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Avoiding Medication Pitfalls

Jeffrey Delafuente, M.S.

Jeffrey Delafuente, M.S., is Professor of Pharmacy and Director of Geriatric Programs at VCU School of Pharmacy. Jeff joined the VCU faculty in 1998 with the responsibility for developing research and education programs in geriatric pharmacy practice. He has co-edited three editions of the textbook Therapeutics in the Elderly, has 29 contributed chapters in 19 books and numerous publications in clinical and scientific journals. Jeff's current research interests are safe and effective medication use in the elderly; therapeutic and economic outcomes from drug therapy; and educational innovations. He has been interviewed and quoted in publications such as Time Magazine and USA Today and has appeared in an NBC news report broadcast nationally.

Educational Objectives

1. Discuss the prevalence and risk factors for adverse drug events in older people.

2. Identify selected medications that often should be avoided in older people.

3. Discuss methods to ensure safe medication use.

Background

For elderly people, morbidity and mortality from many common maladies, such as heart disease, cholesterol disorders, cancer, hypertension, diabetes, and many others, have decreased due to advances in drug

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therapy. However, the potential for drug-related problems is significantly increased in older patients. Drug-related problems include unwanted side effects, difficulties with following prescribed directions, unafford-ability of the medication, over- and under- treatment, and improper dosage. Often, these problems are predictable and preventable. Drug-related problems often prevent desired therapeutic goals from being achieved, are often masked as new medical problems, and have tremendous costs, both economic and humanistic. Selecting medications for use by elderly people can be a challenging and difficult task. Unlike younger adults, elderly individuals often have multiple medical problems and use multiple medications. Drug-drug interactions, drug-disease interactions, and physiologic alterations from aging must be considered before prescribing a medication in an older person.

Adverse Drug Events

In 1994, Leape and colleagues identified medications as the most common cause of adverse events in hospitalized patients, accounting for more than 19% of all adverse events. In this study, patients aged 65 years and older had the highest adverse drug event rates of all age groups. Cardiovascular, anticoagulation, and antibiotics were common classes of drugs involved in these adverse events. An adverse drug event is usually defined as an injury caused by a medication. Gray and colleagues (1998) examined adverse drug events in hospitalized patients 70 years of age and older. Approximately 15% experienced an adverse drug event, with cardiovascular and narcotic pain medications as the most common causes. Drug-induced confusion was a common outcome caused by narcotic pain medications, anxiety medications, and an antidepressant. Although numerous studies have been published examining adverse drug events in hospitalized patients, little data are available to know the scope of the problem in community-dwelling elderly. Studies indicate that as many as 10 - 20% of geriatric hospitalizations are caused by adverse drug events. Since most adverse drug events do not result in hospitalization, the magnitude of these problems in non-hospitalized individuals must be greater. It has been estimated that adverse drug reactions in community-dwelling elderly account for 2.2 million physician visits and 1.1 million laboratory tests each year (Chrischilles, Segar, Wallace, 1992).

Risk Factors for Adverse Drug Events

Elderly people are predisposed to unwanted effects of medication for numerous reasons. Some of these reasons include age- and disease-associated alterations in physiology that can affect how the body

metabolizes, eliminates, and responds to drugs, the presence of multiple concurrent diseases, and the use of multiple concurrent drugs, including prescription, nonprescription and herbal remedies. Other identified risk factors include low body weight and age greater than 85 years.

The risk of adverse drug reactions and geriatric syndromes such as delirium, cognitive impairment, falls, and incontinence increases as the number of medications taken increases (Hanlon, Schmader, Ruby, Weinberger, 2001). Patients taking four or more medications are at increased risk of falling, and the risk is greatest in patients taking psychotropic drugs (American Geriatrics Society, British Geriatrics Society, and American Academy of Orthopaedic Surgeons Panel on Falls Prevention, 2001). Older people and their caregivers must be educated to identify common medication side effects and how to seek help. All too often onset of a new problem, such as incontinence, is ascribed to old age and proper medical attention may not be sought. Patients, caregivers, and health care providers must share the responsibility for monitoring the occurrence of adverse drug events and resolving them promptly. A medication that a person has taken for many years may be the cause of a new drug-related problem and must not be overlooked as a cause.

