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The Aging Woman and HIV/AIDS: Increasing Risk and Incidence

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Educational Objectives

1. Discuss the increasing incidence of HIV in the aging population.

2. Describe the ways HIV affects the aging person.

3. Identify implications for HIV education and risk assessment of the older population.

Background

The number of older adults in the U.S. with HIV/AIDS is increasing. The most recent statistics from the Centers for Disease Control (1999) place the number of adults ages 50 and over with AIDS at about 10% of all persons with AIDS. It is likely that there are many more cases of HIV/ AIDS in the over-50 population that are unknown. Older adults often put them-selves at risk without realizing it when, after the death of a spouse, divorce, or separation, they begin to seek out sexual relationships. Many seniors have never been tested and do not consider themselves at risk for HIV and AIDS.

The transmission of HIV through sex with an infected partner is a change from the past when most elderly people were exposed to HIV only through contaminated blood transfusions. Since 1986, when the nation's blood supply was made much safer, older adults generally become

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infected and transmit the disease via hetero- and homosexual sex, intravenous drug use, or by being the sexual partner of an intravenous drug user. Women over 50 are particularly at risk because of vaginal thinning and dryness that occur during menopause. These changes predispose them to small abrasions or tears in the vagina during sexual intercourse, putting them at greater risk of infection. Over 70% of infected older women are of African American or Latina heritage (CDC, 1999).

Older adults know less about how HIV is spread than any other age group (National Institute on Aging, 1999). Consequently, they do not get tested for HIV regularly. Men who have sex with men, adolescents, and young adults are the major focuses for HIV health education. This means that sexually active seniors are not receiving crucial information about HIV testing, the use of condoms, and the importance of not sharing needles. Perhaps the reasons for the lack of health education to this group are cultural misconceptions that older adults are not sexually active, therefore, not at risk for HIV. While the waning of hormones and the decline of health may lead many older adults to forgo sex, new developments in the treatment of sexual impotence and loss of libido are allowing older adults to continue to lead active sex lives. A new pharmaceutical product for men, Viagra, helps them to sustain an erection facilitating the sex act. The use of testosterone for men, and small doses of testosterone for women to increase libido, is gaining popularity for aging men and post-menopausal women who thought their sex lives were over forever.

Case Study

When Doreen's husband died suddenly ten years ago, she thought it was the most devastating event that she would ever experience. Now, years later, when one talks to the 60+ year-old, attractive widow and grandmother of four, one senses a certain tentativeness, almost sadness. She still recalls clearly the day when her entire life changed forever.... February 9, 1997. It was on that day that she received a letter from a health insurance company to which she had applied for new coverage. The letter told her that she was denied coverage because of a certain "risk" factor. She quickly consulted her family doctor who carried out a number of tests, including a test for HIV antibodies. The HIV test came back positive.

Doreen does not fit the usual description of a woman with HIV. She was a virgin on her wedding night, and she remained monogamous until her

husband's untimely death. She waited several years before beginning to date again, and then dated only those men who were friends of her friends and family. On several occasions, she was intimate with a man she met at a senior's dance, a friend of a friend, but that was a number of years ago. She relates now that this behavior was so unlike her, but that she was lonely and he was "such a gentleman" to her. They did not use condoms. She thinks that this is probably the man who infected her.

Doreen began treatment right away on the advice of her physician. She has suffered from side effects and adverse reactions, and her medications have had to be changed several times. Several years went by after Doreen's diagnosis before she began to wonder if her symptoms of fatigue and aches and pains were related to HIV or aging. She still finds it difficult to talk about her diagnosis with anyone except her physician. To this day, even her children do not know of her HIV positive status.

Discussion

Older adults with HIV/AIDS were likely infected with the virus years before being tested. Many are already in more advanced stages of HIV/ AIDS at the time of their diagnosis. Signs and symptoms of the disease, such as fatigue and weakness, may be mistaken as problems related to the aging process. Health professionals almost never ask their aging patients about drug use or unprotected sex. They need to. Prevention and risk-reduction education aimed at the older adult needs to be stressed. Also, assessment of at-risk practices promotes quick and effective diagnosis and treatment of HIV. As we age, our immune systems become less effective, and, for this reason older HIV/AIDS patients do not live as long as younger people who contract the virus. Medical treatment should be started as soon as possible in order to increase the chances of living longer.

Older adults with HIV may be prone to more severe depression than younger people with the disease (National Institute of Aging, 1999). They need assistance to cope with the emotional aspects of having this stigmatic disease. They may intentionally disengage from family and friends because of shame. Jane Fowler, a 65-year-old woman infected with HIV, is one of the founders of the National Association on HIV Over Fifty (NAHOF). She learned of her diagnosis over 10 years ago when she was a successful 55-year-old career woman. She states, "…due to the dual stigma of living with a sexually transmitted disease and of being 'old', …the dual stigma makes it especially difficult for seniors to disclose to family and friends, thereby forfeiting sup-port that might be

forthcoming" (Fowler, 2000). Older adults with HIV/AIDS need an outpouring of support and under-standing from family, friends, health professionals, and the community, especially since their disease may progress quicker than in younger individuals. Additionally, many older women, as caregivers to grandchildren, are providing care at a time when they themselves need to turn to others for support. The grueling responsibilities of caring for children at an older age may be physically, emotionally, and financially devastating. It can hasten progression of any chronic illness or disease.

Conclusion

In conclusion, while there is no cure for HIV/AIDS, there are promising new treatments and resources available that support older adults with HIV/AIDS. The true assurances of success-ful outcomes, however, are awareness, health education, and early intervention. Behaviors such as condom use, making sure sexual partners are HIV negative, not sharing needles, and getting tested are the keys to prevention, reduction of risk, and successful treatment of HIV in older adults.

Resources

The following resources are just a few that may provide information about HIV/AIDS.

