the hallmark of the *Best Practices Awards Program*. "Not only is it important to recognize stellar programs, but it is equally important to use them as models for other communities. The 'Age Wave' is coming fast, and there is no time for every provider and each locality to start from scratch," said Dr. Dick Lindsay, Chair of the Best Practices Committee. "Virginia has great examples of exceptional programs that support older adults and their caregivers, and we need to leverage their 'lessons learned' to teach others how to replicate their success." This guiding principle of the awards program is so important that it has been incorporated in as a requirement that a portion of the prize money be used to assist in replication efforts.

Nominations for the *Best Practices Awards Program* will be accepted beginning January 15, 2010 and must be received by March 15, 2010. Nominees/applicants may be a single entity or a collaborative group and may represent state or local government, private sector non-profits, facilities, higher education institutions, or faith organizations. Award winners will be announced in April and presentation ceremonies will be conducted in May in honor of Older Americans Month. Nominations must be made on the Council's official nomination form which can be found on the Council's webpage www.vda.virginia. gov/council.asp or obtained from the Virginia Department for the Aging by contacting Dr. Bill Peterson at (804) 662-9325 or bill.peterson@vda.virginia.gov. Additional details about the awards program, selection criteria, and nomination instructions are also available on these sites.

The Commonwealth Council on Aging is composed of 19 citizens who are appointed by the Governor and the General Assembly to represent all geographic areas of Virginia. The Council helps state government meet the needs of older Virginians. In 2009, the Council recognized eight community programs as demonstrating best practices within the Commonwealth. Descriptions and highlights about these programs can be reviewed at www.vda.virginia.gov/pdfdocs/2009-CCOA-Awards.pdf.

COMMONWEALTH OF VIRGINIA

Alzheimer's and Related Diseases Research Award Fund

THE VIRGINIA CENTER ON AGING
VIRGINIA COMMONWEALTH UNIVERSITY

Purpose: The Commonwealth of Virginia established the Award Fund in 1982 to promote research into Alzheimer's and related diseases. Because of a commitment to program balance, the Fund encourages scientifically rigorous applications from a broad spectrum of disciplines. Studies may involve:
(1) the underlying causes, epidemiology, diagnosis, or treatment of Alzheimer's and related diseases;
(2) policies, programs, and financing for care and support of those affected by Alzheimer's and related diseases; or
(3) the social and psychological impacts of Alzheimer's and related diseases upon the individual, family, and community.

Funding: The size of awards varies, but is limited to $37,500 each. Number of awards is contingent upon available funds.

Eligibility: Applicants must be affiliated with colleges or universities, research institutes, or other not-for-profit organizations located in Virginia. The Fund encourages partnerships between community-based agencies/facilities and academic institutions.

Schedule: A non-binding letter of intent with tentative title, non-technical abstract, and a 4-5 sentence description of the project in common, everyday language for press release purposes must be received by March 5, 2010. Letters on letterhead with signature affixed will be accepted electronically. Applications (hard copy required; with an additional electronic copy e-mailed subsequently) will be accepted through the close of business April 1, 2010, and applicants will be notified by June 18, 2010. The funding period begins July 1, 2010 and projects must be completed by June 30, 2011.

Review: Three qualified technical reviewers, one of whom is identified by the applicant, will review proposals for scientific merit. The Awards Committee will make the final funding decision.

Application: Application forms, guidelines, and further information may be obtained on the World Wide Web (www.vcu.edu/vcoa/ardraf.htm) or by contacting:

Constance L. Coogle, Ph.D.
Alzheimer's & Related Diseases Research Award Fund
Virginia Center on Aging
P. O. Box 980229
Richmond, Virginia 23298-0229
Phone: (804) 828-1525
Voice Mail: (804) 828-2243
FAX: (804) 828-7905
E-Mail: ccoogle@vcu.edu

Focus on the Virginia Center on Aging

Paula Knapp Kupstas

Paula Knapp joined VCoA in 1996 on a very part-time basis while completing her dissertation. Much in her life has changed since then. For one, she changed the filing status on her income tax return from 'single' to 'married filing jointly.' She defended her dissertation and received a Ph.D. in health economics from the Johns Hopkins School of Public Health, now the Bloomberg School, and briefly entertained having a vanity license plate reading 'DR PK.' (A name change from Knapp to Kupstas allowed her to retain her nickname of PK.) She began teaching a health care finance course in the VCU Department of Health Administration and took on various initiatives at VCoA, including some work with a fledging group interested in addressing the issue of domestic violence in later life, the Central Virginia Task Force on Older Battered Women (OBW).

