

Case Study

Alcohol, Medications, and Older Adults

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Educational Objectives

1. Describe patterns of simultaneous use of alcohol and Central Nervous System (CNS) - acting medications among older adults.
2. Understand the mechanisms of interaction between alcohol and CNS-acting medications and their consequences.
3. Identify strategies to prevent alcohol-medication interactions among older adults.
4. Recommend resources for older adults and service providers for identifying and managing problematic alcohol and medication use.

Background

As we grow older, drinking alcohol may have unexpected and serious consequences. Demographics, different bodily composition with age, and common challenges we experience in later life may trigger changes in both the consumption of alcohol and how our body responds

to it. Baby-boomers, those born between 1946 and 1964, tend to consume more alcohol compared to previous generations, so the prevalence of alcohol-related problems is projected to increase as they age. An overall understanding of alcohol use by older adults requires attention, as well, to patterns of drinking and other interacting factors, such as age, gender, marital status, income, existence of co-morbid conditions, and history of drinking (Merrick et al., 2008). Research studies report varying patterns of alcohol use in older adults, in part attributable to their using different measures of alcohol consumption, and different definitions and cut-off limits for drinking categories. The National Survey on Drug Use and Health (NSDUH, 2010) reported that in 2009, 39% of older adults consumed alcohol in the past month; of these, 29% were current drinkers (at least one drink in the past 30 days), 8% were involved in binge drinking (five or more drinks on the same occasion on at least one day in the past 30 days) and 2% reported heavy alcohol use (five or more drinks on the same occasion on each of five or more days in past 30 days). Generally, the use of alco-

hol declines with advancing age and the occurrence of health problems (Merrick et al., 2008). Some 50% of older adults aged 60-64 years reported alcohol use in the past month, compared to only 39% for those aged 65 and above (NSDUH, 2010). Merrick et al. (2008), studying community-dwelling Medicare beneficiaries aged 65 years and above, concluded that "9% were involved in unhealthy drinking (defined as monthly use exceeding 30 drinks per typical month and 'heavy episodic' drinking of four or more drinks in any single day), with higher prevalence in men (16%) than in women (4%)." Alcohol use in older adults is also found to be associated with race, family history of alcohol abuse, educational level, smoking status, and mental illness (Merrick et al., 2008); the researchers also noted that alcohol use is often under-reported because of some respondents' inability to recall precisely and the desire to present themselves in a favorable way.

Alcohol use among older adults is influenced by various social and health related factors. Some may drink to induce sleep or to uplift a

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depressed mood (Ferreira & Weems, 2008). Moderate drinking has been associated with improved social interactions and self-reported health status among older adults (Ferreira & Weems, 2008). Benefits of moderate drinking in diminishing the risk of cardiovascular events and mortality, touted by several studies, promote the daily intake of alcohol (Ferreira & Weems, 2008). Moreover, late-life related changes such as retirement, loss of loved ones, and disease conditions, might induce an older adult into habitual drinking (Ferreira & Weems, 2008). However, health conditions like diabetes, gout, upper gastrointestinal conditions, insomnia, depression, and cancer actually worsen with alcohol consumption (Moore, Whiteman & Ward, 2007). Alcohol may, initially, help an older adult fall asleep, but it interferes with staying asleep and may induce or worsen the sleep disorder (Moore, Whiteman & Ward, 2007).

Several studies have found an association between alcohol use disorders and depressive symptoms (Choi & DiNitto, 2010; Moore, Whiteman & Ward, 2007). Older adults who indulge in heavy/binge drinking to cope with depressive symptoms have higher risk of having alcohol problems (Choi & DiNitto, 2010).

Alcohol-related disorders can co-occur with psychiatric illness, such as depressive symptoms, anxiety or major depressive disorder (Choi & DiNitto, 2010). In 2009, the NSUDH report stated that 11% of older adults (ages 65 and above) reported some kind of mental illness, while 7% of the population

aged 50 and above reported co-occurrence of alcohol dependence/abuse and mental illness. A German study (Du, Scheidt-Nave & Knopf, 2008) found that approximately 8% of the non-institutionalized older adults reported combined use of psychotropic drugs and alcohol.

