

Case Study

The Necessity of Leisure and Physical Activity

by Alison Clarke, C.T.R.S., and
Stephanie Goode,
Sheltering Arms Physical
Rehabilitation Centers

Educational Objectives

1. Explain the value and benefit of physical and leisure activity across the lifespan, regardless of physical limitations.
2. Identify barriers to participation in physical and leisure activity.
3. Discuss strategies to engage and maintain physical and recreational activity participation.

Background

By the year 2030, one in five Americans will be 65 years or older. Encouraging older adults to become and stay active has emerged as an important public health priority (CDC-HAN, 2014). While the physical and emotional benefits of exercise are increasingly well known, just 40 percent of older adults are engaged in regular

leisure-time and physical activity (Belza and Workgroup, 2007). Participation in physical and recreational activity tends to decline with age; however, increasing one's activity level and being involved in community life reduces medical complications and costly secondary disabilities. Adults managing a chronic condition or living with a lifelong disability may encounter physical, cognitive, social, or emotional barriers that affect their ability to maintain an active and healthy lifestyle. Regardless of setbacks, however, it is necessary to make adjustments or adaptations to ensure active participation in leisure activities to enhance quality of life. Research supports the concept that people with active, satisfying lifestyles will be happier and healthier (ATRA, 2003).

Nearly half of working age adults with disabilities in the United States engage in no aerobic physical activity, an important health behavior to help avoid chronic diseases. Arthritis, the most common chronic health condition in later life, often persuades people not to exercise when, in fact, active movement and exercise could be quite beneficial.

Adults with disabilities are three times more likely to have heart disease, stroke, diabetes, or cancer than adults without disabilities. Adults with mobility limitations (serious difficulty walking or climbing stairs) are the least likely to participate in aerobic physical activity. In a recent study, exercise training interventions (including aerobic and resistance) with older adults showed improvement in physiological and functional measures, and suggested longer-term reduction in incidence of mobility disability; moreover, a relatively high level of physical activity was related to better cognitive function and reduced risk of developing dementia (Paterson & Warburton, 2010).

Research also supports positive outcomes from recreation interventions for individuals with physical and/or developmental disabilities and older adults (ATRA, 2003). Engaging in community and physical activity helps to produce a sense of purpose, facilitates well-being, reduces depression, and decreases loneliness, all of which improves overall life satisfaction (ATRA, 2003). Leisure activities can also provide

Inside This Issue:

VCoA Editorial, 6
DARS Editorial, 8
VCoA Focus: Beverly Soble, 10
Elder Rights Award, 11

Couch Conversations, 12
Slow Gait, 13
Strength of Medicare, 14
Medicaid Fraud, 16

Shepherd's Center Programs, 16
Lindsay Institute, 17
ARDRAF Final Reports, 17
Calendar of Events, 18

opportunities for socialization, relaxation, entertainment, competition, and creative expression. There is evidence that participating in enjoyable and personally meaningful activities can be a useful coping mechanism both immediately after the onset of illness or traumatic injury and over time (Hutchinson et al., 2003).

What is Leisure and Why is it Important?

Leisure is unobligated time or “free time.” It is an attitude or emotional state of mind that one fosters about an experience, which can restore a sense of normalcy and control in one’s life. Leisure is a personalized experience; what one person identifies as a leisure activity may not be seen as a leisure activity by someone else.

A leisure experience is a continuum that includes the anticipation and planning of the activity, the actual participation in the activity, and remembering or reflecting on the activity. For example, the entire leisure experience for a travel trip includes the preparation, research, reservations, and packing, happenings while on the trip, as well as photos and memories created on the trip. All of these components encompass the leisure experience.

Benefits of participating in leisure include opportunities for enjoyment, a sense of well-being, competition, creative expression, socialization, laughter, relaxation, a new challenge, and even simply entertainment (ATRA, 2003). When physical or emotional challenges cross our paths, activities once enjoyed are often not considered

critical and, as a result, depression, isolation, and decreased physical activity can diminish overall quality of life. Hall (2005) places leisure activities in a larger perspective: “Most individuals do not enjoy activities until they have gained the skills to appropriately participate. Learning such skills may require multiple attempts at the same activity. Leisure also provides a basis for faith. If an individual is truly participating in leisure, they will have faith in their abilities, themselves, the activity and others, if applicable. In this reference, faith includes belief and confidences. This aspect of the definition is closely related to self-efficacy, and an important part of leisure.”

Types of Physical Activity

The increased energy demand for everyday tasks requires those living with physical disability to improve cardio-respiratory fitness. To maintain health, 20-40 minutes of aerobic exercise is recommended three to five times a week. Individuals participating in exercise can rate the strenuousness of exercise on a Rated Perceived Exertion (RPE) scale; that is, they can rate their effort from very easy (7) to extremely difficult (20). To be aerobic, exertion should be rated “somewhat hard” (13) to “hard” (16-17) on the RPE scale. Aerobic exercise can be accomplished through walking, stationary cycling, use of the arm ergometer, wheelchair pushes, etc. Strength training can include the use of resistance bands, free weights or weight machines (Franklin et al., 2000).

Individuals engaged in aerobic exercise may also calculate their

Target Heart Rate, determined by an exercise professional, and should attempt to reach and maintain this rate throughout their exercise. However, patients and professionals need to be aware of the potential effects of medications and implantable devices that can affect heart rates. For example, beta blockers and pace makers limit how fast the heart can beat, thereby skewing the measurement and making it unreliable as an indicator of exercise intensity. At the same time, strength training sessions are a valuable addition to an exercise routine; this can include functional or body weight exercise, resistance from elastic bands, conventional free weights, weight machines and, for those who are extremely deconditioned, water resistance. A typical protocol would consist of strength training on two non-consecutive days with one-three sets of eight-12 repetitions based on initial assessment by a qualified fitness professional. Flexibility exercises should be performed before and after all types of exercise.

It is highly recommended for an individual to receive medical clearance and meet with a qualified fitness professional prior to beginning a new exercise program. A fitness professional will help set realistic goals and develop a plan to achieve them. Gradually increasing time, distance, intensity, etc. will prevent muscle soreness or injury that may discourage return to activity.

Barriers to and Strategies for Participation

Barriers to leisure participation typically fall into the categories of attitudinal, physical/cognitive, and

financial resources. Attitudinal barriers are defined as feelings that leisure is not important, being unmotivated to pursue an activity, or the mindset of being unable to participate in the activity. Physical and cognitive barriers that impede participation include lack of initiation, the “I can’t do it anymore” outlook as a result of limited mobility or endurance issues, or challenges with safe participation due to poor problem solving. Financial resources can be a barrier, as some leisure activities are costly and require transportation or adaptive equipment that the individual may see as too expensive.

To overcome such barriers may require several actions, such as exploring leisure interests, examining obstacles, and making modifications to reclaim a lost activity. Modifying rules, using adaptive equipment, and exploring new functional leisure interests are strategies to resume participation. For instance, an avid golfer who can typically drive the ball 200 yards is experiencing a decrease in strength and endurance and can only drive the ball 100 yards consistently. A strategy for this individual would be to tee the ball up 100 yards down the fairway. There is still engagement in an activity that is outdoors, allowing opportunities for socialization, competition, challenge, and physical activity, while making adjustments to accommodate decreased physical stamina. The benefits of continued modified participation greatly outweigh giving up the activity. It is beneficial to schedule leisure time and physical exercise along with activities of daily living.

The majority of adults with disabilities will become more physically active if it is recommended by a health care professional, although fewer than half of patients receive any recommendations or guidelines from their health care provider (CDC Vital Signs, 2014). Some of the common excuses for not participating in an exercise program include lack of energy, fear of injury, lack of motivation, and lack of resources and skill set. Strategies for older adults to overcome these barriers include understanding that physical activity will increase energy level. Initially selecting an activity that requires minimal time may help get a person started on the right track. Learning how to exercise appropriately considering age, fitness level, skill level, and health status will minimize risk and concern of injury, according to Brown et al. (2010).

Getting Started

Beginning a leisure interest or physical activity routine can seem daunting, particularly when a health condition or physical limitation is involved. The following steps are helpful in getting started, as well as maintaining an active leisure lifestyle.