Medications to Avoid

Many adverse drug events occur because prescribers select less than optimal drugs or fail to use appropriate lower doses in elderly people. In 1991 Beers and colleagues published the first systematic attempt to define inappropriate prescribing in elderly patients. These investigators designed criteria to evaluate medication use in frail nursing home residents. They developed a list of medications for which, in general, the risks of adverse events outweighed the potential benefits. This list of potentially inappropriate medications included drugs that should almost always be avoided in the elderly, or drugs for which the dose and duration of therapy should be limited to avoid adverse events. Applying the Beers' criteria to various settings showed that the rate of inappropriate prescribing ranges from approximately 14% to 40% (Beers et. al, 1992; Golden et al., 1999; Stuck et al., 1994; and Wilcox, Himmelstein, & Woolhandler, 1994).

More recently new criteria were developed by Beers (1997) to list drugs that are potentially inappropriate for any elderly person, regardless of setting. Some of the listed drugs or drug classes to avoid are: propoxyphene (Darvon®), indomethacin (Indocin®), most muscle relaxants, long-acting benzodiazepines (Valium®, Librium®, Dalmane®), amitriptyline (Elavil®), diphenhydramine (Benadryl®), and meperidine

(Demerol®). These drug should be avoided because safer and equally or more effective drugs are available. In general, drugs on the Beers list of inappropriate medications should not be used; however, in some circumstances with appropriate monitoring, their use may be warranted. In 1999, the federal Healthcare Financing Administration incorporated most the 1997 Beers' criteria into federal regulations governing medication use in skilled nursing facilities to decrease the incidence of adverse outcomes from selected medications. As new drugs constantly enter the marketplace, the Beers' list of potentially inappropriate medications quickly becomes outdated.

Safe Medication Use

Older people should be maintained on the fewest number of medications prescribed at the lowest effective dose to minimize drug-related problems. All too often, new drugs are added to treat a side effect of another medication, a practice that should be avoided. Nonprescription drugs and herbal products can also contribute to drug-related problems and older individuals should not use these products without the advice of a knowledgeable healthcare provider. The need for continued medication must be reassessed periodically, and drugs no longer necessary should be discontinued. All people using medications should understand the directions for use and these directions should be periodically reinforced.

Case Study

Mrs. Little is an 82-year-old widow who lives alone in her house. Her daughter, who lives nearby, calls every morning to check on Mrs. Little. Recently, when there was no answer, her daughter went to the house and found Mrs. Little lying on the kitchen floor. She was taken to the emergency room by an ambulance. Mrs. Little was found to be confused, had a broken hip, and was admitted to the hospital for evaluation and treatment.

Mrs. Little used the following medications while at home: digoxin (Lanoxin®) 0.25 mg/day, furosemide (Lasix®) 40mg/day, diazepam (Valium®) 5 mg as needed for anxiety, and nonprescription Sominex tablets (contains 25mg diphenhy-dramine) as needed for sleep. Mrs. Little had developed cold symptoms and had begun taking a nonprescription cold and flu capsule (contains pseudo-ephedrine 30 mg and diphenhy-dramine 25 mg) twice daily.

Within 24 hours following admission to the hospital, Mrs. Little's confusion cleared and she underwent surgery to repair her hip. She was later discharged to a nursing facility for continued care and recovery from surgery.

Study Questions

1. What would be an appropriate approach to determine if Mrs. Little's fall was related to her medication?

2. What potential problem existed in Mrs. Little's use of nonprescription medication?

3. What advice should be given to older people and their caregivers regarding safe use of medications?

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From the Executive Director, Virginia Geriatric Education Center

Iris A. Parham, Ph.D.

We recently received the wonderful news that a training program was funded by the Helen Keller National Center for the Department of Rehabilitation Counseling in cooperation with the Gerontology Department and the VGEC. Dr. Chris Reid is the PI and Ms. Paige Berry is the Project Director. Students will receive funding to complete training in the areas of rehabilitation counseling, aging studies, and deaf-blindness. This builds on the jointly developed Certificate in Aging Studies that was spearheaded last year with Dr. Brian McMahon, the

Rehabilitation Counseling Department Chair. If there are any students interested in completing this innovative Rehabilitation Counseling master's degree with emphasis on working with older adults who are deaf-blind, please contact Dr. Chris Reid at creid@mail2.vcu.edu or (804) 827-0912.