Nat'l Assoc. of HIV Over Fifty
c/o Midwest AIDS Training & Education Center
808 S. Wood Street, MSC 779
Chicago, IL 60612
(312) 996-1373
www.hivoverfifty.org

AARP
601 E St. NW
Washington, DC 20049
(202) 434-2260
www.aarp.org/griefandloss

CDC National Prevention
Information Network
P.O. Box 6003
Rockville, MD 20849

(800) 458-5231
(800) 243-7012 TTY
www.cdcnpin.org or www.cdc.gov (select option for data and statistics)

Study Questions

1. Discuss the ways that HIV affects older adults. What are some of the unique problems encountered by older adults with HIV/AIDS?

2. Discuss the appropriateness of resources available specifically for this population. What special factors need to be considered when developing HIV/AIDS prevention/risk reduction pro-grams for the older population?

References

AIDS among Persons ≥ 50 Years. Morbidity and Mortality Weekly Report, January 23, 1998.

Centers for Disease Control and Prevention. (1999). HIV/ AIDS Surveillance Report, 11 (2): 1-45.

Fowler, J. P. (2000, May/June). HIV over 50. Positively Aware, 45-47.

National Institute of Aging. (1999). HIV, AIDS and Older People. (DHHS Publication, Age Page). Washington, DC: National Institutes of Health.

Stine, G. (2000). AIDS Update (Rev. ed). Prentice Hall: Upper Saddler River, New Jersey.

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From the Executive Director, *Virginia Geriatric Education Center*

Iris A. Parham, Ph.D.

The big news for the VGEC this quarter is the announcement by the Bureau of Health Profes-sions, Health Resources and Services Administration that we were just re-funded for five years beginning July 1, 2000. We are very excited about this new project and are delighted that, in addition to already training 40,000+ health professionals, we will have the opportunity to train another 15,000+ practitioners to serve our elders. This project is consistent with the hallmarks of the VGEC. These have been: the development of collaborative community partnerships that have been the vehicle to provide and extend training; the use of technology and innovation to reach the broadest possible base of trainees

and to meet the needs of the truly underserved health practitioner audience; the design of all curriculum to integrate the interdisciplinary team perspective; the emphasis on creating geriatric curricula and training materials sensitive to ethnogeriatrics; and, finally, the evaluation of training outcomes on how they affect quality of care of the elderly.

This new VGEC project is designed to build on the foun-dations established above and meet the unmet training needs of practitioners who serve elderly Virginians. This solid foun-dation will be built upon with the establishment of new com-munity academic partnerships, new academic partnerships, and new training and education programs that are innovative, technologically sophisticated, and importantly, accessible to the health practitioners who most need geriatric education and training. The VGEC will continue to work with its outstanding and very dedicated university partners in the various schools and disciplines (allied health professions, medicine, nursing, dentistry, humanities and sciences, education, pharmacy, and social work) and the Virginia Center on Aging, the Virginia Department for the Aging, V4A, and the VAA. We have also established new partnerships and enhanced well-developed relationships with a number of significant community alliances. These partnerships include: (1) Eastern Virginia Medical School; (2) University of Virginia-Geriatric Medicine and Nursing; (3) Bon Secours Richmond Health System; (4) Jefferson Area Board for the Aging (JABA), an area agency on aging having an adult day health center affiliated with a Montessori school on site; (5) Southside Area Health Education Center (AHEC); (6) Virginia Health Quality Center (VHQC), Virginia's federally designated Medicare Peer Review Organization and the HCFA designated national resource for clinical area support for breast cancer; (7) Virginia Department of Medical Assistance Services (VDMAS), and the Virginia Department of Social Services; (8) Sentara Health System; (9) Virginia State University; (10) Southside Virginia Community College; and (11) Richmond City Schools.

The following is a listing of the project's Objectives.
Objective 1: Provide interdisciplinary and discipline-specific training to an increasing number of health professionals in geriatrics via: (1) distance education modules, credit courses, and formal academic certificate programs; (2) formal mentoring programs; and (3) continuing education conferences and workshops delivered through a variety of education techniques across the state.
Objective 2: Develop a comprehensive Geriatrics Health Professionals Mentoring Program.
Objective 3: Develop a Geriatric Case Management Initiative targeted to

the training and career development of Certified Nursing Assistants and Licensed Practical Nurses.

Objective 4: Develop and disseminate new educational materials using on-line instruction (synchronous and asynchronous) emphasizing critical areas as identified in *Healthy People 2000*: rehabilitation focus (aging and disabilities), tobacco use (with an emphasis on oral health), pressure ulcers, diabetes, substance abuse, breast cancer, and dementia.

Objective 5: Develop training via V-TEL for faculty in the area of grantspersonship targeted to the aging population, so that additional funding can be secured for other intra-and inter-institutional aging initiatives.

Objective 6: Establish annual two-day professional develop-ment programs on meeting the health care needs of underserved elderly populations.

Objective 7: Collaborate with fellow GECs to provide an annual videoconference on special topics beginning in Year 3.

Objective 8: Utilizing joint specializations already developed over the history of the VGEC, expand and enhance clinical training opportunities for students. Emphasis will be placed on interdisciplinary team training and placements. The activities related to this objective will also include an emphasis on increasing cultural competencies in ethnogeriatrics.

Objective 9: Develop a "Kids Into Health Careers" program designed to promote career development in health care and aging. This objective provides the opportunity to collaborate with local schools (elementary, middle, and high schools) senior centers, and long-term care communities.

In summary, this is an exciting project that will allow us to accelerate our work in geriatric education across the Commonwealth. We look forward to working with all of our outstanding partners. The next column will update the final chapter of the current GEC grant funding.