Generally, there is little control or monitoring of what alcoholic beverages older adults consume, and drinking is an individual decision. However, as the quick review above suggests, a lack of awareness or guidance about alcohol use in older adults might have serious consequences, given aging-related physiologic changes affecting the response to alcohol, the presence of co-morbid health conditions, and numerous interactions between alcohol and medications in older adults.

Alcohol and CNS-acting Medication Interactions

Aging related changes in physiology affect the distribution and metabolism of alcohol. Alcohol distribution in the body depends on age and gender, as older people and females have less body water and more body fat as a percent of body weight, and alcohol distributes in body water. Thus, for a given amount of alcohol consumption, the blood alcohol level is higher in older adults than in their younger counterparts. In addition, older adults and females have lower levels of alcohol-metabolizing enzymes, which results in reduced alcohol metabolism (Moore, Whiteman & Ward, 2007).

The central nervous system (CNS) is the part of the nervous system

that consists of the brain and spinal cord. Several medications, including antidepressants to treat depression, sedatives to induce sleep, and antipsychotics to control psychosis, act on the CNS. Importantly, some of these CNS-acting medications show exaggerated response in older adults for two fundamental reasons: 1) there are age-related changes in CNS functions, like altered neurotransmitters or number of receptors, and 2) there is increased sensitivity with age to some drugs, such as benzodiazepines, opioids, and anaesthetics (Bowie & Slattum, 2007). Significantly, most of the CNS medications, from antidepressants to anti-anxiety medications, sedatives, opioid analgesics, antipsychotics, certain anticonvulsant and certain antitussive agents, are CNS depressant, as is alcohol. So, when an older adult consumes CNS medications with alcohol, it could lead to exaggerated sedation, impairment of motor skills, and impaired judgement, any of which could increase the risk of injury (Moore, Whiteman & Ward, 2007). Apart from CNS-acting medications, several other medications also have the potential to interact with alcohol and cause adverse events. For instance, nonsteroidal anti-inflammatory drugs (NSAIDs) are associated with increased risk of gastrointestinal bleeding; and anti-hypertensive medications to lower blood pressure (such as hydralazine and α -blockers) are associated with incidences of orthostatic hypotension, when consumed with alcohol (Moore, Whiteman & Ward, 2007).

Consequences of Concurrent Use of Alcohol and CNS-Medications

Simultaneous use of alcohol and

CNS medications may result in such adverse events as a fall, fall-related fracture, or traffic accident. These may lead to emergency department visits or hospitalization and increased use of healthcare resources. A Swedish study (Stenbacka, 2002) showed that high alcohol intake and use of sedatives/hypnotics were significantly associated with injurious falls among older women, defined as aged 60 and above. A very recent study reports that, out of 524,050 emergency department (ED) visits involving drugs (including illicit substances and pharmaceutical agents) and alcohol taken together, 8,600 visits (2%) were documented in older adults (Drug Abuse Warning Network [DAWN], 2011); this study identifies drugs for insomnia, anxiety (primarily benzodiazepines), and narcotic pain relievers as the major drug categories involved in emergency visits. Clearly, older adults are vulnerable to harmful effects when taking alcohol and CNS-medications at the same time and need to be alert to prevent harmful results.

Managing Alcohol and CNS-Medication Intake

Prudent practice suggests the following: Avoid drinking alcohol and taking CNS-medications whenever possible. Read the labels on medications, which can help identify which medications should be avoided with alcohol. Healthcare professionals can increase awareness about alcohol and medication interaction in older adults. Some over the counter (OTC) products like sedating antihistamines and common non-steroidal anti-inflammatory drugs, such as ibuprofen, naprox-

en and aspirin, can also interact with alcohol (Moore, Whiteman & Ward, 2007). So, easy access to an OTC medicine does not mean that it is totally safe and without precautions. Limit alcohol consumption. According to recommendations by the National Institute of Alcohol Abuse and Alcoholism (NIAAA), older males should not consume more than one alcoholic drink a day (a standard drink is 15 grams ethanol, meaning 12 ounces of regular beer, five ounces of wine, or 1.5 ounces of 80-proof distilled spirits); and for older females, the limit is "somewhat less" than that recommended for males (Blow & Barry, 2003). Older adults should be encouraged to drink within the recommended limits if they choose to consume alcohol and to use caution when mixing alcohol with medications.