This work with OBW on domestic violence in later life culminated in 2002 in a grant proposal to the Virginia Department of Criminal Justice Services (DCJS), submitted by VCoA as administrator. In 2003, she delivered a grant award acceptance letter to DCJS for the proposed project. Later that day, her physician ordered 1½ weeks of bed rest before another delivery, that of baby Abby.

Balancing work, teaching, and family life has been quite a learning experience. On the first day of school last fall, Abby reported that school is awesome. This was a reminder that it's still pretty awesome to learn and do new things.

Since writing that first successful grant proposal on behalf of the now-renamed Central Virginia Task Force on Domestic Violence in Later Life, other funded projects have followed, including support from the Virginia Sexual and Domestic Violence Victim Fund administered by DCJS. This allowed us to expand to full-time the position of the coordinator who oversees the projects on behalf of the Task Force. Many of you know Lisa Furr, who has served in this position since 2006.

The collaboration within the Task Force bore more fruit in 2006, when Paula wrote, on behalf of the newly formed Central Virginia Training Alliance to Stop Elder Abuse, Neglect and Exploitation, a proposal for a multi-year federal training grant to address elder abuse. The US Department of Justice Office on Violence Against Women selected it as a pilot grantee, one of only 10 in the nation. The Training Alliance delivers trainings for law enforcement, sends prosecutors to a national training, and offers judges the opportunity to attend a national judicial institute. Participating organizations also engage in a review of policies and protocols, based on multidisciplinary collaboration, to aid in improving the identification, investigation, prosecution and adjudication of cases of elder abuse, neglect, and exploitation. In 2008, the Training Alliance, through Paula, applied for and received continuation funding to conduct additional activities in the Richmond area that include training for direct services providers and strategic planning around outreach and service delivery.

Paula is a study technical advisor with the Older Dominion Partnership. She also has been working with VCoA Director Ed Ansello and Lisa Furr on a partnered project with Senior Navigator called *Take Back Your Life* which is developing and piloting a community-based, interactive, and confidential Internet project in the Petersburg/ Tri-Cities area. It is raising awareness about domestic violence in later life and demonstrating how faith- and community-based leaders can help people in abusive situations take back their lives. It gives these leaders a better understanding of the issues and equips them with resources for those in need.

Getting back to the matter of balance in life, recently Abby helped her mom at the office by composing the following "to-do" list:

1. Get here.
2. Get everything you need.
3. Organize.
4. Work.
5. Finish.
6. Pack up.
7. Go home.
8. Have fun!

The first six items are made easy by the delightful colleagues with whom Paula gets to work. Items seven and eight are easy, too, with husband David and daughter Abby. Along with being an actuary, David

- continued on page 14

Finding Your Gerontology Career Niche: An original essay by the author of *101 Careers in Aging*

by C. Joanne Grabinski, MA, MA, ABD, FAGHE

The growth of the elderly population in the United States should signal increasing opportunities for professionals with gerontology expertise and experience. Certainly, the current drive to expand health care holds the promise of new positions and new types of programs and services for older Americans. With budget cuts and downsizing in all sectors of the economy, however, the tendency to think in gloom and doom terms masks the potential for development of creative ways to continue serving the needs of our older citizens. While there are many existing and emerging new opportunities for gerontological professionals, it is not always easy to find one's niche in the field of aging.

Defining Terms

To better understand these expanding opportunities for gerontological professionals, it is helpful first to define and clarify some basic concepts. *Gerontology* is most commonly defined as a field of study that encompasses biology, psychology and sociology of aging as its core *disciplines*. This is not, however, to ignore the importance of other disciplines (such as economics, history, philosophy, religion, and anthropology) that are now recognized as relevant to the study of aging. Gerontology also is the "umbrella" term that covers a wide array of subfields, including *geriatrics*, which refers to the biomedical aspects of aging. Academic programs in an array of *professions*, such as social work, interior design, and an array of allied health fields (e.g., nursing; nutrition and dietetics; occupational and physical therapy; communication disorders/audiology and speech pathology, pharmacy; therapeutic recreation) also include gerontology coursework and open doors to careers paths that are gerontology-related.