We also need to now take the opportunity to congratulate our own recent M.S. in Gerontology graduate, Ms. Katie Benghauser, on her new job and wish her great success in her new aging career. We thank her for her many contributions to the work of the VGEC. She will be greatly missed. We have also lost our valuable secretary, Ms. Felicia Brown, who also graduated and moved to a neighboring state. She, too, will be greatly missed. However, we have the good news that Ms. Angela Rothrock has been hired as Senior Project Coordinator for the VGEC, and she brings excellent credentials and experience to this position. We will spotlight her in the next newsletter issue. Until then, enjoy the summer and join us as we celebrate.

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From the Director, *Virginia Center on Aging*

Edward F. Ansello, Ph.D.

"At risk." It struck me in reviewing the contents of this issue how much of it is focused on elders at risk: at risk of HIV/AIDS, at risk of burning out in providing care to another over a long period of time, at risk of developing life-threatening or life-altering diabetes. Commissioner McGee's report of activities in the first year of the Commonwealth Council on Aging effectively is speaking to conditions that have been identified as placing older Virginians at risk, conditions as diverse as increasing frailty or disabilities among individuals, insufficient demographic data upon which to make policy and practice decisions, and great gaps in transportation, housing, and community-based health care services.

I am impressed by the thoughtful presentations in this issue to address these conditions that place older Virginians at risk. Some speak to public awareness, alerting older Virginians to matters previously given little thought and clarifying their own role in maintaining their well-being. Advancing age does not confer immunity from sexually transmitted diseases. Lifestyle does contribute substantially to the development of diabetes in later life and to its rapid ascendancy into a major health care challenge. Family caregivers need to know that they are not alone; there are sources of help already existing in our communities that can be tapped. Others herein describe goals and activities for Virginia to initiate through her agencies and departments. The refunding of the VGEC is wonderful news for the Commonwealth. Its record of success in training professionals directly benefits those at risk. The Commonwealth Council on Aging has developed short- and long-term goals to help ensure that necessary infrastructures like housing and transportation exist for more Virginians to have successful (less at risk) later years. The Virginia Center on Aging will continue its efforts to conduct, in partnership with others, an update of its Statewide Survey of Older Virginians, last completed in 1980; this will, in turn, ensure that Virginia's agencies and departments have sufficient information on the physical, health, mental health, caregiving, resource utilization, and other characteristics of older adults in order to plan and deliver services most effectively to those who remain "at risk." This issue's contents represent the multi-lateral approaches that must be taken to reduce the numbers who bear this label.

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From the Commissioner, *Virginia Department for the Aging*

Ann Y. McGee, Ed.D.

This past spring, the Commonwealth Council on Aging completed its first full year of operation. This group of 19 citizen members, appointed by the Governor and the General Assembly, has dedicated itself thus far to the task of identifying the critical issues impacting older Virginians.

Many of the Council's members have experience in the realm of aging services. Others are new to the field. Together, they provide Virginia's law-makers and policy makers with unique viewpoints and a broad perspective of the challenges we face. In its first report, the Council listed four main issues:
1) Family members and friends provide 80 percent of the care for older adults who are frail and have disabilities. Increasing pressures on caregivers are threatening this traditional support system.
2) Expansion of older segments of the aging population is likely to increase the number of frail and disabled people – those who need at-home support or quality, affordable long-term care.
3) There is a need for reliable scientific demographic information on which to base policy and funding decisions for older populations.
4) Many Virginians of all ages and from all socio-economic groups have not prepared adequately for retirement.

Having completed this first important step, the Council has begun to outline key strategies for addressing the needs of this growing segment of our population. Council Chairman, J.W. Burton of Altavista, appointed three task-oriented committees to research the issues and recommend actions to the full Council: the Planning and Development Committee, the Legislative Committee, and the Public Relations Committee. Chaired by Catherine Galvin of Front Royal, the Planning and Development Committee is developing a detailed strategic plan for the Council. This strategic plan is based on six main goals approved by the full Council:
1) To have an effective transportation system which is affordable, sensitive to the needs of older persons - urban, suburban, and rural - and responsive to the strengths of individuals and community requirements.
2) To have safe and suitable housing alternatives for older Virginians.
3) To develop and sustain an integrated home and community-based network of services which assures a senior's self-determination, dignity, and responsible choice.

4) To have, by 2010, a quality, cost-effective health care system, with emphasis on wellness and preventive measures and appropriate access, which responds to the needs, and respects the rights of, older persons.
5) To provide increased opportunities for older Virginians to invest in their communities through employment and by volunteering their time and talents.
6) To have Virginians of all ages planning for their successful aging.

The Legislative Committee, chaired by Suzanne Obenshain of Harrisonburg, developed four requests that were approved by the Council and presented to the Governor and the General Assembly:
1) Requested the Joint Commission on Health Care to address the issue of the rising cost of prescription drugs and the lack of affordable supple-mental health insurance to help older people with their drug expenses.
2) Requested $1.5 million in General Funds to increase the number of local ombudsmen who respond to public questions and concerns about nursing homes and other long-term care facilities.
3) Requested $50,000 in General Funds for each of Virginia's 25 local Area Agencies on Aging for the purchase of vans or buses equipped for people in wheelchairs, to improve transportation for the elderly in their communities, or for other transportation services.
4) Requested the Secretary of Health and Human Resources to expand the existing Medicaid transportation brokering initiative to all regions of the Commonwealth.

The Council also recognizes the importance of educating the public about the issues and initiatives it has identified. Thus, the Public Relations Committee, chaired by Barbara Taylor of Culpeper, has been working with the Virginia Department for the Aging to develop public relations and marketing strategies. This committee oversaw publication of the Council's first annual report and has assisted the Department with publications and development of a new slogan and logotype.

During 2000-2001, the Council plans to develop more-detailed strategies and recom-mendations for addressing the needs of older Virginians. All of the Council's meetings are open to the public, and meeting dates are published in the Virginia Register and online in the Commonwealth Calendar at www.vipnet.org/cgi-bin/calendar.cgi.