Our Kids-Into-Health Careers initiative is moving forward at a significant pace under the leadership of Dr. Ayn Welleford. The most recent session had over 118 participants and more information on this objective will be forthcoming in the next several months. We have also finalized the dates for the Validation Training which will be a terrific opportunity for professionals in this region (see related article, page 14). We are also working closely with Drs. Tom Mulligan and Mike Godschalk from the VAMC and the VCU School of Medicine to contribute to the 13th Annual Virginia Geriatrics Conference. This highly successful conference was started by a group of geriatricians from the MCV campus/VAMC Geriatrics program and has grown to a joint effort among all three of the Virginia Medical Schools with their affiliated VA Medical Centers, the Reynolds Foundation Initiative and the Virginia GEC. The conference will be held Friday through Sunday (March 15-17, 2002) at the Homestead. According to Dr. Mulligan, "the goal of the conference is to provide current information on topics germane to the health care of older adults. For example, topics for this year's conference include: management of Parkinson's Disease, swallowing disorders, and stem cell research." This program is targeted to clinicians, such as physicians, nurse practitioners, physician's assistants, allied health professionals and pharmacists. All other health professionals are welcome. According to Dr. Mulligan, "historically, the conference has benefited from the best teachers from across the state." The price will be $395 for MDs, $295 for NPs, PAs, pharmacists, students, or others. For further information, email Ms. Lucy Lewis, lblewis@hsc.vcu.edu or Dr. Thomas Mulligan, Thomas. Mulligan@med.va.us.

Lastly, the videotapes from the Breast Cancer videoconference funded by the Virginia Health Quality Center are available for distribution. If you would like to purchase a copy, please visit our breast cancer website at http://views.vcu.edu/sahp/ gerontology/vgec/breastcancer. You may also contact Ms. Angela Rothrock at the VGEC or email her, rothrag@aol. com. It has been a wonderful and challenging fall.

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From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

On September 11, 2001

Much has been said about terrorism and religious fanaticism in light of the horrific attacks on Americans and the American way of life on September 11th. Like others, I grieve for the many innocent victims, both the dead and the living, of these despicable acts, and hope that those responsible are made accountable. I also take comfort in the depth of character of our country. As a gerontologist, I wish to offer an additional perspective. One of the consequences of these assaults is the elimination for thousands of people of the "Gift of Time" that we in this country have come to take for granted. By the gift of time I refer to the 25 or more years that were added to the average American's life expectancy during the twentieth century because of medical, health care, and lifestyle improvements. These extra years allow us the possibilities of seeing our children established as adults in the world, witnessing the full bloom of our marriages, relationships, and careers, and imagining the vista of years of retirement. For thousands of Americans, the brutal events of September 11th removed their gift of time, the promise of a long life with all of its potential.

What we take for granted, this gift of time, is a privilege that only the developed nations can access. The focus of much of my professional work, aging with lifelong disabilities, is not an issue in less developed countries because there is little possibility of growing old, even without disabilities. The average life expectancies at birth in Afghanistan and Pakistan, for example, are 46 and 61 years, respectively. Infant mortality in Afghanistan today is 149 of 1000 live births, over 21 times the rate in the United States.

We are a privileged nation. We are a nation of people who tend to enjoy our lives, our families, our communities, and our liberties fully, over a lengthy course of life. Perhaps the horrific tragedies of September 11th will deepen our appreciation of how special life and the gift of time are. Perhaps we will see more clearly that growing older is a privilege to be valued, an extension of opportunities to learn, to hope, to grow, to share, to help, to believe. Perhaps we will see that we truly are members of communities and not only self-centered individuals. Perhaps we will

recognize that there are others, communities and nations, without the privilege of growing to be old who could benefit from our concern and action.

This could be a time not only of bringing to justice those who terrorize our way of life, but also of bringing justice, in this context greater participation in the gift of time, to developing communities and nations. Can we see how one's view of the life course ahead can influence how one lives and acts? Would working to share more broadly the gift of time help change the climate that breeds terrorism?

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From the Commissioner, Virginia Department for the Aging

Ann Y. McGee, Ed.D.

Center for Elder Rights Helps Aging Virginians

(Note: The names of all the individuals mentioned in this article have been changed to protect their confidentiality.)

Imagine that you are the sole caregiver for a person with a debilitating disease. This person requires constant care, leaving you no time to accomplish everyday tasks such as grocery shopping or laundry. You can't pursue outside interests, go to church or shop for groceries. Feeling tired, frustrated, and desperate for help, where would you turn for assistance?

Mr. Swenson, a retired Navy officer in Norfolk, faced this situation in caring for his wife who suffered from debilitating arthritis. Fortunately, he called the Center for Elder Rights, a resource with knowledge and talents developed specifically to help aging members of Virginia's population.

On September 14, 2001, the Center for Elder Rights celebrated its one-year anniversary. The Virginia Department for the Aging's Center is a central contact point for older Virginians, their families and caregivers who need information on and assistance with aging and long-term care issues. The Center for Elder Rights was tailor-made for people just like Mr. Swenson.