Case Study # 1

Mrs. O is an 80-year-old white woman who lives in an assisted living community. At the time of her medication review by a pharmacist, her family expressed concerns that she had been "loopy and out of it" recently. She also experienced a fall in the evening but was not injured. There hadn't been any recent changes in her medications; but during the pharmacist's interview, Mrs. O mentioned drinking wine in the evening. The medication technician, who often works on Mrs. O's floor, stated that she "stays up all night drinking wine and watching TV then sleeps throughout the day." The medication technician was not sure how much she drinks nightly or whether she was drinking more than usual. Mrs. O was taking 16 scheduled prescription medications

and five "as needed" medications. Her scheduled prescriptions included: lisinopril, nadolol, and amlodipine for hypertension; furosemide for edema; levothyroxine for thyroid replacement; albuterol for asthma; pantoprazole for gastroesophageal reflux disease (GERD); solifenacin for urinary incontinence; citalopram, bupropion, and quetiapine for depression; trazodone for insomnia and depression; tramadol for pain; and supplements of potassium and Vitamin D. Additionally, trazodone (sleep-inducer), promethazine (for nausea and vomiting), docusate (for constipation), acetaminophen, and cholestyramine (for loose stool) were prescribed as needed. Evaluation of her medication regimen indicated that bupropion, quetiapine, trazodone, and tramadol have the potential to interact with alcohol, increasing her CNS depression and her risk for falling. The pharmacist recommended to the physician to change trazodone to use only when needed, and to discontinue quetiapine, if possible. Mrs. O's physician educated her about the potential risk of mixing alcohol and her medications, and her physician, pharmacist, and family each advised her to stop her drinking. Mrs. O did, in fact, stop her alcohol consumption and some changes in her drug regimen were instituted, after which her functional and cognitive status improved noticeably.

Case Study #2

Ms. SP is an 82-year-old white female who suffers from chronic obstructive pulmonary disorder (COPD). She had a medical history of aortic aneurysm, which was treated surgically, and was diag-

nosed previously with depression, for which she was treated with antidepressants. She was a smoker for the last 40 years and a moderate alcohol-drinker. After moving to a senior congregate living center, she started drinking more heavily, which led to incidences of falls and a fractured arm. Her prescriptions consisted of 11 medications: Advair (combination of fluticasone and salmeterol), tiotropium, albuterol, montelukast, and Mucinex (guaifenesin and pseudoephedrine) for COPD; paroxetine for depression; simvastatin for cholesterol; and supplements (iron and calcium). She was also taking digoxin for congestive heart failure and primidone for tremor. However, during the interview she did not mention a history of tremor or heart failure. After checking for potential drug interactions, it was found that primidone and ethanol have a moderate interaction, while paroxetine and ethanol have a minor level of drug interaction. After the fall incident, her physician advised her to quit drinking. Ms. SP underwent three sessions of counselling with her physician and then decided to abstain from drinking and smoking. Subsequently, she has not reported any incidence of fall or other forms of injury. This case illustrates co-occurrence of depression and alcohol intake, resulting in simultaneous use of alcohol and antidepressants. As noted, the concurrent use of alcohol with some prescription drugs increases the risk of falls and injury.

Conclusion

These cases demonstrate the dangers associated with mixing alcohol and CNS-acting medications. Older

Some commonly used CNS-acting medications

Sedatives/hypnotics/anti-anxiety drugs

Alprazolam (Xanax)
Zolpidem (Ambien)
Temazepam (Restoril)
Hydroxyzine (Vistaril)
Doxepin (Sinequan)
Buspirone (Buspar)
Chlordiazepoxide (Librium)
Clorazepate (Tranxene)
Eszopiclone (Lunesta)