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Focus on the Virginia Geriatric Education Center

Iris Parham, Ph.D.

Dr. Iris Parham has been the Executive Director of the VGEC since its inception. She also serves as the Chair of the Gerontology Department of the School of Allied Health Professions. Dr. Parham is a psychologist who received her Ph.D. from the Andrus Gerontology Center at the University of Southern California. She received her Master's degree from West Virginia University and is a card-carrying University of Texas alum. Dr. Parham is a Fellow of the Gerontological Society of America and a Charter Fellow of the Association for Gerontology in Higher Education (AGHE). She is a member of the Program of Merit review committee for AGHE. Her major interests are in the area of distance education and alcohol abuse prevention and treatment in the elderly. She is also teaching in the distance-based Ph.D. program in Health Related Sciences, also housed in the School of Allied Health Professions; this interdisciplinary Ph.D. program has a specialization in aging as well as seven other areas.

Dr. Parham is originally from East Texas and grew up fishing the Gulf and eating gumbo. She is the mother of a beloved 17-year old, is celebrating her 25th wedding anniversary next month, and spends all of her leisure time hiking or admiring and collecting quilts anywhere she has the opportunity to find them.

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Focus on the Virginia Center on Aging

Edward F. Ansello, Ph.D.

"It's hard to believe that last November I celebrated 10 years as Director of the Virginia Center on Aging," Dr. Ansello observes. "Good work and great people have made it pass so quickly." He reflects on the growth of VCoA in expertise and reputation. Staff size, too, has grown. "VCoA has a greater depth of focus on aging with disabilities and related family caregiving, in addition to our long tradition of commitment to lifelong learning, technical assistance, and information sharing. The Alzheimer's and Related Diseases Research Award Fund (ARDRAF) is becoming more widely recognized as the excellent stimulant to creative investigations that it is. We are also associated with innovative strategies for providing services to aging adults with developmental disabilities and to their caregiving families."

Dr. Ansello's long-term collaboration with Dr. Matt Janicki of New York has resulted in a new book, Community Supports for Aging Adults with Lifelong Disabilities, just published this summer by Paul Brookes Company, the premier publishing house in the area of developmental disabilities. In the four years from the book's concept to publication, he says that he "finally entered the 20th century electronically, just as it was ending! Matt and I must have sent each other dozens of attachments and hundreds of e-mails. It's almost odd now that it's finished. No daily messages. Time to start another book."

When he's not writing or editing, or otherwise involved at the office, Dr. Ansello is in demand on the lecture circuit, presenting not only on aging with disabilities issues, but also on pre-retirement planning and maintaining overall wellness. He says that his family is central to his own well-being. He and his wife, Paulette (renowned for her cooking), will celebrate 20 years of marriage this September. They have two children still at home, Cassie, 15, and E.J., 11.

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Virginia Commonwealth University's Department of Gerontology - Graduation 2000

On May 13, 2000, the Department of Gerontology, School of Allied Health Professions, Virginia Commonwealth University invited its faculty, staff, students, and their friends and family to celebrate its graduating class of nine (six masters students and three certificate students). The event was held at the Southside Church of the Nazarene immediately after Allied Health's graduation ceremony.

2000 Honors and Awards

Jason Rachel and Jane Hixon
A.D. Williams Award. An annual award is made to a student who demonstrates, by virtue of high scholastic attainment and professional competence, unusual promise and ability in the field of aging.

Tara Beatty and Katie Benghauser
Gerontology Student of the Year. Each year, the faculty chooses a graduating student who has exhibited outstanding scholastic achievement and demonstrated services in gerontology.

Janet Watts
Distinguished Alumni Award. Each year, the Gerontology Student

Association, in consultation with the departmental faculty, chooses an alumna or alumnus who best exemplifies the standards of the profession.

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Tall Ships and OpSail 2000: Lifelong Learning at VCoA

Jane Stephan, Ed.D.
Asst. Director of Education
Virginia Center on Aging

The Virginia Center on Aging's three programs to celebrate the arrival of the Tall Ships in Hampton Roads were a huge success! One program was a week-long Elderhostel (June 15-20) with 44 hostelers from across the nation. The other two programs were four nights in length (June 12-16) and were designed by VCoA especially for lifelong learners. These two groups, totaling 99, included retired Navy and Coast Guard officers and many happy "landlubbers." Each group had separate daytime classes and field trips, but shared evening sessions, some meals, and free time with each other.

The intermingling among the groups was testament to the conviviality and excitement engendered by the learners themselves, the three coordinators, and our wonderful instructors, who did triple duty in teaching their classes. Pete Wrike lectured on pirates; Bob Comet educated everyone about OpSail; Harold Cones provided an understanding of wind, waves, and navigation; John Quarstein imparted a history of the Wooden Navy; and John Ickes performed and sang Sea Shanties that had people laughing, and clamoring for more.

The three groups had daily field trips to Hampton Roads locales offering special programs for OpSail: the Naval Museum in Norfolk, the Winslow Homer exhibit at the Chrysler Museum, lectures and guided tours of the extensive model ship competition at the Mariners' Museum in Newport News, and lectured tours of the Yorktown Victory Center and its Colonial Shipbuilding section.

One of the highlights of the week was our cruise on the tall ship American Rover, which glided smoothly past the visiting tall ships, navy vessels, and other craft on the sparkling waters of the Elizabeth River. The true high point of all of the programs was the Parade of Tall Ships on June 16th. Undaunted by 95 degree temperatures, our students lined the waterfront at the Chamberlin Hotel from 8:00 a.m. until noon. More than 100 ships from over 50 nations passed directly in front of us. A naval

band played Sousa marches and patriotic music in the gazebo behind us, vendors provided sustenance, and our learned students correctly identified each type of ship well before the announcer. The parade was a grand culmination to a wonderful week of successful programs and super people!