Center staff told Mr. Swenson about programs in his community that could help him care for his wife and provide him with some respite from the constant demands of being her caregiver. His wife was referred to a community health center with a special program for persons with arthritis, in which she was able to participate three days a week. This gave Mr. Swenson some free time to accomplish every day tasks, as well as maintain contact with his friends at the local Veterans of Foreign Wars post. Center staff also referred Mr. Swenson to a support group in the Tidewater area that allowed him to learn new caregiving skills and to share his concerns with others in similar situations.

Governor Jim Gilmore understood that many people become confused when confronted with the array of aging services and programs currently available. To help them, he worked with the General Assembly and the Virginia Department for the Aging to create the Center, the only state-administered elder rights center in the United States. "When people need help in solving a problem, one of the most difficult challenges they face is determining exactly what kind of help they need and where to find it," the Governor said. "The Center for Elder Rights connects an individual or family that needs help with service providers that can help them. This is especially important for an older person who may not have relied on others in the past, and therefore doesn't have a support system in place. The Center is also an extremely valuable resource for an individual or family in the midst of a crisis. They need to find help quickly, and the Center's staff makes it easy for them to obtain assistance."

One example of this philosophy is Ms. Green. A resident of a large state mental health facility for more than 20 years, Ms. Green was admitted to the facility shortly after the birth of her only child. Even though her condition had slowly improved over the years, she had no family who could help her move out of the facility or to supervise her care in the community. Her case was referred to the local Virginia Public Guardianship and Conservator Program in Marion, Virginia. Program staff worked to reunite her with her daughter, found her a place to live in the community, and provided supervision and assistance for her to successfully maintain her independence outside of the mental health facility. The public guardianship program also reunited Ms. Green with a grandchild she had never seen. This program is a service of the Center for Elder Rights.

The initial vision for the Center was that it would be "high-touch and low-tech", so people would feel comfortable when contacting it. To help achieve this comfort, the Center has a nationwide, toll-free telephone

number that is not menu-driven: a real person answers the phone. After an initial contact, Center staff follow-up with the customer to make sure that the information given was helpful, or to answer any additional questions the caller might have.

Mrs. Wilson of Harrisonburg, Virginia, is just one of the many individuals who have called the Center to their advantage. Mrs. Wilson called the Center for Elder Rights with questions about whether she needed Medigap insurance to supplement her Medicare and health benefits from her former employer. After her call, Center staff mailed her a variety of publications about Medigap insurance, including information about policies available in Virginia. They also referred Mrs. Wilson to an insurance counselor in her community. The counselor, a trained volunteer with the Virginia Insurance Counseling and Assistance Program (VICAP), met with Mrs. Wilson and helped her review her current benefits and explore options for additional coverage.

The Baby Boom generation - approximately 79 million people - are the largest, most active and fastest-growing senior population ever to exist in the nation's history. As Boomers age, they will increase the demand for aging services and information. "The Center for Elder Rights was created in anticipation of meeting the growing needs of our citizens," said Dr. Louis F. Rossiter, Secretary of Health and Human Resources for the Common-wealth of Virginia. "It is uniquely suited to help members of Virginia's aging population, their families and caregivers in finding the information and services they need." In its first year of operation, the Center provided more than 100,000 copies of various publications to aging Virginians and their caregivers. Center staff referred over 1,000 clients to partner agencies, and counseled over 550 individuals on a variety of topics.

One topic of great interest to many has been the cost of prescription medications. Mr. Lee, a 75-year-old retired coal miner living in Big Stone Gap, Virginia, with black lung disease, called the Center for Elder Rights to see if he could receive help with the cost of his prescription medications. His income was too high to qualify for Medicaid, but his housing costs, groceries, and other expenses did not leave him enough money to purchase all of his prescribed medications. Center staff provided Mr. Lee with information on prescription assistance programs offered by the pharmaceutical companies that manufactured his medications. They also referred him to the "Pharmacy Connect Program" offered by his local area agency on aging. Through this program, Mr. Lee met with a local counselor who helped him apply to each drug company to

receive free medications.

Not only are the Baby Boomers growing older, they also find themselves caring for their aging parents in record numbers. Mirroring the complexity of society, the number and sophistication of fraudulent schemes directed at innocent people have also increased. Often, these scams target members of the aging population; therefore, another goal of the Center for Elder Rights is to help citizens avoid falling victim to fraud and scams.

An example of this type of assistance was the telephone call that the Center received from Mrs. Jefferson, a resident of Arlington, Virginia. She needed assistance with her 90-year-old grandfather who lived alone and had no friends or family nearby. Because of his isolation, he would willingly talk to "telemarketers" who convinced him to purchase products and services that he did not need or want. Center staff provided Mrs. Jefferson with materials that would help her teach her grandfather to hang up the telephone when the telemarketers called so that he would not fall victim to fraud and scams. They also referred her to a local adult day care center where her grandfather was able to spend time with his peers. He became involved in a number of recreational and social activities that helped relieve his loneliness and improve the quality of his life.