Antidepressants

Citalopram (Celexa)
Escitalopram (Lexapro)
Sertraline (Zoloft)
Paroxetine (Paxil, Pexeva)
Duloxetine (Cymbalta)
Fluoxetine (Prozac)
Venlafaxine (Effexor)
Amitriptyline (Amitriptyline)
Mirtazepine (Remeron)
Bupropion (Wellbutrin)

Antihistaminics/antiemetics

Fexofenadine (Allegra)
Cetirizine (Zyrtec)
Chlorpheniramine (Chlor-Trimeton)
Meclizine (Antivert)
Diphenhydramine (Benadryl)
Promethazine (Phenergan)

Antipsychotics

Risperidone (Risperdal)
Ziprasidone (Zeldox, Geodon)
Olanzapine (Zyprexa)
Clozapine (Clorazil)
Aripiprazole (Abilify)
Quetiapine (Seroquel)
Haloperidol (Haldol)
Chlorpromazine (Thorazine)
Perphenazine (Trilafon)
Fluphenazine (Permitil)

Opioid analgesics

Codeine
Hydrocodone (Vicodin)
Oxycodone (Percocet)
Morphine (Avinza)
Meperidine (Demerol)
Fentanyl (Actiq)

Anticonvulsants

Phenytoin (Dilantin)
Pregabalin (Lyrica)
Lorazepam (Ativan)
Clonazepam (Klonopin)
Diazepam (Valium)
Phenobarbital (Luminal)
Topiramate (Topamax)
Primidone (Mysoline)
Gabapentin (Neurontin)

Note: The above list of medications is not exhaustive.

Note: Some medications listed above are used for more than one health condition (such as clonazepam is used in controlling seizures and panic attacks and lorazepam is used in anxiety and insomnia)

adults, because of age-related changes in physiology, existing health conditions, and complex medication use, can be vulnerable to harmful effects of alcohol and medication interactions. These, in turn, may diminish quality of life and may result in costly healthcare expenses. Importantly, these effects are avoidable, so steps should be taken to educate and increase

awareness about alcohol and medication interactions among older adults.

Study Questions

1. Discuss at least two likely consequences of consuming alcohol and CNS-medications concurrently.
2. Why are older adults more vulnerable to alcohol and CNS-med-

ication interactions?

3. How can a potential alcohol and CNS-medication interaction be prevented?

Useful Links for More Information

1) Alcohol and Aging Awareness Group (AAAG) is a state level group consisting of public and private organizations that are collaboratively educating and training older adults and their service providers about alcohol and medication misuse. AAAG's upcoming projects include screening, brief intervention, referral to treatment, web-based training for service providers. For more information, please contact:

(804) 213-4688 or (www.abc.virginia.gov/Education/olderadults/aaagroup.html)

2) Alcohol use in older adults. National Institute of Aging (NIA). (www.nia.nih.gov/healthinformation/publications/alcohol.htm)

3) Harmful interactions: mixing alcohol with medicines. NIAAA publication. (<http://pubs.niaaa.nih.gov/publications/Medicine/medicine.htm>)

4) Alcoholism and alcohol abuse: signs, symptoms, and help for drinking problems. (http://helpguide.org/mental/alcohol_abuse_alcoholism_signs_effects_treatment.htm)

5) How to talk to an older person who has a problem with alcohol or medications. (www.hazelden.org/web/public/hff10730.page)

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Editorials

From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

Forever Young

Bob Dylan turned 70 years old this spring. Many older Americans and quite a few Baby Boomers will identify Dylan with their youth. During the 1960s he wrote, among other things, the anthems that seemed to capture, if not advance, the generational divide between younger and older. His songs were noteworthy for inventive but straightforward lyrics, whether signaling the end of a personal relationship (*It Ain't Me, Babe*) or summing the costs of war (*Blowin' in the Wind*). I suspect that his reaching age 70 has prompted not a little bit of realization among many that our personal times are a-changing.