In terms of professional practice directly with and/or on behalf of older persons, it is more common to refer to the *field of aging* and many of the existing jobs in this field are positions within the formal *aging network*; this network includes the Administration on Aging (AoA) at the federal level, State Units on Aging (SUAs) such as the Virginia Department for the Aging, Area Agencies on Aging (AAAs), and local level county or city agencies (such as county or city commissions, bureaus or departments of aging) funded through the Older Americans Act (OAA), state budgets, and other relevant legislative initiatives at the federal and state level—for example, Retired Senior Volunteer Programs (RSVP) and the National Center on Elder Abuse (NCEA).

Beyond the Aging Network

The aging network is only one sector of our society in which career positions exist for professionals in the field of aging. Opportunities exist for persons with gerontological expertise and experience in an array of related professional fields, including clinical psychology; social work and applied sociology; medicine and nursing; allied health fields like health and long-term care administration, dietetics, ophthalmology, audiology and speech pathology, pharmacy, and occupational, physical and recreational therapy; interior design and architecture; and elder law.

Emerging positions are now visible in fields such as library science; intergenerational studies; adult/older adult education; bibliotherapy and art, music, dance and drama therapy; human factors engineering, gerontechnology and ergonomics; transportation; media and communications; conflict resolution and family mediation; and business fields (e.g., marketing, banking, and advertising)—to name just a few. New subfields, such as financial gerontology, spiritual/religious gerontology, and family gerontology, are gaining visibility and recognition. Especially exciting to me is the growth in entrepreneurial gerontology, which allows professionals with gerontological backgrounds to assess, identify, develop and offer programs and services to meet previously unmet needs and interest of elders in unique ways.

Although most of these career opportunities are in direct service with older adults and/or those who provide personal, family, and social support for elders, many career paths also exist for professionals to work indirectly on behalf of older persons or older populations. There are three broad pathways: research, policy, and education. Research is one major pathway, most frequently practiced by faculty members in academic settings or through affiliation with a university, free-standing, government or corporate research center. Policy is

another major pathway for individuals interested in patient/client advocacy (e.g., as an ombudsperson or grass-roots advocate), policy development (e.g., as a legislator or legislative aide), policy analysis (e.g., as a policy specialist for an organization that advocates for older persons), or policy enforcement (e.g., as an elder law attorney, law enforcement officer who specializes in elder abuse, regulation reviewer). For the past 30 years or so, education has been a career pathway for those who want to teach about and conduct research related to aging in higher education (e.g., at community colleges, four-year colleges, universities, professional schools), but it more recently has been emerging as a pathway through K-12 aging education programs and intergenerational programs/services.

Categories of Work

Professional education and training programs specific to aging (e.g., certificate and degree programs at community colleges, four-year colleges and universities, professional schools, and postdoctoral fellowships) now make it possible to categorize paraprofessionals and professionals who work with and/or on behalf of older persons into three categories according to the schema I proposed in my chapter on "Careers in Aging" in the *Encyclopedia of Gerontology: Age, Aging and the Aged, 2nd ed.* (2007, Elsevier) and in my book, *101 Careers in Gerontology* (2007, Springer):

Gerontology workers work in settings relevant to older adults, but have no training or education, except for an informal orientation to their work settings, specific to aging (e.g., certified nursing assistants (CNAs) in long-term care facilities and receptionists at AAA or county/city commission on aging offices).

Gerontological specialists have added a gerontological component (e.g., an undergraduate minor or graduate certificate in gerontology) to a degree in a related field (e.g., interior design, nursing, clinical psychology, family studies, applied sociology) or they have completed a pre- or post- doctoral fellowship in gerontology or geriatrics. The primary focus of their professional practice is with and/or on behalf of older adults. Recognizing that the professional roles of gerontological specialists are diverse, Peterson, Douglass, and Lobenstine Whittington (2004, AGHE) outlined seven types of work done by these professionals: advocacy, direct service provision, education and training, management and administration, marketing and product development, program planning and evaluation, and research.

Gerontologists have completed a full undergraduate or graduate degree in gerontology or aging studies. If the primary focus of their professional practice is with and/or on behalf of older adults, a gerontologist also can be a gerontological specialist. Not all gerontological specialists, however, are gerontologists.

This schema is the beginning of what I see as an emerging *career ladder* in the field of aging. Keep in mind, however, that this career ladder (and related terminology) is not yet formally recognized across the field. Further development of such a career ladder, with clear role definitions and preparatory educational paths, would, I believe, lead to appropriate recognition of the field, expand career opportunities for gerontological specialists and gerontologists, offer greater status for these professionals, and increase the likelihood that competent and knowledgeable professionals are available to meet the needs of older adults. Additionally, it would provide the basis for licensure and other types of credentialing designed to protect clients from those who claim they are "gerontologists" without having legitimate claim to such a title.