Over the past year, staff at the Center for Elder Rights experienced great satisfaction in helping their fellow citizens improve both their knowledge on aging issues and, in many instances, their quality of life. "We are delighted with the Center's performance during its first year of operation," said Secretary Rossiter, "and we look forward to providing Virginia's citizens with enhanced access to aging services and information in the future."

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Focus on the Virginia Geriatric Education Center

J. James Cotter, Ph.D.

J. James (Jim) Cotter is an Assistant Professor in the Department of Gerontology and in the Division of Quality Health Care, Department of Internal Medicine, Virginia Common-wealth University. Dr. Cotter began teaching in the Department of Gerontology in 1997 and joined the Virginia Geriatric Education Center in 2001. At the VGEC he will facilitate the development of the Geriatrics Health Professionals

Mentoring Program.
He received his Ph.D. Degree from Virginia Common-wealth University, School of Allied Health Professions, Department of Health Administration in 1996. He teaches courses at VCU on the problems, issues and trends of the aging, health care outcomes, and organizational theory and the US health care system.

Beginning as a outreach worker to older persons in Buffalo, NY, in 1975, Dr. Cotter has developed, implemented, managed and evaluated aging services programs at the local and state levels for 25 years. In 1985, he had the good sense to move to Virginia where he served as Assistant Director of SEVAMP Senior Services, the area agency on aging in Tidewater Virginia until 1988. As Director for Programs at the Virginia Department for the Aging from 1988-1994, he directed and managed services and programs at the 25 area agencies on aging of Virginia.

Currently, he serves on Governor Gilmore's Commission on Alzheimer's Disease and Related Disorders and on the Board of Directors of the South Richmond Adult Day Care Center. He is a member of the Gerontological Society of America, the Southern Gerontological Society, the Association for Health Services Research, and is a past president of the Virginia Association on Aging.

Dr. Cotter's research interests include transitions of care between health care settings, changing organizational behavior, special care for persons with Alzheimer's disease or related dementia, the innovative delivery of health care services, such as telemedicine, and the evaluation of health and social services.

He reads voraciously (yes, even poetry), loves movies (foreign and domestic, high brow and low brow), and wishes he could find more time for hiking Virginia's countryside. He has three children - a son who attends the School of the Arts, Virginia Commonwealth University, another son who is a senior in high school, and a daughter in eighth grade.

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Focus on the Virginia Center on Aging

Barbara Brandon

Barbara Brandon has just joined the staff of VCoA in September, assuming the duties of receptionist, secretary, and program assistant to the Center's Elderhostel program. Her responsibilities include clerical work, data entry, Elderhostel registrations, and preparation of materials for Elderhostel programs.

Barbara retired from Virginia Commonwealth University (Academic campus) in December 1998. During her 28 years at VCU she worked in the department of Records and Registration as the office manager. During her last four years of employment she worked with the Foreign and International students through the English Language Program and was the coordinator of Off Campus Registration. She found working with Foreign and International students to be very rewarding and stimulating, especially when it led to the opportunity of visiting Kuwait twice for one-month visits.

After almost three years of retirement, she decided to return to work to use her skills in management and to prevent "intellectual dullness." A “people person,” she enjoys interacting with others. Barbara is the mother of three: two daughters and one son. She has four grandchildren: three grandsons and one grand-daughter. Her many interest include gardening, landscaping, interior decorating, and reading.

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Important Facts About Cataracts

Virginia's Eye MDs

Eye MDs (ophthalmologists) across Virginia want to debunk a few myths about this common problem, and to remind people they do not have to live with vision loss from cataracts.

A cataract is the clouding of the eye's normally clear lens, which blocks the passage of light to the retina. A cataract forms slowly and causes no pain. Some stay small and do not affect vision very much. If it becomes

large or thick, it usually can be removed by surgery.

Cataracts are one of the leading causes of blindness around the world. However, in most cases, vision loss from cataracts is reversible. New techniques developed over the past decade have made cataract surgery one of the most successful procedures available in terms of restoring quality of life to patients.

There are no drugs or exercises that will make a cataract disappear, and, contrary to popular myth, cataracts are not removed by using lasers. Cataract surgery is most often done as an outpatient procedure under local anesthesia. The cloudy natural lens can be replaced with an artificial lens to give the eye proper focusing power. In most cases, the improvement in the patient's vision is profound. For some of them, it really is like a miracle.