I remember vividly seeing Dylan at the Newport (Rhode Island) Folk Festivals two consecutive summers. The festival was held in an old baseball park in the city, a small, uninviting structure of high wooden walls painted green and topped with wire. I was there the legendary night when Dylan "went electric" and many in the crowd booed his apparent abandonment of the Holy Grail of folk music, the acoustic guitar. Revisionists since then have argued that the crowd really was angry at the emcee Peter Yarrow or at the brevity of Dylan's music set; but people around me down the sidelines along the first base side yelled insults at Dylan that are not printable. The Newport police had instituted a policy that summer for-

bidding overnight sleeping on the beach and many in the crowd consequently were tired and irritable, but the booing and anger were real.

Nonetheless, for many Bob Dylan's music and messages endured for years thereafter, through the Vietnam War era and beyond, as integral parts of the times we had lived through. Gerontologists theorize that each of us is shaped by the influences of cohort (birth group) and historical time. If there's a oneness of who we were and who we are, if we are one thing, our past and present combined, then Dylan's music is in many of us.

Two of Dylan's best known pieces, *Like a Rolling Stone* and *The Times They Are A-Changing* epitomized the restless, alienated spirit of so many of the young. Other songs captured the bitterness or sweet regret of failed relationships, as in *Positively 4th Street* ("You got a lotta nerve to say you are my friend") and *Just Like A Woman*. At the time, he seemed at once to write for a generation and for the individual listener. Like the Modernist Movement in poetry (T.S. Eliot, Ford Madox Ford, D.H. Lawrence), Dylan created images to which each listener brought a personal meaning.

"Forever Young" is the most popular song on a later album, his 1974 *Planet Waves*, a song since covered by several artists. Dylan wrote it for his children, having one step-daughter and three sons and a daughter of his own at the time. The writer of protest songs penned a heartfelt wish for his children, a wish any parent can identify with. It's also a wish that endures across

the ages and across the life course. It is as meaningful in later life as at its beginning.

May God bless and keep you
always,
May your wishes all come true,
May you always do for others
And let others do for you.
May you build a ladder to the stars
And climb on every rung,
May you stay forever young,
Forever young, forever young,
May you stay forever young.

May you grow up to be righteous,
May you grow up to be true,
May you always know the truth
And see the lights surrounding you.
May you always be courageous,
Stand upright and be strong,
May you stay forever young,
Forever young, forever young,
May you stay forever young.

May your hands always be busy,
May your feet always be swift,
May you have a strong foundation
When the winds of changes shift.
May your heart always be joyful,
May your song always be sung,
May you stay forever young,
Forever young, forever young,
May you stay forever young.

Forever Young is not a paean to age denial. Its message is neither age- nor time-limited. Rather, it seems to me to invoke virtues or characteristics that never grow old: charity to others, acceptance of kindness, hope, righteousness, courage, fortitude, industriousness, and joy.

Dylan was encouraging his children to aspire to goodness in what lay ahead. To be sure, the issues being faced are quite different in the early years than later in life. But the prin-

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principles Dylan so simply advanced in *Forever Young* pertain even so. Facing these issues with courage remains an essential trait in a meaningful life. For instance, being courageous may mean, at any point in life, fighting or accepting a dire health diagnosis, if each involves honest self-examination and appraisal of effects on others. Being true to oneself really does not have an expiration date, nor is joy the property of any age group. But in fairness, these virtues do seem to become harder to recapture at times.

"When the winds of changes shift" epitomizes life, doesn't it? Just when one seems to be in a comfortable routine, things change. No matter when in the life course, things change. When this happens, Dylan wished a strong foundation to face these winds. Relationships, faith, a moral compass.

In *Forever Young* Dylan spoke encouragingly to the hearts of his children, for sometimes, early in life we are outsiders thought too young to be valuable in making important decisions. Sometimes in later life we are thought too old to do the same. From this perspective, Dylan's lyrics resonate for those of us later in life.

Dylan is still performing and has recently sold out venues around the world. His audiences are said to range the life course. He is no golden-throated troubadour, but his 70th birthday is a good time to recognize that some messages are timeless.

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

Jim Rothrock
Commissioner, Virginia Dept. of
Rehabilitative Services (DRS)

Blueprints, Boomers, and Ben & Jerry's—but no BBQ

During the spring and now in our simmering summer, I have had the good fortune of traveling around the state seeing, learning about, listening to, and participating in programs that are more and more responsive to the talents and needs of Vintage Virginians and Virginians with disabilities. The groups have sharp contrasts and emerging similarities that demand attention, if our Commonwealth will have communities for these neighbors, whose numbers are growing report after report.