- 1) Set leisure time as a priority.
- 2) Keep a weekly time account of how much leisure or “unobligated time” you have.
- 3) Understand what the motivators of the leisure activity are. Why do you want to do it?
- 4) Modify the activity if necessary.
- 5) If the activity you are interested in is just too challenging now, explore new functional interests.
- 6) Find a “leisure buddy.”

7) Make a leisure contract with yourself: a) List four activities you least enjoy doing; b) List four activities you most enjoy doing; c) List four reasons you are not doing what you like to do; d) List three things you can do to manage your leisure time better; and e) Circle one thing and start doing it tomorrow.

Finding the motivation to kick start a physical activity routine can be overwhelming but implementing the following strategies may help get you started:

- 1) Find a physical activity “buddy” who you can plan to engage in regularly scheduled exercise.
- 2) Enroll in a structured exercise class which often ensures that you will attend the class on a given time and day of the week.
- 3) Purchase an exercise DVD to do in your own home.
- 4) Initially set achievable small physical activity goals, for example, a 10 minute walk twice a week, and add additional minutes or increase frequency as you are successful.
- 5) Identify professionals in the community who can serve as resources for information and assistance. Work as much as possible with existing community groups, such as the YM/YWCA, community centers, senior centers, health and sports clubs, schools, places of worship, and hospital wellness programs, etc. Contact local parks and recreation programs, enroll in a structured activity program, or sign up for group social outings through a church or civic group. If it is planned, organized, and scheduled, active participation is a more likely outcome.

Sheltering Arms: Partner for L.I.F.E Program

The benefits of participating in physical and recreational activity highlight a need for individuals with physical disabilities, older adults, and individuals managing chronic conditions to access services that can improve quality of life and physical activity level. Sheltering Arms is dedicated to helping people find within themselves the power to overcome serious setbacks following illness, injury, or accident through internationally recognized physical rehabilitation programs. The Sheltering Arms commitment does not end when therapy or physician services are complete. For more than a decade, Sheltering Arms has provided a comprehensive portfolio of community-based recreation and health and wellness services to meet the needs of the community. These services make up the Partner for L.I.F.E. program (Leisure, Interaction, Fitness, and Enjoyment), empowering individuals to embrace a lifetime of recreation and wellness. Its special programming provides an opportunity for people to re-engage in activities they once enjoyed and maintain an active social and physical lifestyle despite their limitations. The services provided are open to the public and do not require a physician referral.

The following case studies demonstrate the success of Sheltering Arms clients who have actively pursued engagement in physical and recreational activities to enhance their quality of life.

Case Study #1

Beth, a single 58-year old woman who was diagnosed with onset of Relapse/Remitting Multiple Sclerosis (MS) at 39 years of age, came to Sheltering Arms Hospital in two years ago for a recent MS exacerbation. Prior to this admission, due to her functional decline, she had returned to live with her mother and reported an inactive, passive leisure and physical activity lifestyle. Her symptoms included left leg numbness, weakness, and difficulty walking. During Beth's inpatient hospital stay, she received physician and nursing services, as well as physical, occupational, and recreational therapy services. After her discharge from the hospital, she resumed living at home with her mother and began outpatient physical and occupational therapy three mornings a week at the Sheltering Arms Midtown Center, while also participating in Club Rec (social recreation program) in the afternoon. She was discharged from outpatient therapy services after receiving two months of physical and occupational therapy, and continued to attend a full day of Club Rec three times a week for the past year and a half.

In a recent interview, Beth shared the many successes and outcomes that she has accomplished since her initial enrollment in Club Rec. She states that her participation in the program resulted in an increased level of engagement in physical, recreation, and social activities. She regularly participates in physical activity in the onsite fitness center, utilizing the support and encouragement of the fitness specialists. She participates in cardiovascular activ-

ities using the upper extremity ergometer arm bicycle and stationary bike, and has recently progressed to three minutes on the treadmill with a goal to increase to five minutes. She notes significant improvement in her endurance and physical strength. In addition, she has used the strength training equipment, progressing to pressing 200 lbs on the leg press. With a smile of satisfaction, Beth reports, "I am pumping iron." She has also been working on core strengthening activities during her designated fitness center times at Club Rec and reports improvement in her balance.

In addition to the physical strength and endurance improvements Beth has noted from her fitness workouts, she has also identified that her recreation and social life have improved because of then programs. During a typical week at Club Rec, Beth participates in an average of 12-15 organized group activities led by recreational therapists. She chooses her areas of interest from an array of activity offerings, consistently participating in the craft programs, spirituality group, sewing/upholstery group, and cognitive group activities, which she claims have helped improve her memory and recall. Beth also participates in one or two group community outings a week, providing her opportunities to shop, go out to eat, and see movies in the theater, which she does not have the ability to do on her own since she does not drive.

When asked what her involvement in recreation and physical activity has done for her, Beth states, "I am stronger physically, mentally, and spiritually. I am living independent-

ly since participating in these structured programs.” Beth reports many improvements in managing her MS since she has made an effort to change her lifestyle by increasing her activity level. She says, “I used to be quiet, but my confidence has improved and I am no longer feeling isolated. I have made new friends who have become like family to me and we provide encouragement for each other.”

Beth also notes a significant improvement in her outlook by sharing, “I wasn’t a very positive person. I was depressed and isolated, and all of that has changed. I am emotionally healthy and laughing now more than ever. Increasing my social and activity life has changed my outlook on life.”

Case Study #2

Richard, a retired engineer, suffered a heart attack in June 2008, at age 65. After undergoing valve-replacement surgery, he suffered a secondary stroke and developed pneumonia and stage-3 kidney failure. In September 2008, he was released from a rehabilitation hospital and subsequently received outpatient occupational, physical, and speech therapies for four weeks. He was discharged from all therapies in February 2009. Following these eight months of hospitalization and rehabilitation, Richard decided to join the fitness center at the Sheltering Arms Bon Air Center.

Over the course of the next five years, Richard participated in an independent exercise program developed with the direction and advice of Sheltering Arms fitness professionals. At the start of

Richard’s exercise program, improving aerobic and muscular endurance was the primary goal. Using a combination of a recumbent bicycle, an upper body ergometer, and treadmill, Richard gradually increased his time exercising at an RPE of 11-14 (light – somewhat hard). He began with two intervals of 10-15 minute bouts before reaching his goal of 30-45 minutes of continuous aerobic exercise. His resistance program consisted of multi-joint, functional exercises, at a low to moderate intensity (40-50% 1 Repetition Maximum), utilizing the major muscle groups. Examples of these exercises would include modified squats, step-ups and modified lunges. The program has helped him improve his overall balance, muscle strength and endurance. He completed his first 5K in May 2009 and 10K in 2010. Since then, he has participated in several other Richmond area 5K benefit walks. Although Richard has lost some of his fine motor sensation and movement in his hand, he is able to perform yard work and other activities of daily living with little difficulty.

Richard’s kidney function has remained stable and his A1C levels have been consistent. His cardiologist has decreased his cholesterol medicines and he no longer takes an ACE inhibitor to control blood pressure. Currently, Richard’s fitness goals include keeping up with his two grandchildren, ages one and four and being able to travel to Denver, Colorado to visit his adult children. Richard has also taken his dedication to a healthier lifestyle one step further by “giving back.” He serves as a mentor for others through his positive words of

encouragement as a volunteer at Sheltering Arms Hospital. As he says, “Without this place, I would not be here. My life is full.”

Conclusion

Physical activity and personal engagement in satisfying leisure activities remain central to wellness throughout life. Their importance does not diminish with age, disability or chronic illness. While chronic conditions and impairments may present challenges as we grow older, by using assistive devices and creative thinking, modifications can (and should) be made to make activities accessible and enjoyable. Exercise programming should be monitored regularly and may change, based on an individual’s disease progression, stabilization or improvement. In addition to various documented health benefits, such as decreased blood pressure, increased insulin sensitivity, and improved cardio-respiratory endurance, participating in physical and leisure activities tend to decrease isolation and increase inter-personal and community socialization, integral facets of independent living and quality of life.

Study Questions

1. What are common barriers to an active lifestyle for those living with a disability?
2. Why are leisure activities important in the recovery process?
3. Why is aerobic endurance exercise important for those with physical disability?