On the cover of my book on careers in gerontology, the cover designer posed the question, "Is Aging the Field for You?" An equally important question is, "If I think Aging is the field for me, how do I find my niche within the field?" Here is my advice:

1) Assess your specific interests in gerontology by thinking through questions like: What gerontology-related disciplines and/or professions intrigue you the most? Would you prefer to work in direct service to elders or indirectly on their behalf? Which level of the proposed gerontology career ladder is the best fit for you? Which type of job role do you prefer?

2) Discuss career options with discipline-specific and/or gerontology program, department, or center administrators, faculty members, and students on your campus or a nearby campus.

3) Browse Websites of gerontological/geriatric professional organizations, such as the Gerontological Society of America (GSA), American Geriatric Society (AGS), Association for Gerontology in Higher Education (AGHE), American Society on Aging (ASA), National Council on Aging (NCOA) — for career-related information (e.g., AGHE's Careers in Aging page, GSA-AGHE's AgeWork, ASA's Job Search).

4) Also browse Websites of discipline- and profession-specific organizations, such as the American Psychological Association (APA), American Sociological Association (ASA), National Council on Family Relations (NCFR), American Bar Association (ABA), American Dietetics Association (ADA), American Public Health Association (APHA) - to learn about aging-specific organizational units and potential career paths within these fields.

5) Meet, visit with and shadow professionals in specific gerontology-specific or gerontology-related career positions that are of interest to you.

6) Include at least one practicum or internship experience in any certificate or degree programs you complete. Add extra hands on experience with and/or on behalf of elders through volunteer opportunities.

7) Get involved with a local, state, regional, or national organization with an aging/gerontology focus. Many of these professional organizations have student or associate memberships.

8) Attend conferences, seminars and workshops focused on aging that are offered in your locale.

9) Find a gerontology professional to become a career mentor for you. This may or may not be your academic advisor.

Gerontology and the field of aging present a rich array of career path options. We have mentioned only a few here. Enjoy exploring your options and best wishes on your journey to find your specific niche!

C. Joanne Grabinski, MA, MA, ABD, FAGHE, is President/Educator & Consultant with AgeEd in Mt. Pleasant, MI; Lecturer, Gerontology Program, Eastern Michigan University, Ypsilanti, MI; and Lecturer, Human Development: Gerontology, Saint Joseph College, West Hartford, CT. She is an AGHE Fellow. She can be reached at jgrabinski@me.com or (989) 773-3813.

Paula Knapp Kupstas, *continued*

is a girls soccer coach and Girl Scout troop leader. He and Paula are presenters for the Catholic Engaged Encounter marriage preparation program and are currently serving as local leadership. Paula, David, and Abby are all active in their church.

Alzheimer's Association Publishes New Activities Guide

With the release of ***Connections: A Complete Activities Guide for Persons Diagnosed with Dementia,*** family caregivers, home-care providers, and long term care facilities now have a complete color-coded activities guide that contains tools to provide meaningful programs for persons with dementia. This book is the first publication of the Alzheimer's Association, Central & Western Virginia Chapter (CWVA).

Connections was designed by Ellen Phipps, CTRS, of the Alzheimer's Association, CWVA, and Barbara Braddock, Ph.D., of the University of Virginia, to help caregivers structure the day and modify the environment in order to provide an opportunity for engagement in life for their family member. The guide provides the necessary tools and strategies for enhanced relationships between caregivers and care-receivers.

This book teaches caregivers strategies and techniques to relieve the unmet needs of boredom and frustration for their family member, thereby reducing caregiver stress. It also combines proven principles of Montessori Based Programming for Persons with Dementia, Therapeutic Recreation, and Guided Cognitive Intervention into a new approach.

This book lists for $34.95 (plus shipping). For a copy, call (434) 973-6122 or visit www.alz.org/cwva.

"Just One More Bite, Dad": Nutrition and Hydration Care at the End of Life*

by James A. Avery, MD, FACP
Senior Vice President and
Chief Medical Officer,
Golden Living

When I was in junior high school, my grandfather was dying in his small apartment. I would sit in the next room watching television and listening. "Just one more bite, Dad," I heard my mom plead over and over. "Please, Dad, just one more little bite." It is now 35 years later and I am a hospice physician. I can still recall the distress in my mom's and my grandma's voices as they desperately tried to coax Grandpa to eat.