This editorial, although a tad random, I hope will be successful in sharing with you some of the highlights of my travels, without mention of my study of the best BBQ joints in our state.

Locals Have it Right, Already

At the Commonwealth level, several agencies have been discussing how to increase collaboration. Yet I have found in so many communities where there are "boots on the ground," that the locals have already seen the value of collaboration. I will not try to recite these communities for fear of forgetting some, but it is so exciting to see the results when Community Services

Boards (CSBs), Centers for Independent Living (CILs), Brain Injury programs, and AAAs work at some level to share space, staff, resources, expertise, and customers. Through formal agreements and informal practices, the cooperative services that they offer expand the choices of adults who can benefit from long term services and supports. Over my career I have noticed that, myself included, there is a certain "statecapitolcentricism" that is grounded in the belief that all great ideas must emanate from our own capitol square. But alas, the locals have already figured out how to make systems work better in so many cases, and a lesson we, in Richmond, can learn is to look to localities for innovation and creativity.

Blueprint for Livable Communities

In my last editorial, with significant help from Rebecca Wilkens, my colleague at DRS, we announced a new resource that we are promoting to inspire and energize local folks to come together and plan to make their community more livable. We envision our Commonwealth achieving distinction as communities pull together local leaders to work toward common goals, such as accessible and responsive transit and paratransit services, housing that is affordable and accessible, and wrap-around support services that sustain people at every stage of life to live in the community environment.

The Blueprint for Livable Communities website (first iteration) can be found at www.vadrs.org/vblc. The workgroup driving this

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statewide initiative has acknowledged from the beginning that no singular template can work for our Commonwealth. From Abingdon to Accomack and on up to Arlington, Virginia is as diverse as it is large. Our *Blueprint* does not suggest a single model, but rather offers a compendium of best practices, a directory of leaders who have been *change agents* in their own communities, and resources that can be replicated to fit unique combinations of local circumstances. One of the centerpieces of our site is the **Transportation and Housing Alliance Toolkit**. This resource, designed by experts in Charlottesville, lays out a clearly defined livable community planning process that can be adapted across our Commonwealth.

The objective of Virginia's *Blueprint for Livable Communities* is to share information that will help generate necessary conversations and new connections at the local and regional levels on how to achieve community livability. The key is not necessarily the document that is produced but the process that takes place when requisite local experts come together for the common goal of a livable community.

DRS and VDA will be working to update the *Blueprint* website to keep current information on it and planning to schedule presentations at state and regional conferences to "spread the livability gospel". At a recent conference, we even broke into song with the new *Blueprint* anthem, paying homage to the old Olivia Newton John "physical" classic, now parodied as: "*Let's get Livable, Livable.....*"

Aging within Disability and Impairments of Seniors

Recently, I was in a discussion with representatives from the Departments for the Deaf and Hard of Hearing and the Blind and Vision Impaired. They stridently reminded the others in the session that their (DDHH's and DBVI's) consumers were aging. Although these two agencies have been successful in providing services to remove or minimize sensory barriers in most cases through devices, interpreting services, counseling and orientation, community organization, and a wide array of other responsive services, the aging network will need to remind itself of the growing numbers of blind, vision impaired, deaf, and hard of hearing Virginians who may be accessing services through agencies like our Triple As. The Americans with Disabilities Act clearly notes how both public and private entities need to be physically accessible, capable of providing materials in alternative formats, and able to communicate through interpreters and technology. So we all should continually *assess our access*, assuring that a Vintage Virginian with sensory disabilities can access the regular array of services that are offered. Communication accessibility should be the standard of all Commonwealth programming.

Politics: They Too Are Still Local

In New York's 26th Congressional District, a race to replace a retired member of Congress was decided largely upon the voting power of those who were concerned that Medicare was up for substantive changes. This underscores the

importance of being engaged politically and participating in this process (whether you are an "I", an "R", or a "D") based on your beliefs and values. Be sure you always exercise your franchise; get out and vote, and do not be shy in letting candidates know your opinions.