References

ATRA. (2003). *A viable option in*

Editorials

health and rehabilitation services: *Treatment to prevention*. Alexandria, VA: American Therapeutic Recreation Association .

Belza, B. and the PRC-HAN Physical Activity Conference Planning Workgroup. (2007). *Moving ahead: Strategies and tools to plan, conduct, and maintain effective community-based physical activity programs for older adults*. Centers for Disease Control and Prevention: Atlanta, Georgia.

Brown, D.R., Heath, G.W. & Levin Martin, S. (Eds.). (2010). *Centers for Disease Control and Prevention (CDC). Promoting physical activity* (2nd edition). Champaign, IL: Human Kinetics Publishers.

Centers for Disease Control and Prevention Research Centers Healthy Aging Research Network (CDC-HAN). (2014). *Accessed at www.cdc.gov/aging/han/pub-summary.htm*.

Centers for Disease Control and Prevention Vital Signs website. (2014). *Accessed at www.cdc.gov/vitalsigns*.

Franklin, B.A., Whaley, M.H., Howley, E.T. & Balady, G.J. (Eds.) (2000). *American College of Sports Medicine. ACSM's guidelines for exercise testing and prescription* (6th edition). Philadelphia: Lippincott Williams & Wilkins.

Hall, E. (2005). Living well in 2005. The benefits of leisure for people with disabilities. *Access Today*. *Accessed at www.indiana.edu/~nca/monographs/18livingwell.shtml*.

Hutchison, S. L., Kleiber, D. P., Ploy, D., & Dattilo, J. (2003). Leisure as a coping resource. Variation in coping with traumatic injuries and illness. *Leisure Sciences: An Interdisciplinary Journal*, 143-161.

Paterson, D.H., & Warburton, D.E. (2010). Physical activity and functional

limitation in older adults. *International Journal of Behavioral Nutrition and Physical Activity*, 7-38.

Resources

Sheppard, L., Senior, J., Park, C. H., Mockenhaupt, R., Bazzarre, T., & Chodzko-Zajko, W. (2003). Strategic priorities for increasing physical activity among adults age 50 and older: The national consensus conference summary report. *Journal of Sports Science & Medicine*, 2(4), 169.

www.accessstr.com (adaptive recreation equipment)
www.cdc.gov/virginia.disabilities
www.ncpad.org

About the Authors



Alison Clarke is a C.T.R.S (Certified Therapeutic Recreation Specialist) and Community Recreation Services Director at Sheltering Arms. A graduate of West Virginia University with a BS in Recreational Therapy and a Certificate in Gerontology, she is an advocate for community programs that ensure that all individuals maintain an active and healthy lifestyle regardless of setbacks and limitations that may arise across their lives.



Stephanie Goode is Aquatic/Fitness Manager; a certified athletic trainer, she has been with Sheltering Arms health and wellness since 2005. She believes everyone can benefit from exercise, regardless of age or ability, to improve quality of life.

From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

Calorie Labeling in Restaurants

Seventy percent of people in the USA are overweight or obese, reports the World Health Organization (WHO). Chain restaurants with 20 or more locations in the US will soon have to display calorie information on their menus, including drive-through menu boards, according to requirements of the Affordable Care Act. Will knowing what we are consuming make a difference in how "healthy" we eat? Will older adults pay attention? Will there be any effect on the "obesity epidemic"?

Eating out at restaurants is very popular and accounts for a surprisingly large proportion of calories consumed, even among older adults, famous for looking for "early bird specials." The majority of us do want to know what we are eating, with about 80% nationally in favor of menu labeling in chain restaurants, according to a recent representative national survey. Still, does knowing translate to changing our eating behavior, that is, to improving our nutritional intake? Will this change affect older adults in a meaningful way?

There's quite a bit of contradictory data regarding the effectiveness of telling consumers the nutritional value of what's on the menu. Drs. Jason Block and Christina Roberto, Harvard Medical School and Harvard School of Public Health,

Editorials

respectively, contributed an overview this summer to JAMA Online assessing the impact of menu labeling so far. They cite Bollinger & Sorensen's 2011 study of over 100 million transactions at Starbucks in New York City (subject to menu labeling), and at Starbucks in Boston and Philadelphia (not subject to menu labeling at the time), which found a significant calorie reduction (6%) per transaction after calorie labeling compared with before labeling. A 2013 study by Auchincloss and colleagues that appeared in the *American Journal of Preventive Medicine* reported that people dining at restaurants with calorie labels (in Philadelphia) purchased 151 fewer calories than those dining in restaurants without calorie labeling (outside Philadelphia), after controlling for demographic characteristics.

But Block and Roberto also cite other studies that report minimal or no effects of calorie labels, including research conducted by Dumanovsky and colleagues and published in the *British Medical Journal* in 2011; this study of over 7,300 New York City fast-food diners before and 8,489 diners after calorie labeling found no overall association between labeling and meal calorie content (828 calories before, 846 after).

Why the inconsistencies? The various studies used different population groups and sub-groups, a range of study sample sizes, different dining settings, and different times before and after menu labeling was introduced. Of course, "menu labeling" itself varied, with jurisdictions requiring different means of informing the consumer. Moreover,

some studies used control groups, while others did not.

Sampling differences aside, we do not know the long term effect of menu labeling. Will we consumers continue to take note of nutritional values posted or will we "attenuate" to them, becoming accustomed to and eventually ignoring the labels? Health care analysts have long worried that notices and warnings on cigarette packaging lose their impact upon those with a nicotine habit. Indeed, there's a current controversy about the cause and effect of becoming obese: do we grow fat because we eat too much or do we eat too much because we are fat and our fat cells impel us to eat more? In other words, if we are eating too many calories as a life pattern, is this pattern breakable? Put still another way, is the obesity epidemic feeding upon itself?

Additionally, there's the freedom of choice issue. Some say that governments at any level, whatever their motivation for the well being of their citizens, should not be trying to "control" diets; there's a freedom of choice issue at hand. Others maintain that, with the pooled resource process that is the core of both public and private health insurance policies, we have a vested interest in improving health because we pay for it if we don't.

Regardless of one's philosophical leanings, there seems to be a sustained and growing interest in identifying the nutritional value of what we put into our mouths. This may be, in part, practical, as data indicate that we eat out more frequently. Following this logic, requiring restaurant chains to report the calo-

ries of their offerings is likely to have an effect on public health because we eat out so often. Even older adults. People eat at fast food restaurants because they are "affordable."

Fast food, however, is loaded with excessive amounts of calories, sugar, sodium, and more. For example, according to this summer's *Consumer Reports* and the *Nutrition Action Health Letter*, Burger King's Triple Whopper contains 1,160 calories, 75 grams of fat, and 1050 mgs of sodium; McDonald's Crispy Chicken Bacon Clubhouse Sandwich has 750 calories, 38 grams of fat, and 1,720 mg of sodium; Hardee's 2/3 Pound Monster Thickburger hefts 1,330 calories, 66 grams of fat, and an astounding 1,990 mgs of sodium; Taco Bell's Cantina Burrito-Steak carries 750 calories, 28 grams of fat, and 1,940 mgs of sodium. Each of these items is in the \$3-\$4 range. Indulging in a Starbucks Caramel Ribbon "frappuccino" gives us 600 calories and an estimated 21 teaspoons of added sugar.

Fortunately, I suspect that many of today's older adults are unlikely to indulge regularly in the burgers and fries diet. But there are significant exceptions, primarily due to income and geography. Socioeconomic status does play an important role. Living on the edge financially, a person is more likely to choose the cheapest items on the fast food menu. As others have noted, good nutrition is expensive, while poor nutrition is affordable.

There's also an age effect in play, I believe. Adolescents and young adults may be more likely to con-

Editorials

sume outrageous food items regularly because of self-perceived immunity from consequences or because they challenge restrictions or because they do not project the effects long term. However, if they grow older, they will bring this lifestyle into later life.

Already, some restaurant chains have begun to reduce the calorie content of their menu items. Anticipating response from the public after menu labeling laws go into effect, some chains elected to reduce calories, e.g., Burger King has a lower-calorie french fries option; McDonald's is allowing customers to substitute salads for fries in value meals; and Taco Bell is revamping its menu choices. Such chain-wide changes could create a positive public health consequence.