Eating is a natural part of life. Food plays a role in giving us energy and keeping us healthy. However, when a body is preparing to die, it is natural that eating should stop. This situation is a difficult concept for many caregivers and loved ones to accept.

Is my loved one starving to death?

No. Starvation is what happens when a healthy person does not get enough food. When a person who is seriously ill or dying does not eat, this is not starvation. It is usually a marker or sign that your loved one has entered the dying process. When someone is very ill, the body slows down and there is a gradual decrease in eating habits. Feelings of thirst and hunger gradually shut down. In many people, the stomach and intestines may not even be able to use the nutrition.

I remember how my grandfather first stopped eating meats and began, for the first time in his life, to prefer fruits and vegetables. Then he began to ask for only soft foods. Finally, only liquids and ice cream were preferred. And then he simply said, "I just don't feel like eating." This is a common progression in many patients.

When my loved one's appetite slows down, what can I do to increase intake?

Here are some suggestions:
• Do not force your loved one to eat or constantly remind her of her decreased appetite. A soft, gentle approach may help the most; remember, it is her choice.
• Time meals with pain medications so comfort level is maximized.
• Make mealtime a pleasant time; candles, flowers, and soft music or TV may help.
• Make the most of breakfast; the appetite tends to decrease as the day goes on so.
• Offer favorite foods in small amounts.
• Try offering small amounts of nutritional supplements such as Ensure® or Boost®.
• Have drinks available, and consider giving liquids in other forms such as gelatins, puddings, Italian ices, and ice cream.
• Allow your loved one to rest after meals.

Remember that feeding your loved one may cause discomfort or increased anxiety. There comes a time when it is OK not to eat or drink. Support your loved one's decision.

Is not eating and drinking painful?

Healthy people feel hunger pangs and thirst when they do not eat and drink, but people who are very sick do not feel these sensations. Dehydration may actually bring relief from some problems. For example, vomiting may stop and pain from tumors may lessen. Coughing, congestion, and mucus in the lungs may also decrease. The medical evidence is quite clear that dehydration in the last phase of a terminal illness is a very natural and compassionate way to die. The only uncomfortable symptom of dehydration is a dry mouth, which can be alleviated with good mouth care, ice chips, and sips of water.

What if my loved one wants to eat or drink? What should I do?

Some people are not able to swallow correctly due to illness. In this situation it is possible that eating or drinking could cause food or fluid to fall into the lungs, which can cause pneumonia or breathing problems. However, if your loved one is alert and wants to eat or drink, the pleasure of eating and drinking may override other concerns. Tiny amounts of ice cream, ice chips, yogurt, Italian ices, and applesauce can usually be given safely, even to the sickest patient. You should discuss this with your physician.
I remember a patient I had who loved the taste of beer but was unable to swallow liquids anymore. The hospice team helped his wife to make slushy ices from frozen beer!

Should artificial nutrition or hydration be started?

Each person's situation is unique. If a person isn't able to swallow because of a temporary medical problem, artificial nutrition (feeding tubes or intravenous nutrition) can be given until he or she recovers. However, as the body weakens or the disease gets worse, tube feedings and IVs can be a burden and increase the risk for infection and pain; in other words, these may do more harm than good. Feeding tubes may feel uncomfortable, and they can become plugged up, causing pain and nausea. Fluids can cause bloating, diarrhea, and aspiration. Sometimes patients may need to be physically restrained or sedated to keep them from pulling out the tube or intravenous line. For each person, the benefits of artificial hydration and nutrition need to be weighed against the risks. Your doctor and hospice professionals can help you with this decision.

What happens when a dying person does not eat or drink?

People who do not receive food or fluids because of illness will eventually fall into a deep sleep and usually die in one to three weeks. This is the common last phase for most dying people, whether the fatal disease is cancer or some other disease. The medical evidence is quite clear that this is a very natural and compassionate way to die.

Back to my grandfather: As you now understand, the problem was not that my grandfather was not eating or drinking. His not eating and drinking was simply a signpost that he was in the last phase, the dying phase, of his life. As this became clear to my mother and grandmother, they thankfully stopped coaxing him to eat or drink and instead began preparing emotionally and spiritually for his death. Ice chips, lemon Italian ices, and vanilla ice cream were his total intake for the last three weeks of his life. Visits from friends and family, bedside prayers for peace and comfort, and reflections about his life became commonplace occurrences in that little apartment.