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Recognizing Respite Care as a Life Line

Elizabeth A. Morley, MSW
Program Coordinator
Virginia Dept. for the Aging

Although long an important concern for professionals in the aging services field, the subject of respite care has truly entered the public consciousness. Politicians from both major parties now acknowledge that the bulk of long-term care for older adults is provided informally by their families and friends.

Iowa Senator Charles Grassley's plan for reauthorization of the Older Americans' Act calls for more than $125 million in caregiver support, and Senator Michael DeWine of Ohio has proposed setting aside a portion of these funds for the growing number of grandparents who care for grandchildren in their homes. There already has been an encouraging expansion of respite care programs nationwide – including new funds appropriated in Virginia this year.

Statistics support this shift in the attention of lawmakers and policy makers. The physical and emotional impacts of long-term, informal caregiving are well-documented and affect every generation more and more each year. Here are just a few of the more striking figures that demonstrate the need for programs such as adult day care, in-home respite care, and other programs that offer relief for family caregivers:

• Informal caregivers now provide nearly 80 percent of the long-term care for older adults – including many who suffer from Alzheimer's disease and other forms of dementia. The value of this care is estimated to be more than $190 billion annually[1].

• The number of Alzheimer's patients is projected to increase from 4 million to 14 million within 50 years[2].

• One in every four U.S. house-holds now includes a caregiver – one who has provided care to a relative or friend 50 or older during the preceding 12 months. That amounts to 22 million households[3].

• Sixty-four percent of these caregivers also work full-time, and their time

away from work because of caregiver respon-sibilities results in an estimated loss of productivity ranging from $11 billion to $29 billion annually[4].

• During the next decade, the number of caregivers who also work full-time is projected to increase to 15.6 million, or one of every 10 workers[5].

One in 10 grandparents has been a primary caregiver for grandchildren for at least six months[6].

Caregiving takes its toll on workers, who today often find themselves responsible for aging parents and school-age children at the same time. In addition to job-related impacts due to absenteeism, early retirements, turnover and loss of productivity, studies indicate real health impacts on caregivers.

In a 1999 study by MetLife, nearly three-fourths of the family caregivers surveyed said their health had suffered because of caregiving responsibilities. Twenty percent reported significant health impacts.

The good news is that more than 60 percent of the respondents in the MetLife study said they are willing to ask someone else for support. Although the number of formal employer-sponsored respite programs is still low, other studies have shown that corporate awareness of the impacts of caregiving is increasing.

The public and private sectors are recognizing that informal caregivers are the greatest assets in our system of long-term care in this country, and that this system of caregiving exists because of strong family commitments among Americans. The result has been, and will continue to be, more options and more innovations in caregiver support.

Adult day programs in some communities are branching out to combine childcare and adult care together in the same facilities, promoting intergenerational interaction and providing relief to the working caregivers "sandwiched" between the two generations. One community in Georgia is now providing mobile adult day care services, and many interfaith organizations are promoting the use of volunteers as companions for homebound older adults.

This year, the General Assembly appropriated new funds for an Adult Day Care Incentive Grant program. This program will offer seed grants of up to $100,000 to establish adult day care services in underserved areas

to meet the respite care needs of informal caregivers. The grants encourage commun-ities to develop collaborative relationships among local organizations, churches, synagogues, and other com-munities of faith that have a vested interest in families.

To learn more about these grants, contact Janet Honeycutt at the Virginia Department for the Aging, (804) 662-9341 or 1-800-552-3402.

Footnotes

[1] Administration on Aging, Family Caregiving in an Aging Society, web site text of a March 1999 presentation by Sharon Tennstedt of the Institute for Studies on Aging, New England Research Institute, www.aoa.dhhs.gov/caregivers/FamCare.html.

[2] Alzheimer's Association, Alzheimer's Disease Statistics, web site text, www.alz.org/media/understanding/fact/stats.htm.

[3] Administration on Aging, Tennstedt.

[4] MetLife, The MetLife Juggling Act Study, Balancing Caregiving with Work and the Costs Involved, November 1999.

[5] MetLife study.

[6] Administration on Aging, Grandparents Raising Grandchildren, web site text, www.aoa.dhhs.gov/factsheets/grandparents.html.

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Help End Medicare Fraud

The National Committee to Preserve Social Security and Medicare (NCPSSM) is working hard to combat Medicare fraud, waste, and abuse. To further this work, the Committee has created a list-serv that will keep individuals updated, through e-mail, about the latest develop-ments concerning this important issue. Once individuals become registered as part of the list-serv, they are able to comment and post relevant information. If you would like to be invited to participate in this list-serv, please write to: Office of Multiculturalism & Diversity, NCPSSM, PO Box 77196, Washington, DC 20077-4516. You may also contact (800) 966-1935 or www.ncpssm.org.

For more information about Medicare, visit www.medicare.gov. This site features information on eligibility and enrollment, health plan options, tips on avoiding fraud, and access to the Nursing Home Compare database which provides the most recent inspection results of certified nursing homes.

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Virginia Commonwealth University, Department of Gerontology - Fall 2000 Courses

For information regarding these courses, the registration process, or the gerontology program, please contact Monica Porter in VCU's Department of Gerontology at (804) 828-1565.