As Block and Roberto note, menu labeling should be viewed as an early approach in governmental policy to address the obesity epidemic. They advise that researchers should be vigilant as implementation begins. "Specifically, future studies should examine whether calorie labeling increases disparities among those with lower numeracy (the ability to understand and work with numbers) and health literacy or has unintended consequences in populations who might be prone to increase calorie intake after labeling, such as adolescents." To my mind, a major focus should be upon the life course effects of this well-intended intervention.

From the **Commissioner, Virginia Department for Aging and Rehabilitative Services**

Jim Rothrock
Co-authored by Marcia
Dubois and A.J. Hostetler

No Big Summer Respite

This summer, traditionally a time of vacations, has been a time of accomplishment in helping DARS meet its mission of improving the employment, quality of life, security, and independence of older Virginians, Virginians with disabilities, and their families. From meetings to new grants to new staff, DARS was a beehive of activity. Here is some of the buzz.

In September, DARS partnered with the United Way of Greater Richmond and Petersburg to sponsor an Age Wave Leadership Forum for communities throughout the Commonwealth actively planning for the age wave. Thirty-six participants represented Virginia's diverse geographic areas.

The purpose of the meeting was to learn from existing age wave planning initiatives and to develop alignment of efforts and best practices that can be disseminated statewide. Some of the activities included:

- Identifying measurement and data management tools
- Discussing implementation strategies, successes and challenges
- Identifying funding sources and creative strategies to build sustain-

ability into these initiatives

- Brainstorming creative marketing that reflects the vibrancy of our regional and collective work on training, education, and workforce development
- Defining livable communities
- Increasing elder engagement
- Considering alignment opportunities

Feedback from the meeting was extremely positive. Participants expressed renewed enthusiasm for their respective planning efforts and wanted to meet again to continue this collaboration. They also suggested an online forum for shared work and communication. Marcia DuBois has created an Age Wave Planning tab on the Blueprint for Livable Communities website to serve as a repository for information and she will create an e-mail distribution list as well for group members to communicate with one another electronically. Members will also be asked to invite others to join the network.

We will produce a summary document for dissemination to participants and for posting on the website so that the work of these initiatives may be used as best practices by other planning groups throughout the Commonwealth. Next steps will include identifying a few key common indicators to measure progress in age wave planning statewide.

Another successful venture was in the realm of securing new federal grants to expand the efforts of the Aging Network across our Commonwealth.

We just received notice of two

federal grants to strengthen Virginia's support networks of care as the Commonwealth faces an aging population that will experience chronic diseases and an increasing prevalence of dementia. Although the age wave of Baby Boomers has long been coming, Virginia lacks sufficient training for care providers, as well as first responders and even the formal or informal caregivers, to respond adequately to this growing demand. These new grants will help the Commonwealth inventory and assess available services and supports for people with dementia as well as for individuals with disabilities, and their families and caregivers, identify gaps, and develop a plan to serve these vulnerable populations better.

A \$441,131, three-year grant from the Administration for Community Living will help expand Virginia's No Wrong Door system (the name and philosophy behind Virginia's Statewide ADRC System), train NWD partners, and implement the New York University Caregiver Intervention pilot program, with the goal of establishing Virginia as a dementia-capable state, with programs tailored to the unique needs of people with Alzheimer's disease or other dementias, and their caregivers.

The grant will help initiate the intervention program in the greater Charlottesville and Williamsburg areas to provide better coordinated services for many of the roughly 130,000 Virginians who have dementia and their families and caregivers. Putting the supports and coordination of services into place now is key, given federal estimates

that predict the number of cases of Alzheimer's in Virginia to increase 46% to 190,000 cases in 2025.

Each case represents a person who needs care, whether from a family member, often a daughter, who may know little about the services available to their loved one with dementia or for themselves. The grant also aims to help caregivers feel more confident in that role, with more satisfaction with their social and emotional support networks, lessen the depression that can often hit caregivers, and help the caregivers feel more comfortable in responding to the behavior that can sometimes affect people with dementia. The agency hopes to expand the program beyond the pilot locations to other locales across the Commonwealth.

Virginia is striving at the local and state levels to address these intertwined issues. In response to the *2011 Dementia State Plan*, the General Assembly created the position of "dementia services coordinator" to review existing programs, identify gaps, reduce duplication and work with agencies to deliver services more effectively to Virginians with dementia. In 2013, DARS hired the Commonwealth's first coordinator, who also supports No Wrong Door.

Additionally, DARS recently received notice of a three-year lifespan respite grant of \$117,695 from the ACL. Lifespan respite care programs are coordinated systems of accessible, community-based respite care services for family caregivers of children or adults with special needs. The program helps to support, expand, and streamline

delivery of planned or emergency respite services. The need for respite care for these families is great. For example, an estimated 447,000 people in Virginia provided 509 million hours of unpaid care in 2013 to individuals with dementia, at a value of \$6.3 billion.

These many hours of caregiving often take a toll on families, who may not know where to turn for services, how they can take a break, or even how they can take manage to see the dentist. This new respite funding comes almost two years after the agency received a previous grant to provide respite to Virginia families who care for a loved one with disabilities or chronic conditions. Under a limited voucher program, qualified caregivers received up to \$400 reimbursement for respite-related costs. More than 400 Virginia families were assisted with those vouchers, with some recipients reporting that they were able to take time for themselves for the first time in years.

Finally, we at DARS were honored to have Robert Brink join our team as Deputy Commissioner for Aging Services. Bob distinguished himself with 17 years of service in the Virginia House of Delegates. His experience on the Joint Commission on Health Care and the House Appropriations Committee assure that his contributions will be a great asset for all that we do.

Bob will also assume authorship of the DARS editorial in this publication and you can look forward to his offerings.

Focus on the Virginia Center on Aging

Beverley A. Soble



Beverley Soble has long been, and continues to be, an important member of the Advisory Committee of the Virginia Center on Aging. As she transitions into retirement from the Virginia Health Care Association (VHCA), her employer since October 1985, she is grateful for the opportunity to reflect on how she stumbled into the field, as well as the many positive changes in long term care that she has observed.

Extensive community volunteer involvement and work as a Medical Technologist (M/ASCP) in acute care led Beverley to VCU to complete a Master degree in Social Work Administration. After working as a Program Director with the Virginia Department of the Visually Handicapped (now the Virginia Department for the Blind and Visually Impaired) and the Virginia Rehabilitation Center for the Blind and Visually Impaired, a colleague mentioned a newly created position with the Virginia Health Care Association and suggested she apply. In a combination of fate and luck, she seized the opportunity and has been at VHCA ever since.

As VHCA's Vice President for Regulatory Affairs, Beverley has made a career of working with all sides. Engaging providers, advocates, legislators, and state agency staffs has easily been the most enjoyable and rewarding aspect of her professional career over the years. Anyone

who has met and interacted with Beverley surely knows that she can be direct but honest, quick-witted, and totally devoted to resolving important issues and advocating for older adults.

In her position at VHCA, Beverley has witnessed positive and challenging changes to the long term care profession. Early in her tenure, Beverley guided the Association and Virginia's providers through the passage and subsequent implementation of the Omnibus Budget Reconciliation Act (OBRA) of 1987, the most far-reaching overhaul of long term care service delivery and accountability. Since then, she has continued to witness the evolution of long term care. She notes that when she started, nursing facilities provided custodial care, while assisted living facilities were considered retirement options. Over the years, however, nursing facilities have progressed to operate as "mini-hospitals" providing step-down care, while residents in assisted living facilities continue to present with more complex care needs than originally intended in those settings.

In thinking about this evolution and what she is most proud of in her time at VHCA, Beverley mentions several regulatory and legislative changes, including requirements for licensure of assisted living facility (ALF) administrators; training, testing, and registration of Medication Aides; public disclosure obligations around services and staff qualifications in ALFs; and regulations related to safe and secure units in assisted living facilities.

Beverley also contributed to the

development of Virginia's Advanced Nurse Aide Education program; Virginia's Pressure Ulcer Resource Team, a public-private partnership which has worked diligently to prevent and treat pressure ulcers in long term care; and the Virginia Restraint Reduction Initiative, which saw the Commonwealth improve dramatically from the highest ranked state for restraint use in nursing facilities to one of the lowest. Most recently, she has provided valuable input to two DARS-led studies; one on dementia care best practices and one on needs and trends for adult protective services.