(*Excerpted from *Family Matters*, A Resource for Patients, Families and Caregivers from AseraCare Hospice)

Arthritis Foundation Upcoming Fundraisers

Crystal Ball (Richmond)
February 20, 2010
The Jefferson Hotel
6:30 p.m. - 11:00 p.m.

2010 Arthritis Walks

April 24
Arthritis Walk Richmond
Arthritis Walk Peninsula

May 1
Arthritis Walk Williamsburg
Arthritis Walk Hampton Roads
Arthritis Walk Charlottesville
Arthritis Walk Fredericksburg
Arthritis Walk Shenandoah Valley

May 15
Arthritis Walk Loudoun

May 22
Arthritis Walk Prince William

For information on these events, call (804) 359-1700.

From the Virginia Department for the Aging, *continued*

Public input must be solicited, additional relevant data collected, some issues explored further, desired outcomes defined, recommendations prioritized and made actionable, benchmarks for measuring progress established, and a process for evaluating effectiveness designed and implemented.

To this end, the work group will continue its collaborative efforts and expand as new partners are identified. The most important change needed, however, is not contained within the Plan, but rather requires state and local leaders to move the aging of Virginia near the top of their public policy agenda. Working together with the new administration, the legislature, and local governments, VDA and its partners will bring together state and local leaders to position the Commonwealth and its communities not only to meet the growing needs but also to maximize the untapped resource, Virginia's aging population. There is much work to be done. The future is almost here.

To obtain a copy of the Four-Year Plan for Aging Services, visit VDA's website at www.vda.virginia.gov or contact Dr. Bill Peterson at (804) 662-9325 or bill.peterson@vda.virginia.gov.

Arthritis Coalition's State Action Plan

Arthritis is all around. Consider the following from the Virginia Arthritis Action Coalition (VAAC):

Arthritis is the term used to describe more than 100 different conditions that affect joints, as well as other parts of the body. The word arthritis is commonly used as an umbrella term for all types. Nationally, arthritis affects nearly 50 million people or one out of every five, including adults and children, making it one of the most common diseases in the U.S. Arthritis is associated with aging, so as the nation's population continues to age, arthritis is expected to affect an estimated 60 million Americans by the year 2020. At the same time, individuals with arthritis often have co-morbidities, with over 30% of those with doctor-diagnosed arthritis reporting one or more other chronic conditions, such as heart disease or diabetes.

Arthritis is one of Virginia's most common chronic health problems, affecting almost one in three (29%) residents 18 years of age or older and costing the Commonwealth over $3 billion dollars yearly in direct health costs and lost productivity.

Arthritis affects all race and ethnic groups: with 28% of non-Hispanic white adults, 27% of Hispanic adults, and 25% of black adults reporting doctor-diagnosed arthritis. The percentage of women with doctor-diagnosed arthritis is almost 10 % higher than men, or almost one out of every three women in Virginia having a diagnosis and one of every four men. Over 37% of Virginia residents with arthritis have some limitations in their daily activities. Of Virginians age 65 years and older, over 57% have arthritis and, among those at midlife (ages 45 to 64), the percentage is over 40%.

The numbers can be overwhelming and may distract from an appropriate response, namely, taking action. For this and other reasons, the multi-disciplinary partners in the non-profit Virginia Arthritis Action Coalition (VAAC) launched the ***Virginia Arthritis Action Plan*** for the prevention and management of arthritis.

Goals for the ***Virginia Arthritis Action Plan*** include:

• Increase the awareness among people with or without arthritis of available resources, so they are prepared to seek early diagnosis and/or develop/improve self-management skills.

• Increase the public awareness of the many forms of arthritis, the signs and symptoms of arthritis, and the importance of early diagnosis and self-management.

• Increase awareness among healthcare providers of the need for the early detection and management of arthritis as well as available arthritis resources.

• Increase the availability of arthritis prevention programs in Virginia.

• Increase knowledge and awareness of arthritis and related conditions and the benefits of evidence-based interventions and programs that support Virginia residents who suffer the effects of these conditions.

• Increase the availability, accessibility, and participation in effective evidence-based physical activity, weight control, and self management programs for Virginia residents with arthritis and related conditions.

• Develop support systems in Virginia for persons with arthritis.

• Increase knowledge of Virginia health care professionals about arthritis prevention, diagnosis and treatment, and the programs available for their patients/clients.

• Support data systems to track the occurrence and impact of arthritis.

• Increase effective arthritis prevention awareness strategies for at-risk populations.

• Examine state level mechanisms for reporting, collecting, and analyzing prevalence data for selected chronic diseases, including arthritis.