12336 GRTY 410 001 Intro to Gerontology Osgood Tues & Thurs
11:00 - 12:15 BUSNS 1106

12337 GRTY 501 001 Physiological Aging Harkins Wed
2:00 - 4:40 BUSNS 2118

12339 GRTY 602 901 Psychology of Aging Welleford Mon
7:00 - 9:40 RANDM 120

12340 GRTY 603 901 Research Methods Owens Wed
6:00 - 8:40 RANDM 120

12341 GRTY 605 901 Social Gerontology Osgood Thurs
5:00 - 7:40 RANDM 120

12342 GRTY 606 901 Aging & Human Values Welleford Tues
7:00 - 9:40 RANDM 120

12343 GRTY 607 901 Field Study in Gerontology Parham

12344 GRTY 615 901 Aging & Mental Disorders H. Wood Thurs
6:00 - 8:40 SANGER 1-050

12346 GRTY 642 001 Practicum in Clin. Geropsych Parham

12348 GRTY 692 801 Independent Study Parham
12349 GRTY 692 802 Independent Study Harkins
12350 GRTY 692 803 Independent Study Osgood

12351 GRTY 798 803 Thesis Parham
12352 GRTY 799 803 Thesis Parham

16005 GRTY 792 001 Independent Study Parham
16004 GRTY 792 002 Independent Study Osgood
16006 GRTY 792 003 Independent Study Harkins
16003 GRTY 792 004 Independent Study Welleford

Video Courses

12338 GRTY 601 001 Biol & Physio Aging Harkins

12345 GRTY 616 001 Geriatric Rehab Welleford

12347 GRTY 691 901 Geriatric Interd. Team Training Parham

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The Commonwealth of Virginia

Alzheimer's and Related Diseases Research Award Fund

Announcement of 2000-2001 Awards

The Virginia Center on Aging administers the Alzheimer's and Related Diseases Research Award Fund (ARDRAF) for the Commonwealth of Virginia on an annual basis. This fund provides seed money to stimulate innovative research into
biomedical, clinical, psychosocial, and other aspects of dementia.

UVA James P. Bennett, Jr., M.D., Ph.D. & Christine Thiffault, Ph.D. (Dept. of Neurology) "Mitochondria Membrane Potential in Alzheimer's Disease"
This study will focus on the biophysical and biochemical aspects of mitochondrial depolarization and repolarization, a cyclical phenomenon observed in living neuroblastoma cell lines, and how these events are altered in Alzheimer's disease (AD). The investigators have pioneered a unique cellular model that reproduces many of the mitochondrial abnormalities associated with AD. It is hypothesized that abnormal cyclical mitochondrial depolarization is a major contributor to the

observed amyloid secretion and deposition that is a pathological hallmark of AD. If this hypothesis is correct, pharmacological interventions aimed at restoring normal mitochondria membrane potential provides a strategy to reduce the elevation of amyloid secretion and ameliorate loss of neurons in AD. (Drs. Bennett and Thiffault may be contacted at 804/924-8374)

Goodwin House Sheila Caswell, Mary A. Corcoran, Ph.D, O.T.R., & Karen Love, B.S. "A Staff-Developed Program to Enhance Care Quality for Residents with Dementia"

This project will engage nursing home staff in designing high quality care for residents with dementia. Staff will be taught to use principles of care based on the Montessori educational approach for children. These principles guide the staff to simplify both the physical environment and everyday activities to match the abilities of each resident. By empowering facility staff to direct an aspect of daily care, the investigators anticipate positive outcomes related to staff retention, quality of care, and caregiving self-efficacy. It is also expected that patient functioning will be enhanced and disruptive behaviors will be reduced. The effectiveness of this care approach should generalize to different long-term care settings and across a variety of cognitive impairments. (Ms. Caswell and colleagues may be contacted at 703/824-1167)

VA Tech Sherry Schofield-Tomschin, Ph.D. & Anna Marshall-Baker, Ph.D. (Dept. of Near Environments) "Tactile and Visual Stimuli in Alzheimer's Care Units: Incorporating Quilts in the Living Environment"

Facilities for individuals with Alzheimer's disease and other forms of dementia are frequently under-designed. Careful design planning can provide therapeutic environments that benefit the well-being of residents and improve the quality of their lives. Well-designed spaces for individuals with dementia typically include culturally meaningful objects and features that compensate for sensory deficits. In this study, the investigators will use a behavioral mapping technique to examine the impact of hanging quilts in the public areas of an assisted-living facility that provides special care for residents with Alzheimer's disease. It is anticipated that the quilts will attract the attention of residents, encourage tactile interaction, and in some cases, interrupt wandering behavior. This study is the first in a series to identify more fully appropriate components of the physical environment that can enhance the quality of life for elderly individuals and those with dementia. (Drs. Schofield-Tomschin & Marshall-Baker may be contacted at 540/231-

3250)

VCU/MCV Mohammed Kalimi, Ph.D. (Dept. of Physiology)
"Amyloid Beta Protein-Induced Hippocampal Cell Death: Mechanism of Action"
Amyloid beta protein (A beta) is known to mediate the neurotoxicity and inflammatory responses associated with Alzheimer's disease (AD). It is also a major constituent of the plaque formation that is characteristic of AD. Yet the precise cellular and molecular mechanisms by which amyloid beta protein induces neuronal cell death and injury have yet to be determined. Furthermore, the mechanisms by which estrogen and DHEA have been shown to protect hippocampal cells against A beta induced cell death are also unknown. These studies will, for the first time, establish whether these neuroprotective effects are mediated through glucocorticoid receptor activation, and whether a direct link exists between glucocorticoid receptor activation, induction of transcription factor NFkB and nitric oxide pathways, and cell death related to A beta. It is expected that the results will reveal novel biochemical, cellular, and molecular mechanisms with potential implications related to the pathophysiology of AD. (Dr. Kalimi may be reached at 804/828-9500)