Beverley has been a major driving force in the creation of the Geriatric Mental Health Partnership which continues to lead innovative and cross-disciplinary efforts to improve behavioral health care for older Virginians. As mentioned, she has served on the Virginia Center on Aging Advisory Committee for over 10 years, including several terms as Chairwoman.

When asked about what changes or developments may be on the horizon for long term care, Beverley shares a conviction that the health care delivery system, as a whole, needs to be addressed to prepare for the aging population. She also cites a growing emphasis on managed care and continued tension between service scope in nursing facilities and assisted living facilities. In looking to the future, she offers advice for younger people looking to a potential career in the field of aging: follow your passion and your moral compass. Beverley is quick to note that she has always felt that her career was a "calling" rather than a job, and she remains ever

passionate about advocating for quality in long term care.

Beverley grew up in Martinsville, Virginia and currently lives in Richmond, Virginia with her husband, Jerry. She has three children, Michael, Steven, and Larry and four grandchildren, all of whom are particularly impressed by her ever-developing skills with technology devices. In preparing this piece, Charlotte Arbogast, Dementia Services Coordinator at DARS, sat down with Beverley to review her many years in long term care and her even greater accomplishments. We greatly value her accomplishments and look forward to her continued engagement with our Virginia Center on Aging.

Would You Like to Switch from Postal to E-Mail Delivery?

We currently publish *Age in Action* in identical print and PDF versions. *Age in Action* will be transitioning over time to an electronic version only. If you now receive hard copies by postal mail, please consider switching to e-mail distribution. Send an e-mail listing your present postal address and best e-mail address for future deliveries to eansello@vcu.edu.

Thomas G. Fonseca Wins 2014 Virginia Elder Rights Award

On July 24th, the Virginia Elder Rights Coalition presented its 2014 Erica F. Wood Elder Rights Award to Thomas G. Fonseca, a vigorous and creative advocate who has improved the lives of thousands of Virginians in long-term care residences. The Virginia Elder Rights Coalition is a network of organizations, agencies, and individuals working together to promote the rights and autonomy of older Virginians. The Coalition has presented Elder Rights Awards since 2000.

Tom Fonseca is an innovative advocate for elder rights who has left an indelible mark on the lives of thousands of Virginians in long-term care residences. When he served as a volunteer Long-Term Care Ombudsman in a nursing home, he was struck by “the palpable sense of boredom” he saw. To address this concern, he created a non-profit entity, The Fenwick Foundation, www.facebook.com/FenwickFoundation,

to develop social, entertainment, and educational opportunities for residents of nursing homes, assisted living, VA facilities, group homes and senior apartment buildings. From 2011 through April 2014, over 7,600 residents in more than 50 facilities have participated in outings to over 500 different events. The outings that the rest of the world takes for granted would have been impossible for these residents without Tom’s help, and have served to brighten resident lives and change staff attitudes. Tom solicited and received small grants from many

foundations and charitable organizations to sponsor the events. While raising needed funds, this outreach educated other organizations about the needs of residents of nursing homes and assisted living. Tom also promoted use of para-transit options to help residents get around in the community to participate in the fabric of community life. Additionally, Tom served for three years as an active chair of the Arlington Commission on Long-Term Care Residences.

The Virginia Elder Rights Coalition has presented Elder Rights Awards since 2000. Past awardees include: Thelma Bland Watson of Senior Connections, Sen. Joseph Gartlan, journalist Betty Booker, Del. Karen Darner, Secretary of Health and Human Resources Jane Woods, attorneys Harriette Shivers and John Molumphy, paralegal Anne See, the Virginia Long-Term Care Ombudsman Program, Elyse Politi, VICAP Coordinator, Jay Speer of the Virginia Poverty Law Center, Sen. Mary Margaret Whipple, Del. Patrick Hope, and Margaret Sturgill of the Mountain Empire Older Citizens, Inc.



Thomas G. Fonseca receiving the 2014 Elder Rights Award from Virginia Elder Rights Coalition Chair Kathy Pryor.

The Couch Conversations

by Gary Barg

My dad had his own special place on the couch in our living room as I was growing up. Nothing too “Archie Bunker’s chair” about this situation. Just anytime the family was sitting on the couch, that was where he sat. And if you were sitting in that space at any other time, it was still known as “Dad’s space.”

Sometimes late into the night, I used to sit on the other end of the couch talking with him about many varied topics: what happened during the day that was keeping Dad up so late, politics, music, even some of the latest jokes he heard from the guys at his plant. What we never really spoke of was his own childhood. He was born in 1929, spent his early years in Philadelphia, and then moved north to the Delaware Valley area of Pennsylvania. He joined the Marines during the Korean War and was stationed in Miami, Florida, when he met my mom.

The living room in question was in North Miami Beach where I grew up in the 60s and 70s, until moving off for college.

The reason I bring up these couch conversations is that, whenever I would return home to visit after his diagnosis with multiple myeloma in 1990, we resumed these conversations as if no time had passed. One night as I was passing through the living room, I saw him deep in thought. Upon noticing me, he waved me over to sit and started to

tell me what he was thinking about.

For the first time, he spoke of his childhood to me. A therapist he had been seeing asked him to think back to the first place he could remember where he felt safe and at peace. She asked him to think back to that place whenever the pain was too much to bear.

Now, Dad was no fan of therapy. In fact, this was the third psychologist he had begrudgingly agreed to see after deciding that the sessions with the previous therapists were a waste of time and that none of them understood him at all. This particular therapist, however, seemed to hit the spot with this specific exercise.

Dad told me that whenever things would get too stressful as a kid, he would retreat into the woods around his house into a hidden area just the right size to hold a kid and his dreams. There was nothing physically unique about the location, just some sheltering trees and soft grass on a rolling hill, but that was his spot. He smiled as he told me of the time he spent in his own secluded hideout. Although I know that development and the passing decades have erased this private sanctuary, whenever I am in that neck of the woods, I look off into whatever woods I see and wonder...

.... I think that Dad’s story makes clear that respite does not necessarily mean taking a much needed vacation away from home, but can also be found in those private recesses of your mind where peace still reigns. With a little bit of quiet time and some practice, this type of mental respite can be accessed upon demand.

Thanks to Dad, I’m still learning from our couch conversations.

© Reprinted with permission Today’s Caregiver magazine and caregiver.com (800-829-2734).

Long Term Care Resource Training

Learn different options that are available to shift care from a nursing home to an individual’s home with the use of community supports and services. Training will include a variety of resources that can help to prevent the institutionalization of older adults and people with disabilities so they can live a full life in their community. This short, informational training is for anyone in the health or human service professions serving people with disabilities of all ages and older adults. To schedule a training, contact Kelly Hickok, Resources for Independent Living, Inc., at (804) 353-6503 or hickokk@ril-va.org.

73% of the funding for this training was provided by the Virginia Board for People with Disabilities under the federal Developmental Disabilities and Bill of Rights Act.



Slow Gait Predicts Cognitive Decline?

Will results from a large, multi-country research initiative lead to a simple and low-cost means of detecting cognitive impairment? Researchers studied almost 28,000 older adults (mean age 71.6, mean education seven years) in 22 cohorts in 17 countries, including seven in North America, to measure prevalence of motoric cognitive risk syndrome (MCR). This is a newly developed diagnosis that incorporates cognitive symptoms and slow gait in patients without dementia or mobility-related disability. The researchers found MCR to be an early risk factor for cognitive decline. The study was published online July 16th in *Neurology* and reported in *Medscape Medical News* on July 30th.

MCR, a predementia syndrome, is diagnosed with simple questions about memory and accessible ways to measure gait speed, such as using a stop watch to time walking over a fixed distance. "Gait speed has a common metric, high reliability between different protocols, and excellent validity in predicting health outcomes," noted lead author Joe Verghese, MBBS, professor, Department of Neurology and Medicine, Albert Einstein College of Medicine, and chief, geriatrics, Einstein and Montefiore Medical Center, Bronx, New York. Furthermore, unlike neuropsychological, laboratory, and imaging tests that can detect predementia syndromes, gait speed testing is readily available and practical in most settings.