So how do you know if you have a cataract? Some people notice a gradual painless dimming of vision, or distortion or 'ghost' images in either eye. Some older patients mention sensitivity to glare or bright light or trouble driving at night. Also, if patients need frequent changes to their glasses prescription, they should be evaluated for a cataract.

It is uncertain what can prevent the development of a cataract. Some steps which may help include:

-Regular eye exams by your Eye MD. Your Eye MD is specially trained to detect many vision-threatening conditions even before you develop symptoms. The earlier that problems are detected, the better the chance of preventing vision loss.

-Protection from UV-A and UV-B rays. Some studies have suggested that prolonged or frequent exposure to UV-A and UV-B rays may be a factor in cataract and other eye conditions. So, always wear sunglasses that block 99 to 100% of UV rays when outdoors.

Contrary to what you might have heard, a cataract does not have to be "ripe" before it is removed. The best time to have a cataract removed is when it starts to interfere with the things you like to do.

Although it is very safe and effective, cataract surgery is still surgery and there is always a risk of complications. For some people, having cataracts does not particularly affect their quality of life; so for them it makes sense

to put off any cataract surgery until they feel they need it. If you experience vision problems that affect your lifestyle, talk to your Eye MD.

The Virginia Society of Ophthalmology members are committed to heightening public awareness that eye disease and blindness can be reduced through prevention and early detection and treatment. EyeMDs (ophthalmologists) specialize in total eye and vision care: primary, secondary and tertiary (i.e., vision services, contact lenses, eye examination, medical eye care, and surgical eye care), diagnose general diseases of the body and treat ocular manifestations of systemic diseases. For more information, call 804-784-5953 or visit the Society on the web at www.vaeyemd.org

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Geriatric Health Professionals Mentoring Program

Jim Cotter, Ph.D.
La'Quana Fulton

A shortage of health care professionals is crippling our nation's health care system. Services for older persons are under duress. The supply of health care professionals, especially in geriatrics, is not keeping up with the needs of the growing numbers of older persons. As a positive response, the Virginia Geriatric Education Center is developing a cohort of one hundred individuals, who, under the guidance of the VGEC, will serve as advisors or mentors for another health professional in their region for a period of one to two years, depending on the goal of the protégé. Mentoring is the process of pairing a more experienced person (the mentor) with a less experienced person (the protégé) so that the protégé can improve skills and competencies. The process can involve faculty to faculty, faculty to practitioners, and practitioners to practitioners. The VGEC mentor will average one to two hours each month. One of our goals is to mentor health care professionals in geriatrics and gerontology and aging services.

We are now assembling a cadre of mentors for the coming year. Would you like to help in developing the skills and knowledge of another? We hope you will become one of the VGEC Mentors.

What's involved? The Mentor will:

-Attend an introductory mentorship training

-Communicate with the protégé by phone, email, or in person
-Participate in a mentorship discussion board
-Introduce the protégé to professional groups, and opportunities
-Review and comment on career development plans

We hope you will agree to share your wisdom to develop future health care professionals in geriatric health care. All it takes to become a mentor is the desire to make a difference. For more information please contact:

Virginia Geriatric
Education Center
Geriatric Health Professionals Mentoring Program
Contact: La'Quana Fulton
PO Box 980228
Richmond, VA 23298-0228
(804)828-9060
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lmfulton@hsc.vcu.edu

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Commonwealth of Virginia World War II Veteran Honorary High School Diploma

Virginia Board of Education

The Virginia Board of Education asks for your help in getting the word out about a new program available to World War II veterans.

The Virginia Board of Education announces the establishment of the Commonwealth of Virginia World War II Veteran Honorary High School Diploma. This honorary diploma will be awarded by the Board of Education in recognition of the educational, personal, and financial sacrifices made by World War II veterans who served in the United States armed forces.

In order to serve their country during the war, many veterans left school before completing the requirements for their high school diploma. When they returned home, many of these men and women were unable to complete their high school education due to the difficult circumstances of the war. Because these veterans have made significant contributions to this country while gaining substantial knowledge and skills through work,

this new program provides an honorary high school diploma to be awarded by the Board of Education to qualified veterans.

The application process is very simple. The veteran may have been enrolled as a student in any school in any state or territory, or located on or associated with any military base or embassy.

Any eligible World War II veteran may request the Commonwealth of Virginia World War II Veteran Honorary High School Diploma by submitting a very simple statement that includes the following:

1. The veteran's full name;

2. Branch of service;

3. Dates of service;

4. Location of last school attended;

5. A short statement that the veteran was unable to resume his or her high school education upon returning to civilian life; and

6. The veteran's return address.

The information may be submitted by the veteran, by his or her family, or by any veterans organization on behalf of the veteran.