VCU/MCV Elizabeth O'Keefe, M.D., Pamela Parsons, G.N.P., & Peter Boling, M.D. (Department of Internal Medicine)
"Percutaneous Endoscopic Gastrostomy (PEG) for Nutritional Support in Persons with Advanced Dementia and Feeding Difficulties: Do the Outcomes Fulfill the Expectations of the Decision-Maker?"
Feeding tubes, or Percutaneous Endoscopic Gastrostomy (PEG) tubes, are often placed in elderly persons who are unable to eat because of advanced dementia or altered mental states. However, recent studies have shown that tube feeding may not improve the nutritional state of these elders, nor prevent aspiration or improve survival. Furthermore, tube feeding may impair remaining quality of life by increasing restraint use and social isolation. This study will examine the expectations designated decision-makers (typically, family members or legal guardians) have when they make a decision to place a feeding tube in persons with advanced dementia, and whether these expectations are fulfilled in the following months. The results will be used, in conjunction with published data, to improve the information given to individuals faced with the decision to place feeding tubes in their elderly relatives. This tool should facilitate optimal management of a difficult end-of-life decision. (Dr. O'Keefe and colleagues can be reached at 804/828-5323)

EVMS Barbara Freund, Ph.D., R.N. (Glennan Center for Geriatrics and Gerontology) "Use of the Clock Drawing Test as a Screen for Declining Driving Competency in Cognitively Impaired Older Adults"

This investigation aims to determine if the onset of declining driving ability can be predicted by a rapid, simple clinical measure of executive functioning in older adults with cognitive impairment. The study will determine if there is a correlation between the Clock Drawing Test, a simple dementia screening tool, and driving performance. Participants will complete a simulated driving test, and scores will be evaluated in relation to overall driving competence as well as to specific driving errors. The results should have direct clinical relevance and may provide clinicians with a convenient measure for tracking the progression of cognitive impairments upon driving performance. (Dr. Freund may be contacted at 757/446-7040)

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Diabetes: Efforts to Improve Care

Susan Warren, RN, MPH, CDE
Project Manager
Virginia Health Quality Ctr.

Serious, complex, and costly can describe diabetes, the seventh leading cause of death in the United States in 1995. This is particularly alarming because diabetes is believed to be under-reported, both as a condition and as a cause of death. This occurs particularly among older persons with multiple, chronic conditions such as heart disease and hypertension. Of the 16 million Americans with diabetes, half are unaware they have the disease.

A 1998 report from the World Health Organization predicts an epidemic increase in diabetes during the 21st century. Trends show that the elderly population is disproportionately affected by diabetes and that this trend is fairly recent, with about two-thirds of the increase in age-adjusted prevalence occurring in the 1990s.

Risk factors for diabetes include older age, obesity, family history, physical inactivity, and race/ethnicity. African Americans, Hispanic/ Latino Americans, and American Indians are at significantly higher risk. Minority and elderly populations bear the brunt of the growing diabetes epidemic.

Diabetes can affect nearly every organ. It is the leading cause of renal failure and blindness. More than half of the non-traumatic lower extremity amputations in the United States occur among persons with diabetes. Major cardiovascular disease accounts for a large proportion of diabetes-related deaths and hospitalizations. Only recently has it been recognized that cardiovascular disease poses a much greater risk of death and disability than do all of the other complications combined.

These physical costs do not take into account the costs associated with unemployment, work absenteeism, and de-creased quality of life. Inpatient hospital care accounts for a large volume of diabetes-related costs. It is estimated that per capita expenditures for confirmed cases of diabetes in the United States are three to four times greater than for those without diabetes. This ratio is consistent with data showing that discharges from Virginia hospitals for Virginia residents with diabetes have increased 20% from 1994 (the first full year for which hospital discharge data were available) to 1996.

Health care professionals know that diabetes is both treatable and manageable. The difficulty lies in helping people adopt a more health-conscious lifestyle and assisting them in learning how to "self-manage" their disease.

Type I vs. Type II Diabetes

Among the types of diabetes, Type 1 and Type 2 are the most common. Type 1 diabetes was previously called juvenile-onset and, later, insulin-dependent diabetes. Autoimmune, genetic, and environmental factors are believed to affect the develop-ment of this type of diabetes. Type 2 diabetes was previously called adult-onset and, later, non-insulin-dependent diabetes. Approximately 90% of people with diabetes have Type 2. While insulin secretion is a component of this disease, cellular resistance to insulin and the liver's secretion of stored glucose are dominant factors of etiology.

The prevalence of Type 2 diabetes in the 65 and older population has serious impli-cations for Medicare patients. More than 18% of this pop-ulation, 6.3 million people, have diabetes. This is more than double the rate of those ages 20 or older.

Treatment for diabetes focuses on keeping blood glucose at near normal levels. This is accomplished by understanding and balancing the factors that directly influence blood glucose levels: food intake, activity level, stress management and medications (if they are prescribed). According to 1995 and 1996 Behavioral Risk Factor Surveillance System data for Virginia, 18% of surveyed respondents with diabetes never check their blood glucose levels, and 13% either did not remember or only checked it from one to six times a year. Only 28% had heard of glycosylated hemoglobin (HbA1c is a blood test that provides an estimate of average blood glucose control over the preceding 2-3 months). Thirty-three percent reported having vision trouble.

The Virginia Health Quality Center (VHQC), initiated a health care quality improvement project in 1998 to increase dilated retinal exams among Medicare beneficiaries with diabetes. The project took a multifaceted approach involving pharmacists, hospitals, primary care physicians, and eye care specialists, as well as a media campaign that included direct mail to patients. During the active intervention time period there was a significant increase (17%) in eye exam rates in the targeted areas.

This year, the VHQC has expanded its role in the promotion of quality care for diabetes. Its current three-year initiative, part of a Health Care Financing Administration (HCFA) national initiative, focuses on increasing eye exam rates, tests for lipids, and HbA1c tests.

Currently in Virginia, only 74% of Medicare beneficiaries aged 18-75 years have received the HbA1c test within the past year, only 71% have received an eye exam and only 60% have received a lipid profile in the past two years. Clearly, there is room for improvement. An increase in HbA1c rates will increase awareness of actual average blood glucose levels and show when improvement is needed. Eye exams can identify problems early and potentially prevent loss of eyesight. The lipid analysis can identify those suffering from hyperlipidemia so that the condition can be properly managed.