Its simplicity allows the range of

health care providers and even trained office staff members to assess for MCR. This could be an especially attractive feature in developing countries and places where insurance does not cover sophisticated screening tools. "There are other predementia syndromes that have been identified, but almost all of them rely on cognitive testing or biomarkers or doing imaging studies, and these procedures may not be practical in many clinical settings around the world that have few resources," said Dr. Verghese.

The research found MCR in about 10% of study participants, pooling data from countries around the world; prevalence was similar in men and women, but higher in those older than 75 years. The lowest MCR prevalence was in the Australian (2%) and United Kingdom (2%) studies that recruited ambulatory older adults with high walking speeds. The highest prevalence was in French (16%) and Indian (15%) cohorts that enrolled older adults with cognitive symptoms. The findings also showed that those with MCR are about twice as likely as their counterparts without this diagnosis to develop dementia.

MCR is diagnosed independent of cognitive tests. In the studies included in this analysis, cognitive problems were ascertained from standardized questionnaires. Gait speed was measured quantitatively as well as timed over a fixed distance. Slow gait was defined as a walking speed of one standard deviation below age- and sex-specific means individualized to each of the 22 cohorts. Mean gait speed in the analysis was 81.8 cm/s (about 32

inches).

Participants with MCR had worse performance on all cognitive tests than those without MCR, as well as a higher prevalence of vascular and nonvascular disease. Higher education (12 or more years) was associated with reduced risk for MCR, a finding that "needs further scrutiny to gain insights into potential interventions," the authors write.

The researchers looked at MCR and risk for cognitive impairment, defined as a change in score of four or more on the Mini-Mental State Examination (MMSE) during follow-up in four studies. The MMSE is a brief 30-point questionnaire, with scores of 27 or more indicating normal cognition. Three of these follow-up studies were from the United States (Hispanic Established Populations for Epidemiologic Studies of the Elderly [HEPESE], Memory and Aging Project [MAP], and Religious Orders Study [ROS]), and one was Italian (Invecchiare in Chianti [InCHIANTI]). In this analysis, MCR predicted incident cognitive impairment in all four cohorts with adjusted hazard ratios (aHRs) ranging from 1.48 to 2.74.

MCR also predicted incident cognitive impairment when the analysis was restricted to those with baseline MMSE scores of 28 or more, that is, normal cognition (aHR, 1.65).

MCR was associated with increased risk for Alzheimer disease (AD) dementia in the two cohorts that included this subtyping: MAP and ROS, which together included more than 2,000 participants. This finding was "surprising" given that in

earlier research (the Einstein Aging Study), MCR predicted vascular dementia but not AD, said Dr. Verghese. Unfortunately, in this new analysis, the studies didn't include the vascular sub-type of dementia, "so we couldn't say if MCR also predicted vascular dementia", added Dr. Verghese.

Gait speed may not be the strongest motoric predictor of dementia, although there's limited information on the predictive validity of other motoric signs for dementia, such as tone or strength. On the other side of the ledger, so to speak, gait speed itself may be affected adversely by medications, low back pain, arthritis, depression, and other internal and external factors. So there will need to be further research that can exclude these as influences on the findings. Still, gait speed seems to be emerging, from this and other studies, as a potentially valuable and easily measured marker of deterioration in physical and cognitive health.

Visit Our Websites

The website for the Virginia Center on Aging is www.sahp.vcu.edu/vcoa. Visit to learn about programs from lifelong learning to geriatrics training, to access the archives of issues of *Age in Action*, ARDRAF reports, and more. The website of the Virginia Department for Aging and Rehabilitative Services is www.dars.virginia.gov. Visit to learn about services, commissions, boards, and councils on adult protective services, aging, Alzheimer's, guardianship, independent living, and more.

The Strength of Medicare: Takeaways from the Trustees' 2014 Report

(Keith Fontenot and Kavita Patel, contributors to Health Affairs, a leading journal in health policy analysis and research, posted comments August 14th on Health Affairs Blog regarding the 2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Funds. Total Medicare expenditures in 2013 were \$583 billion and the Trustees project that these expenses will grow faster than the economy and workers' earnings, when taken through the 75 year projection. For instance, Scheduled Hospital Insurance tax income would cover only 85 percent of estimated expenditures in 2030 and 75 percent in 2050. The Trustees also project a decline in Medicare's solvency if Congress scales back the Affordable Care Act. Fontenot and Patel's comments are excerpted here.)

Depending on which article you read, either the Medicare Trustees think the program is coming to an end, or the news is great and we don't need to do anything.

The reality is that the recent Trustees' report contains both positive and sobering news: while costs have been flat for the last two years and growth is expected to moderate for some years to come, Medicare's financing is still not in good shape over the long run. Current law benefits exceed financing to pay for them, and the Hospital Insurance

Trust Fund will be unable to pay full benefits in 2030.

We cannot assume the problem will resolve itself, and action is needed to ensure the program's stability. Moreover, health care remains a substantial portion of the national budget, a whopping 25 percent, and addressing federal fiscal imbalances must include health programs.

Below we provide our key takeaways from this year's Trustees' report.

1. For the second year in a row, per person costs in Medicare were essentially flat. Of course, we will continue to see an increase in the number of beneficiaries as baby boomers age, and this decline in the growth of costs per capita comes at a propitious time. The central questions are: how much of this decline will endure and for how long? Costs have declined before, in the late 90s, only to accelerate again. Regardless of if and when the spending slowdown ends, future health care spending will grow from a lower starting point moving forward, and that's the good news.

2. Long-range projections are fraught with uncertainty. The report includes a set of alternative projections that illustrate the effects of Congress scaling back several Affordable Care Act (ACA) reforms of Medicare payments. The results show a significant decline in Medicare's financial solvency. At the same time, actuaries caution that achieving the path set by the ACA will be extraordinarily challenging for providers over the long term, unless they can substantially increase productivity.

3. *If you look at the first 20 years of the forecast, there is positive news.* Twenty years is still a long time in health care, but projections of health spending 20 years out are certainly more likely to be in the range of actual spending than estimates 75 years out. Compared to the 2009 report, before the ACA, the latest projections of Medicare expenditures in 2035 are down from 7.2 percent of GDP to about 5.4 percent, a decline of nearly 1.9 percent of GDP.

4. *The report was noteworthy for having a more realistic perspective on physician payments.* Namely, the Trustees now assume that the mandated 21 percent reduction in Medicare physician payments, which Congress has overridden for twelve consecutive years, is likely to be overridden on an ongoing basis. This makes the forecast slightly more realistic and highlights several challenges with the sustainable growth rate (SGR) formula.

The Path Forward

It is clear that action is necessary to solidify these gains while also addressing future problems, but what kind of action? An array of changes should be considered, but most importantly we need to pursue promising models for sustainable payment reforms that will require movement away from fee for service.

There are a number of examples:

Accountable Care Organizations (ACOs) and Shared Savings

Models: The uptake and interest in both the Medicare ACO programs

and Medicaid and private ACO contracts have been significant, but programmatic changes still need to be made. It is not clear if these models can be replicated by all providers, or if substantial savings can be achieved nationwide.

Bundled Payments: Similarly, there is much public and private interest in bundled payments, with a focus on inpatient efforts and care transitions. This model is much clearer for episodes of care oriented toward discrete procedures or featuring clearly defined start and end points for the bundle. But while unit cost can be contained by a bundle, it does not control volume. Unfortunately, there tends to be very little patient engagement focus within this model.

Patient-Centered Medical Home: Built largely on a fee-for-service basis with person-based payments for improved care coordination, this model is often considered a foundational element for other FFS-based reforms or ACOs because of its simplicity. It generally involves a flat fee per patient per month, but often it lacks financial risk as well as robust clinical outcomes measures.

Promising new areas of payment reform that have received bipartisan attention and support from various organizations include:

Additional Alternative Payment Models: Particularly significant will be models that can emphasize specialty care and its coordination with primary care. Models for shared savings with two-sided risk in oncology and cardiology are emerging in the private sector with

potential for scale in Medicare and other settings.

Post-Acute Payment Reforms: A single bundled payment, determined by a patient's specific care needs, for the care a beneficiary receives upon hospital discharge could, if implemented in combination with strong quality measures for accountability, bring about substantial efficiencies in this sector.