To find out more about arthritis, visit www.vahealth.org/cdpc/arthritis. To download the Virginia Arthritis Action Plan, visit: www.vcu.edu/vcoa/index/vaac09.pdf. Better yet, if you would like to help in the success of the Virginia Arthritis Action Coalition, take action yourself by joining VAAC, which meets every other month; contact Ed Ansello at (804) 828-1525 or eansello@vcu.edu.

Calendar of Events

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

February 3, 2010
Aging Smart Seminar: Tips for Staying Physically and Financially Fit. 9:00 a.m. to 11:00 a.m. The Crossings at Bon Air, Richmond. There is no cost for this seminar. Continental breakfast and door prizes provided. Advance registration is required. RSVP by January 25th by calling (804) 768-7878.

March 16-18, 2010
2010 Rural Health Summit. Institute Conference Center, Danville. For information and to register, visit www.va-srhp.org/2010-rural-health-summit.htm.

March 24, 2010
The Hospice Foundation of America's Living with Grief Teleconference: Cancer and End-of-Life Care. Presented by Crater Caregiver Coalition and John Tyler Community College. 12:30 p.m. - 5:00 p.m. John Tyler Community College, Nicholas Center. For information, call (804) 526-2359.

March 26-28, 2010
Women's Health 2010: The 18th Annual Congress. Sponsored by the VCU Institute for Women's Health and *Journal of Women's Health*, in collaboration with the National Cancer Institute and the American Medical Association. Crystal Gateway Marriott in Arlington, VA. For information, visit www.bioconferences.com/wh or call (800) 5-BIOCON or e-mail vcohn@liebertpub.com.

April 6, 2010
Sexuality and Aging: Dispelling the Myths. The Sixth Annual University of Maine Geriatric Colloquium. Point Lookout Resort and Conference Center. Northport, ME. For information, contact the University of Maine Center on Aging at (207) 262-7920.

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

April 26-27, 2010
Annual Virginia Guardianship Association/Virginia Elder Rights Coalition Joint Conference. Sheraton West Hotel, Richmond. For information, visit www.VGAVirginia.org.

May 16-18, 2010
Transforming Lives: A Wellness Approach. 34th Annual Conference of the Mideastern Symposium on Therapeutic Recreation. Omni Hotel Richmond (www.omnihotels.com/FindAHotel/Richmond.aspx). For information, visit www.mideastsymposium.com.

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

June 2-4, 2010
Virginia Coalition for the Prevention of Elder Abuse 16th Annual Conference. Virginia Beach Resort & Conference Center. For information, contact Joyce Walsh at jwalsh@cityofchesapeake.net.

June 7, 2010
Creative Roads to Inclusion. Annual conference on aging with lifelong disabilities. Holiday Inn Koger Center, Richmond. For information, contact Ed Ansello at (804) 828-1525 or eansello@vcu.edu.

June 8, 2010
Aging Well in Mind, Body, and Spirit. Sponsored by Beard Center on Aging at Lynchburg College in partnership with Centra. Lynchburg College, Lynchburg. For information, visit www.lynchburg.edu/agingwell.xml or contact Denise Scruggs at scruggs.dr@lynchburg.edu or (434) 544-8456.

Age in Action
Volume 25 Number 1
Winter 2010

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

Linda Nablo
Commissioner, VDA

Kimberly S. Ivey, M.S.
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.

Spring 2010 Issue Deadline: March 15, 2010

Virginia Center on Aging

at Virginia Commonwealth University, Richmond, Virginia

www.vcu.edu/vcoa

Staff:

Director
Edward F. Ansello, PhD

Elderhostel Coordinators
Catherine Dodson, MS - Richmond
Jim Gray, MS - Natural Bridge
Nancy Phelps - Hampton
Barbara Wright - Staunton

Associate Director for Research
Constance L. Coogle, PhD

Assistant Director for Education
Jane F. Stephan, EdD

Research Specialist
Paula Knapp Kupstas, PhD

Lifelong Learning Institute
Monica Hughes

Law Enforcement Liaison
Barbara Walker

Program Manager
Bert Waters, MS

Project Coordinator
Lisa Furr, MA

Research Associate
Sung Hong, PhD

Administrative Assistants
Kristin Epperson
Jessica Hellerstein
Tara Livengood, MA
Angela Miller

Editor, *Age in Action*
Kimberly S. Ivey, MS

Advisory Committee:

Frank Baskind, PhD
Jean Cobbs, PhD
Cecil Drain, PhD
William F. Egelhoff, Director Emeritus
Jonathan Evans, MD
Patricia Giesen
Hon. Franklin P. Hall
Robert D. Holsworth, PhD
Ronald J. Hunt, DDS, MS
Paul G. Izzo, JD
Richard W. Lindsay, MD
Christopher M. McCarthy, Esq
Linda Nablo
Kenneth J. Newell, MS, Vice Chairman
Mary C. Payne
Martha B. Pulley
Sheldon Retchin, MD, MPH
Saundra C. Rollins, MSSW
David Sadowski
Robert L. Schneider, PhD
Ralph E. Small, PharmD
Beverley Soble
Alexander Tartaglia, DMin
Marcia A. Tetterton, MS, Chairman
Gordon Walker
Thelma Bland Watson, PhD
E. Ayn Welleford, PhD
Victor Yanchick, PhD

Virginia Department for the Aging

www.vda.virginia.gov

Staff:

Commissioner: Linda Nablo
Faye Cates, MSSW, Program Coordinator
Tim Catherman, MHA, Director of Administration
Madeline Cotton, Graduate Student Intern
Pat Cummins, MA, Program Coordinator
Leonard Eshmont, IT Director
Ben Garrett, Information Specialist
Solomon Girmay, External Financial Auditor
Becky Hunley, Accountant
Janet James, JD, Public Guardianship & Legal Srvcs. Coord.
Georgie Lewis, Receptionist
Nancy Lo, MSW, GrandDriver Coordinator
Deb Loving, Info. Systems Specialist
Tara Malik, Graduate Student Intern
Christy Miller, Bus. Analyst Cert., IT Business Systems Analyst
Kathy Miller, RN, MS, MSHA, Long-Term Care Director
Marica Monroe, CPA, Financial Manager
Ellen Nau, MA, Program Coordinator
Peggy Neider, Community Living Program Coordinator
Charlotte Peterson, Accountant Senior
Bill Peterson, MSW, PhD, Senior Policy Analyst
Katie Roeper, Assistant Commissioner
Patty Samuels, PMP, IT Project Manager
Cecily Slasor, Information Specialist
Elaine Smith, MS, RD, Program Coordinator
Pam Smith, Acting VICAP Coordinator
Jane Snead, Contracts/Grants Coordinator
Jackie Taggart, Executive Secretary Senior

Commonwealth Council on Aging:

Members

Robert B. Blancato, Chair
Betty M. Bowden, Secretary
Ann A. Brown
Gene Ecton Davis
Jeffrey C. Delafuente, MS, FCCP
David M. Farnum
Pete Giesen
Judith Koziol
Richard W. Lindsay, MD
Brenda Kelly Nelum
Valerie Scott Price
Roberto Quinones
Stephen G. Reardon, Esq.
Elvira B. Shaw
Joan Short
E. Harris Spindle
Donald T. Thorne
Vernon Wildy

Ex Officio Members

The Hon. Marilyn B. Tavenner, *Secretary of Health and Human Resources*
Linda Nablo, *VDA*
Gail S. Nardi, *VDSS*
Terry Smith, *DMAS*

Virginia Commonwealth University
Age in Action
Virginia Center on Aging
P.O. Box 980229
Richmond, VA 23298-0229

Return Service Requested

Nonprofit Organization
U.S. POSTAGE PAID
Permit No. 869
RICHMOND, VIRGINIA

Working Together: Third Annual Community Conference on Senior Care

Charlottesville University Area Holiday Inn
1901 Emmet Street, Charlottesville

February 16-17, 2010

Hosted by the Community Partnership for Improved Long-term Care, an initiative of the Legal Aid Justice Center. Co-sponsored by the Alzheimer's Association - Central and Western Virginia Chapter, Drs. Jonathan and Mary Evans, and the Jefferson Area Board on Aging.

Join area direct care workers, practitioners, leaders, and advocates to:

- Exchange information and best practices
- Recognize the challenges and celebrate the accomplishments of long-term care workers to enhance professionalism, leadership, and teamwork, and to reduce turnover
- Participate in skills training for caregivers to better meet the needs of seniors living with the challenges of aging

This conference will offer general continuing education credits to attendees. For more information, please contact Claire Curry at (434) 977-0553, ext. 105 or claire@justice4all.org.

This program was made possible in part by Geriatric Training and Education (GTE) funds appropriated by the General Assembly of Virginia and administered by the Virginia Center on Aging at Virginia Commonwealth University.