To increase rates in these areas, the VHQC and its partners are using a multifaceted approach. Partners include primary care physician offices and other providers of care in the community such as diabetes centers and pharmacies, as well as "trusted sources" in the community, such as churches and area agencies on aging. Collaboration among community organizations, particularly in areas with a high concentration of people with diabetes, is being encouraged.

To help partners increase these key measures of diabetes management, the VHQC will offer a variety of intervention tools and ideas including:
• supplying data on rates regularly,
• providing partners with patient education materials and appointment reminders,
• furnishing office staff with patient and physician reminder systems,
• distributing reminder postcards and letters,
• providing a speaker's bureau, and
• providing access to a video loan library on a wide array of health care topics.

The VHQC welcomes additional partners in its wellness initiative. If you want more information or to get involved, please contact Susan Warren, Project Manager, at (804) 289-5320 or call toll-free at 1-800-545-3814.

References

Department of Health and Human Services, Centers for Disease Control and Prevention (US). National estimates and general information on diabetes in the United States. National Diabetes Fact Sheet 1997.

Department of Health and Human Services, Centers for Disease Control and Prevention (US). Surveillance for diabetes mellitus - United States. CDC Surveillance Report 1980-1994.

Behavioral Risk Factor Surveillance System, 1994-1996, as reported in the Virginia Diabetes Control Program Summary, Published Analysis, 1997.

Jenkins AJ, Lyons TJ. (2000). Preventing Vascular Disease in Diabetes. Practical Diabetology, 3:19-34.

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Calendar of Events

August 21-24, 2000
FCOA 2000: The Conference. Sponsored by the Florida Council on Aging. Tampa Marriott Waterside, Tampa, FL. For info. contact (850) 228-8877 or fcoa1@aol.com.

September 6-8, 2000
UPBEAT Conference 2000: Geriatric Mental Health Care Coordination for the New Millennium. Doubletree Hotel National Airport, Washington, DC. For info. contact (310) 268-4000, Rosansky.Joel@med.va.gov, or vaww.mentalhealth.med.va.gov/Upbeat/.

September 10-12, 2000
Assisted Living Federation of America's Fall 2000 National Conference & EXPO. Seattle Convention Center, Seattle, WA. For info. contact (703) 691-8100 x202 or jzimmerman@alfa.org.

September 14-15, 2000
International Symposium on Aging and Health. Sponsored by the Harvard School of Public Health. American Academy of Arts & Sciences, Cambridge, MA. For info. contact (617) 432-3483, akirsch@hsph.harvard.edu, or www.hsph.harvard.edu/aging.

September 22, 2000
Memory Walk 2000. Annual benefit for the Alzheimer's Association - Northern Virginia Chapter. McLean, VA. For info. contact (800) 728-9255.

October 7, 2000
Memory Walk 2000. Annual benefit for the Alzheimer's Association - Northern Virginia Chapter. George Mason University, Fairfax, VA. For info. contact (800) 728-9255.

October 7, 2000
Memory Walk 2000. Annual benefit for the Alzheimer's Association - Greater Richmond Chapter. Innsbrook, Richmond, VA. For info. call (804) 967-2580.

October 19-20, 2000
Making Aging a Priority on Virginia's Agenda. Annual VAA/VCA conference. Holiday Inn Patriot, Williamsburg, VA. For info. contact (804) 828-1525 or kspruill@hsc.vcu.edu.

October 23-26, 2000
39th Meeting & Exposition of the American Association of Homes and Services for the Aging. Miami Beach, FL. For info. contact (888) 508-9441 or www.aahsa.org.

November, 2000
Meeting Everyday Needs: Aging with Cerebral Palsy and Other Developmental Disabilities. Midtown Inn & Conference Center, Richmond, VA. For info. contact (804) 828-1525.

November 16-17, 2000
Taking the Next Step: Workshop for Minority and Emerging Scientists and Students Seeking Careers in Aging Research. Sponsored by the National Institute on Aging. Washington, DC. For info. contact (301) 496-0765, palmerne@exmur.nia.nih.gov, or www.nih.gov/nia/conferences/taw2000.htm.

January 16, 2001
Legislative Breakfast. Annual gathering sponsored by the Virginia Center on Aging. St. Paul's Episcopal Church, Richmond, VA. For info. contact (804) 828-1525.

February 22-25, 2001
Capitalizing on Professional and Cultural Diversity to Benefit Older Adults. 27th Annual Meeting and Education-al Leadership Conference of the Assoc. for Gerontology in Higher Education. Fairmont Hotel, San Jose, CA. For info. contact (336) 758-4665 or longino@wfu.edu.

April 4-7, 2001
Aging's Traditions, Transitions, Technologies: The Southern Touch. 22nd Annual Meeting of the Southern Gerontological Society. Marriott's Griffin Gate Resort, Lexington, KY. Deadline for Submission: October 16, 2000. For info. contact (423) 439-6275 or lloyd@atsu.edu.

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Making Aging a Priority on Virginia's Agenda

Annual Conference of the Virginia Association on Aging and the Virginia Coalition for the Aging

October 19-20, 2000
Holiday Inn Patriot, Williamsburg, Virginia

Featured Speakers to Include:
Mary Kieger, Senior Navigator
J. James Cotter, Ph.D., Virginia Commonwealth University
Kevin Byrnes, Virginia Department for the Aging

Featured Topics to Include:
Advocacy
Corporate Giving
Technology Use in Planning for Services

Other Conference Features:
Annual Meetings of VAA and VCA
Panel of Physician Educators
Silent Auction

Telehealth

Thursday Evening Reception

Hotel is two miles from historic Colonial Williamsburg!

Registration information is scheduled to be mailed on September 1st. If you have not received this information by late September, or if your agency would like to sponsor this event, please contact Kimberly Smith at (804) 828-1525 or kspruill@hsc.vcu.edu.