Payment models with direct beneficiary engagement: A critical assumption in movement towards value is an emphasis on patient-centered care, a factor that can be incredibly effective when patients and caregiver are truly engaged. Suggestions for the next model of ACOs include direct enrollment/voluntary assignment, which could be important elements in improving care coordination and managing care transitions across different provider settings.

Above all, the most important thing we can do in the short term is to make sure that Medicare is firmly directed away from paying for each individual service, and towards innovative payment models that focus on better, more accountable care. A strong commitment to that direction now is essential to ensuring that we can increase the efficiency and quality of our health care sector and capitalize on recent declines in health care costs.

Virginia's Medicaid Fraud Control Unit Named Best in Nation

The Virginia Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General has won the Inspector General's Award for Excellence in Fighting Fraud, Waste, and Abuse, an award presented annually to the nation's top MFCU by the U.S. Department of Health Office of the Inspector General (OIG.)

MFCU broke its own record for the largest case ever investigated by a state agency for its \$1.5 billion case against Abbott Labs for improperly marketing and promoting the prescription drug Depakote. Virginia's MFCU previously won the OIG Award in 2008 following a similar case against Purdue Pharma which was the largest ever at the time. The award was presented to Virginia MFCU Director Randy Clouse during a ceremony at the U.S. Department of Health in Washington.

"Virginians should be proud that they have a nationally renowned agency protecting their tax dollars, as well as the health of needy Virginians," said Attorney General Mark Herring. "This award is proof that Virginia's MFCU team and its director Randy Clouse are setting the standard for creativity, collaboration, and tenacity in going after providers who would weaken our Medicaid program through fraud or abuse."

Criteria for the OIG Award of Excellence include the MFCU's impact as measured in monetary recoveries and convictions, but also

the use of innovative investigative and prosecutorial techniques and the MFCU's success in collaborating with the OIG Office of Investigations, State Medicaid agency, and other law enforcement partners.

In nominating Virginia's MFCU for this award, the Office of the Inspector General pointed out the unit's strong partnerships and collaborative work with the Virginia Department of Medical Assistance Services, the Offices of the United States Attorney for the Eastern and Western Districts of Virginia, the Federal Bureau of Investigation, the Internal Revenue Service's Criminal Investigation Division, the Virginia Department of Health, the Virginia Department of Social Services, and the United States Department of Health and Human Services' OIG.

The Virginia MFCU of the Office of the Attorney General was certified in 1982 by the U.S. Department of Health and Human Services. The MFCU has a staff of 96 employees, including criminal investigators, auditors, attorneys, and support staff who work together to develop investigations and prosecute cases. The Virginia MFCU works regularly with federal, state and local law enforcement agencies to combat fraud, protect Virginians enrolled in the Medicaid program, and save taxpayer dollars. Since 1982, the MFCU has more than \$1.8 billion in criminal and civil recoveries including affirmative civil enforcement cases (ordered and collected reimbursements, fines and restitutions.)

Shepherd's Center of Chesterfield Fall 2014 Schedule

Adventures in Learning Program!

Wednesdays: 9:00 a.m. - 3:15 p.m.
September 24th - November 12th
Chester Baptist Church, Chester

There are many classes to choose from, including: Tai Chi, Watercolors, Writing Your Life Story, Yoga, Origami, Cooking for One or Two, Electronic Devices, Authentic Thai Cooking, Quilting, Needlepoint, Knitting and Crocheting, Genealogy, Flowers Made Easy, Bible Study, Literature, History, Tube Acrylics, Vintage Films: Hitchcock-The Final Eight, Discussions on Climate Change and The Chesterfield County Age Wave Coalition, Politics, Folk Music, and Line Dancing. For information, please call (804) 706-6689.

2014 DARS Meeting Calendar

Commonwealth Council on Aging (Wednesdays)
January 28, 2015
Held at Senior Connections.

Alzheimer's Disease and Related Disorders Commission (Tuesdays)
December 2, 2014

Public Guardian and Conservator Advisory Board (Thursdays)
November 20, 2014

For more information, call (800) 552-5019 or visit <http://vda.virginia.gov/boards.asp>.

Retirement Movers (and Shakers)

The Pew Charitable Trusts maintains a research and analysis section called Stateline, which is focused on tracking comparative trends and data among the various United States. Stateline recently posted, under the heading *Retirees on the Move Again*, an interactive map for visitors to learn how each state stacks up in the renewed wave of retirement moves, now that the economic recession of 2007 has abated. One can click on any state to learn about the number of moves by individuals ages 55+ during 2006-2009 (recession era), 2009-2012 (post recession era), and current median property taxes.

Movers ages 55+ tend to spell increases in the retiree population for the receiving state, along with increased discretionary spending by the newcomers. Comparing the recession years of 2006-2009 to 2009-2012, Florida, not surprisingly, is the most likely destination for movers 55 and older, gaining about 55,000 older movers each year. Other states attracting these movers include Arizona (25,000), North Carolina (12,000), and South Carolina (11,000); states losing these movers include New York (-31,000) and California (-12,000). Low cost of living and warm weather seem to be what draws these movers. They tend to move from colder or high cost states such as New York, New Jersey, and California in search of warmer and lower cost states like Florida, Arizona, North and South Carolina. Many of the destination states also have relatively low property taxes; for example, Stateline

reports that South Carolina's median annual property tax bill is just \$769, compared to almost \$7,100 in New Jersey.

The Web address is a long one but worth the visit:

<http://www.pewstates.org/research/data-visualizations/retirees-on-the-move-again-85899546600>.

Lindsay Institute for Innovations in Caregiving

On the evening of September 11, 2014, SeniorNavigator hosted a celebration at Pippin Hill Farm in Charlottesville to launch the new Lindsay Institute for Innovations in Caregiving. This is a collaborative effort aimed at improving the health of caregivers, with a special focus on caregivers of individuals with memory impairments. The Institute was renamed for one of its co-founders, Dr. Richard W. Lindsay, for his lifetime achievements and numerous contributions supporting older adults and caregivers in Virginia and beyond. For more information about The Institute, visit CaregivingInnovations.org.



Adrienne Johnson, Executive Director of SeniorNavigator and Project Manager of The Lindsay Institute for Innovations in Caregiving; The Honorable John H. Hager, and Dr. Richard Lindsay, Honoree.

ARDRAF Final Reports Summaries Available

ARDRAF 2013-14 awardees have submitted their grant summaries:

- 1) *Assessment of Whether Genetic Risk Factors for Alzheimer's Disease and Vascular Dementia Are Associated with Cognitive Impairment in Parkinson Disease*, by Matthew J. Barrett, M.D., M.Sc., Bradford B. Worrall, M.D., M.Sc., and Stephen D. Turner, Ph.D. (UVA).
- 2) *The Impact of an Interdisciplinary Virtual Healthcare Neighborhood on Sleep, Healthcare/Social Support, and Self-Efficacy among Caregivers of Elderly Persons with Dementia*, by Christianne Fowler DNP, RN, GNP-BC and colleagues (ODU).
- 3) *Promoting Change and Action in Person-Centered Care Practices Using a Multi-Media Approach*, by Karen Love, B.S., Elia Femia, Ph.D., and Sonya Barsness, M.S.G. (CCAL).
- 4) *Remodeling of DNA Methylation Associated with Increased Beta Amyloid Deposition in Mice*, by Gary D. Isaacs, Ph.D. (Liberty University).
- 5) *Bright Light Therapy for Individuals with Dementia*, by Lisa L. Onega, Ph.D., R.N. (Radford University).
- 6) *Development of Curcumin/Melatonin Hybrids as Neuroprotective Agents for Alzheimer's Disease*, by Shijun Zhang, Ph.D. and Hyoung-gon Lee, Ph.D. (VCU).

For the full summaries and other ARDRAF information, go to www.sahp.vcu.edu/vcoa/program/alzheimers.html.

Calendar of Events

October 5-8, 2014

65th Annual Convention and Expo of the American Health Care Association and the National Center for Assisted Living. Gaylord National Resort and Convention Center, National Harbor, MD. For information, visit www.eventscribe.com/2014/ahcancal.

October 8, 2014

11th Annual Empty Plate Luncheon and Awards Ceremony. Benefit for Senior Connections: The Capital Area Agency on Aging. Richmond. For information, call (804) 343-3023 or email mjames@youraaa.org.