The first honorary diplomas were distributed to the veterans during Virginia World War II Veterans Appreciation Week; however, there is no deadline for requests. Requests will be received at all times throughout the calendar year. The honorary diploma will be mailed to the recipient as soon as the request is received by the Virginia Board of Education.

The members of the Board of Education are pleased to recognize World War II veterans and are grateful for the help of local and statewide veterans organizations in honoring World War II veterans for the contributions and sacrifices they made to protect this country and our citizens. All of us owe a great debt of gratitude to all our veterans who have served to ensure a brighter, stronger future for this Commonwealth and this nation.

A request for an honorary diploma should be mailed to:

Virginia Board of Education Attn: Margaret N. Roberts
P.O. Box 2120
Richmond, Virginia
23218-2120

Requests may also be given by telephone, fax, or e-mail. Call Dr. Margaret Roberts at the Virginia Department of Education at 804/225-2924, fax: 804/225-2524, or e-mail: mroberts@mail.vak12ed.edu.

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Validation Therapy Practitioner Program

Angela G. Rothrock, MS
Virginia Geriatric Education Center

The Virginia Geriatric Education Center is working with Naomi Feil, who developed Validation, and her daughter Vicki de Klerk-Rubin in providing people in the field of healthcare a way of reaching disoriented older people.

What Is Validation?
Developed from 1963 to 1980 by Naomi Feil, M.S.W., A.C.S.W., it is a tested method that helps older disoriented people reduce stress, enhance dignity and happiness. It is accepting the feelings of another person. It is reaching out with empathy to the person with memory impairment. It is a technique which may help to restore one's dignity.

Who Needs Validation?
Individuals diagnosed with Alzheimer's and related disorders who are disoriented in the later stages of life.

How can I become a Validation Practitioner?
By completing this five block workshop taught by Vicki de Klerk-Rubin that will certify its attendees as Validation Practitioners. The workshop will be held in Richmond. Once certified, a Validation Practitioner will be able to: practice individual Validation, give short presentations of Validation for small groups and provide support to interested people.

Block One: February 8 & 9, 2002 Basic Validation Theory and Beliefs, Stages and Techniques, Erickson's Stages and Stage One: Malorientation. How to begin with Validation. Assignments with Stage One Clients.

Block Two: April 12 & 13, 2002 Stage Two: Time Confusion with demonstration and practice. Discussion of experiences. Assignments with Stage Two Clients.

Block Three: July 11 & 12, 2002 Stage Three: Repetitive Motion with demonstration and practice. Discussion of experiences. Assignments with Stage Three Clients.

Block Four: September 13 & 14, 2002 Stage Four: Vegetation with demonstration and practice. Discussion of experiences. Assignments with Stage Four Clients.

Block Five: November 15 & 16, 2002 Written test and practical demonstration of Individual Validation

The cost for each block is $200 for a total cost of $1000.

A $500 non-refundable deposit is due at the time of reservation with the $500 balance due by January 8, 2002. Only 25 spaces remain, so register now!

For more information or to register for the program, contact Angela G. Rothrock at the VGEC, an authorized Validation Organization, at (804) 828-9060,
Fax: (804) 828-7905 or email at arothroc@vcu.edu

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Save Lives-Immunize Against Flu and Pneumonia

Annette M. Holmes, M.S.A., CPM
Virginia Health Quality Center

Flu and pneumonia are significant health problems in the United States, representing the sixth leading cause of death and the most common cause of death due to infectious disease. Influenza is particularly problematic for seniors. More than 90% of deaths from influenza and pneumonia nationally occur in the population aged 65 and above.

In Virginia in 1998, nearly 12,000 people with Medicare were admitted to the hospital with pneumonia-related conditions, accounting for more than

72,000 patient days at a substantial cost to Medicare. In Virginia, there are approximately 1,600 deaths from pneumonia and influenza annually. Of those deaths, 91% occur in people aged 65 and over.

Based upon the most recent Behavioral Risk Factor Surveillance System (BRFSS) survey data available (1999 data), more than one third (34%) of Virginia's 65 and older population had not received the flu shot. Of even greater concern is the fact that according to the same BRFSS data, 45% of this population have never had the pneumococcal vaccine.

Along with the Centers for Disease Control and Prevention (CDC), the Virginia Health Quality Center (VHQC) is urging physicians and health care providers to develop plans to ensure that high-risk candidates get vaccinated first.