October 14-15, 2014

Virginia Assisted Living Annual Fall Conference. Presented by the Virginia Assisted Living Association. The Inn at Virginia Tech, Blacksburg. For information, visit www.valainfo.org.

October 18, 2014

Step Out: Walk to STOP Diabetes. Join the American Diabetes Association for our signature event. As many as 1 in 3 U.S. adults could have diabetes by 2050. One in 10 U.S. adults has diabetes now. Bon Secours Washington Redskins Training Center in Richmond. For information or to register, visit www.diabetes.org/stepoutrichmond or call (804) 225-8038 ext. 3255.

October 19-22, 2014

LeadingAge Annual Meeting and Expo. Nashville, TN. For information, visit www.leadingage.org/Annual_Meeting_2014.

November 1, 2014

The Art of Healthy Aging Forum & Expo. Hosted by Senior Services of Southeastern VA. Cost \$15.00. 8:00 a.m.- 1:30 p.m. Virginia Beach Convention Center. For information, visit www.ssseva.org or email dschwartz@ssseva.org.

November 5-9, 2014

Making Connections: From Cells to Societies. 67th Annual Scientific Meeting of the Gerontological Society of America. Washington, DC. For information, visit www.geron.org/annual-meeting.

November 10, 2014

The Alzheimer's Association Greater Richmond Chapter's 2014 Estes Express Lines Conference on Dementia. Featuring: Adam Rosenblatt, MD, head of the Psychiatric Unit at Medical College of Virginia; Maria Carrilo, PhD, Vice President, Medical and Scientific Relations, Alzheimer's Association; Joyce Simard, MSW, social worker and dementia care specialist; and Karen Stobbe, actress, director, and writer. The Westin Richmond Hotel, 6631 W. Broad Street. For information, visit www.alz.org/grva.

November 11-12, 2014

Annual Conference and Trade Show of the Virginia Association for Home Care and Hospice. The Westin, Richmond. For information, visit www.vahc.org.

November 12, 2014

The Champion's Toolbox: Resources on Safety, Wellness, and Advocacy. Presented by the Area Planning and Services Committee (APSC) on Aging with Lifelong Disabilities. Eastern Henrico

Recreation Center, 9:00 a.m. - 3:15 p.m. For information, call (804) 828-1525.

January 28, 2015

Virginia Center on Aging's 29th Annual Legislative Breakfast. St. Paul's Episcopal Church, Richmond. 7:30 a.m. - 9:00 a.m. For information, call (804) 828-1525.

February 26 - March 1, 2015

The Changing Face of Aging Around the World. AGHE's 41st Annual Meeting and Educational Leadership Conference of the Association for Gerontology in Higher Education. Sheraton Nashville Downtown, Nashville, TN. For information, visit www.aghe.org/am.

March 23-27, 2015

Aging in America. Annual conference of the American Society on Aging. Chicago, IL. For information, visit www.asaging.org/aia.

Age in Action

Volume 29 Number 4
Fall 2014

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

James A. Rothrock
Commissioner, DARS

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: (804) 828-7905. E-mail kivey220@yahoo.com.

**Winter 2015 Issue Deadline:
December 15, 2014**



Virginia Center on Aging

at Virginia Commonwealth University, Richmond, Virginia
www.sahp.vcu.edu/vcoa

Staff:

Director

Edward F. Ansello, PhD

Elderhostel Coordinators

Catherine Dodson, MS - Richmond
Barbara Wright - Natural Bridge and Staunton

Associate Director for Research

Constance L. Coogle, PhD

Elderhostel/Road Scholar Program Administrator

Jeffrey Ruggles, MFA

Project Director

Paula Knapp Kupstas, PhD

Lifelong Learning Institute

Rachel Kelly

Assistant Director, Virginia Geriatric Education Center

Bert Waters, PhD

Project Coordinator

Ruth Anne Young, MEd

Research Associates

Sung Hong, PhD
Myra G. Owens, PhD

Research Assistant

Jenni Mathews

Administrative Assistant

Priscilla Owusu-Mensah

Editor, *Age in Action*

Kimberly S. Ivey, MS

Advisory Committee:

Paul F. Aravich, PhD
Frank Baskind, PhD
James Bennett, MD, PhD
Cecil Drain, PhD
Jonathan Evans, MD
Hon. Franklin P. Hall
James Hinterlong, PhD
Robert D. Holsworth, PhD
Paul G. Izzo, JD
Richard W. Lindsay, MD
Christopher M. McCarthy, Esq
Hon. Jennifer L. McClellan
Kenneth J. Newell, MS
Hon. John O'Bannon
Sheldon Retchin, MD, MPH
Saundra C. Rollins, MSSW
Jim Rothrock
David Sadowski
Robert L. Schneider, PhD, *Chairman*
Ralph E. Small, PharmD
Beverly Soble
Gordon Walker
Thelma Bland Watson, PhD



Virginia Department for Aging and Rehabilitative Services

www.dars.virginia.gov

Staff:

Commissioner: Jim Rothrock

Sharon Andreucci, Chronic Disease Self-Management Education Coordinator
Charlotte Arbogast, Dementia Services Coordinator
Tanya Brinkley, Service Referral Administrative Specialist
Tim Catherman, MHA, Director, Aging Operations
Pat Cummins, MEd, Program Coordinator
Leonard Eshmont, PMP, Director, Information Technology
Jacqueline Freeze, External Aging Services Auditor
Elizabeth Havenner, MSW, VICAP State Director
April Holmes, MS Ed, Prevention Program for Older Adults
David Hominik, Legal Services Developer
A.J. Hostetler, Public Relations Director
Brett Jackson, Performance and Compliance Analyst
Janet James, Esq., Public Guardian Program Coordinator
Georgie Lewis, Customer Service Specialist
Nancy Lo, MSW, GrandDriver Coordinator
Debra Loving, Information Systems Specialist
Amy Marschean, JD, Senior Policy Analyst
Christy Miller, PMP, CSTE, NWD IT Operations Manager
Kathy Miller, RN, MS, MSHA, Director of Programs
Carolyn Mines, IT Help Desk Specialist
Marica Monroe, CPA, Financial Manager
Ellen Nau, MA, Program Coordinator
Peggy Nieder, Program Coordinator
Charlotte Peterson, Accountant Senior
Katie Roeper, Assistant Commissioner
Annette Sherman, Systems Analyst
Cecily Slasor, Customer Service Specialist
Elaine Smith, MS, RD, Program Coordinator
Pam Smith, VICAP Customer Service Specialist
Kathleen Vaughan, MA, No Wrong Door Coordinator

Commonwealth Council on Aging:

Members

Kyle R. Allen, DO, AGSF
Beth Barber, Chair
Robert B. Blancato
Mitchell Patrick Davis
David M. Farnum
Arthur R. Giesen
Joni C. Goldwasser
Carter Harrison
Valerie L'Herrou, JD
Richard W. Lindsay, MD
Shewling Moy
Brenda A. Kelley Nelum
Valerie Price, Vice-Chair
Roberto Quinones
Stephen G. Reardon, Esq
Kathryn B. Reid
Vernon Wildy
Veronica Williams
Sandra Williamson-Ashe, EdD

Ex Officio Members

Robert Brink, *DARS*
The Hon. William A. Hazel, Jr., MD, *Secretary of Health and Human Resources*
James A. Rothrock, *DARS*
William Massey, *DMAS*
Courtney Tierney, *VAAAA*
Lynne Williams, *VDSS*



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

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

Return Service Requested



**13th Annual Alzheimer's Education Workshop
of the Alzheimer's Association Central & Western Virginia Chapter**

***Innovations in Care:
Person-Centered Dementia Care through the Arts***

**November 11, 2014
Holiday Inn Valley View, Roanoke**

Speakers Include:

Teepa Snow, MS, OTR/L, FAOTA

Dementia expert who trains and consults for agencies, facilities, and families.

Scott Kirschenbaum

Director of the highly acclaimed film *You're Looking at Me Like I Live Here and I Don't* featured on PBS's Emmy award-winning series *Independent Lens*.

Registration is due by November 5, 2014. For more information, please call (800) 272-3900.

This program is made possible, in part, by funding provided by the Bureau of Health Professions (BHP), Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS) under Grant No. UB4HP19210 to the Virginia Geriatric Education Center.

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