Persons considered high-risk are:

-persons aged 65 and older;
-nursing home and other chronic care facility residents;
-adults and children with chronic disorders of the heart and lungs;
-adults and children who required regular medical follow-up or hospitalization during the preceding year because of chronic diseases (including diabetes), kidney disease, and other diseases that weaken the immune system;
-children and teenagers (aged 6 months - 18 years) who receive long-term aspirin therapy; and
-women who will be in the second or third trimester of pregnancy during the influenza season.

Some delays in vaccine distribution are projected for this year, but they are not expected to be as great as those in the 2000-01 season. Manufacturers expect 56 percent of the vaccine to be delivered by the end of October, 31 percent by the end of November, and the final 13 percent in early December.

The focus this year is to emphasize to physicians and other hospital care providers that their patients are not "too sick" to be immunized against influenza and pneumococcal disease while in the hospital. The CDC, ACIP, and the Infectious Disease Society of America (IDSA) recommend that the influenza vaccine be administered to high-risk hospitalized patients prior to discharge.

The VHQC encourages you to join in this initiative to fight against influenza and pneumonia. If you want to partner with the VHQC in its immunization campaign, please contact Annette M. Holmes, M.S.A., CPM, project manager, VHQC, at (804) 289-5320 or toll-free 1-800-545-3814.

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Training Programs for Employees of Licensed Assisted Living Facilities in Virginia

Virginia Geriatric Education Center

The Virginia Geriatric Education Center, jointly with the Virginia Department of Social Services, Division of Licensing Programs, is presenting training programs for employees of licensed Assisted Living Facilities in Virginia. The programs are made possible through the use of licensing fees. The programs are specifically designed for direct care staff, nurses, social workers, and administrators of Virginia's licensed Assisted Living facilities.

The 2001-02 year training topics include: The Cognitively Impaired Resident: A Caregiver's Workshop, Managing Aggressive Behavior, Employee Relations, Nutrition in Older Adults, and Activities. Each program will be delivered in eight locations around Virginia.

Two programs are currently in process. Upcoming dates and locations are listed. Attendance is $10 per person.

Registration forms are available through the VGEC by calling 804-828-9060 or online at http://views.vcu.edu/sahp/ gerontology/vgec/vgec.htm

Caring for the Cognitively Impaired Resident: A Caregiver's Workshop

CHANTILLY
Wed., Oct. 10, 2001

DUMFRIES
Wed., Oct. 24, 2001

ABINGDON
Mon., Oct. 29, 2001

ROANOKE
Tue., Oct. 30, 2001

Managing Aggressive Behavior

HAMPTON
Tue., Oct. 23, 2001

CHESAPEAKE
Wed., Oct. 24, 2001

RICHMOND
Wed., Nov. 7, 2001

DUMFRIES
Wed., Nov. 14, 2001

CHANTILLY
Thu., Nov. 15, 2001

ABINGDON
Wed., Dec. 5, 2001

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Calendar of Events

October 15-16, 2001
Governor's Conference on Aging: Touching Lives with Creative Solutions. Radisson Fort Magruder Hotel and Conference Center, Williamsburg, VA. For info contact (540) 231-2041 or www.conted.vt.edu/ aging.htm

November 9, 2001
Fraud, Scams & Slams. Southwest Society on Aging 2001 Oklahoma State Forums.
Norman Regional Hospital. For more info contact loriann@okstate.edu

November 15-18, 2001
2001-A Gerontological Odyssey: Exploring Science, Society and Spirituality. The Gerontological Society of America 54th Annual Scientific Meeting. Chicago Hilton and Palmer House, Chicago, IL. For info contact (202) 842-1275 or geron@geron.org

January 22, 2002
Legislative Breakfast. Annual gathering sponsored by the Virginia Center on Aging to report to the General Assembly and colleagues. St. Paul's Episcopal Church, Richmond, VA. For info contact (804) 828-1525

February 28-March 3, 2002
Teaching and Learning about Aging through Interdisciplinary, Intergenerational, and International Programs. The 28th Annual Meeting of the Association for Gerontology in Higher Education. Hilton Pittsburgh and Towers, Pittsburgh, PA. For more info go to www.aghe.org/annmeetinfo.htm

April 11-12, 2002
The Golden Years and Abuse: Working Together to Improve Services and Promote Independence. Edwin W. Monroe AHEC Conference Center, Greenville, NC. For info contact the Family Violence Program at (252) 758-4400, smunzer@pittfvp.org or Eastern Area Health Education Center at (252) 816-5215

July 20-25, 2002
8th International Conference on Alzheimer's Disease and Related Disorders. The conference will be held in Stockholm, Sweden. For more info go to http://www.alz.org/ internationalconference/program/plenary.htm or email internationalconference@alz.org