Importance of Choice: VDA Plan and Ben & Jerry's

In my career, I have been a big fan and student of the Independent Living Philosophy espoused by our network of Centers for Independent Living (CILs). One of the keys to this programming is the importance of giving IL consumers a range of choices and letting them decide.

As we plan for the future, it is imperative that we continue to imbue this way of thinking into our initiatives. I was recently reviewing the Four Year Plan that VDA is completing for our federal partner, the Administration on Aging. At its core is the commitment to empowering seniors to take control of their future and working with communities to assure that a wider array of choices is available.

This is even more critical when we see that we Baby Boomers are used to a wide array of life choices. We have always had multiple choices and, as we mature, we see no reason to expect any change. I often note that a review of some of our services can be equated to ice cream that comes in vanilla and chocolate. Everyone loves ice cream; but in the world that Boomers look to, vanilla and chocolate will not cut it. In ice cream, Boomers are used to a Ben

& Jerry's array that includes *Cherry Garcia*, *Chunky Monkey*, and *Chubby Hubby*; and as they plan for their future as Vintage Virginians, they will require a wide menu of choices.

Random thoughts perhaps. But I challenge YOU to work towards a Commonwealth that is defined by creativity, accessibility and affordability, effective communication, and choice—lots of them.

Helping Affirm the Dignity of Life

Bon Secours Hospice is helping patients live comfortably in their final days, and it is looking for volunteers in the Richmond region and beyond to help in this service. Bon Secours considers its hospice volunteers to be a "vital part of the Hospice Care Team." Volunteers assist with patient and family care, community outreach, education, and office needs. Special skills such as graphic design, fundraising, or playing an instrument would be welcome. Volunteers work with families in Richmond, Amelia, Charles City, Goochland, King and Queen, King William, New Kent, and Powhatan Counties. The next training will be **Friday, September 16th**, from 9:00 until 4:30 at Saint Francis Hospital in Midlothian. You **do not** have to make a decision about volunteering until after the training. To inquire or register, call Barbara Palmer at 804-627-5323 or e-mail Barbara_Palmer@bshsi.org.

Olive Oil Consumption May Lower Stroke Risk Among Older Adults

Olive oil may do more than just flavor our salads. Jennifer LaRue Huget, writing in the *Washington Post*, reported the findings of a study appearing in the journal *Neurology* (June 15, 2011). It suggests that consuming lots of olive oil is associated with a reduced risk of ischemic stroke. The researchers examined the olive oil consumption and certain health characteristics of 7,600 older adults (ages 65 and above) living in three French cities. After controlling for diet, lifestyle, and stroke-risk factors, the study found that "intensive" olive-oil users (those who used it for cooking and dressing their food) had a 41% reduced risk of ischemic stroke (the kind caused by an artery blockage) during the five-year follow-up period than those who used no olive oil at all. The association did not hold true for hemorrhagic stroke (the kind caused by a ruptured blood vessel in the brain), in part because not enough of those strokes occurred among the people in the study to make a statistically valid connection. It is not clear whether it is the olive oil itself, or the oleic acid it contains, or some other quality of the golden liquid that might confer protection. Nor is it clear whether it's the olive oil alone or as a component of the overall Mediterranean Diet that may be protective against stroke. This diet, filled with fruits, vegetables, whole grains, fish and healthful fats, is commonplace among people in the region studied, and has been found to be beneficial to the cardiovascular system.

New USDA Dietary Guidelines

The seventh edition of the US Department of Agriculture guidelines for healthy eating are now available. They include 23 key recommendations for all Americans, as well as additional recommendations for specific population groups, including older adults. The recommendations encompass two overarching concepts: to "maintain calorie balance over time to achieve and sustain a healthy weight," and to "focus on consuming nutrient-dense foods and beverages."

Because more than two-thirds of adult Americans are overweight or obese, the new Guidelines place greater emphasis on reducing calorie consumption and increasing physical activity. They suggest decreasing the intake of various foods and nutrients, including limiting sodium to 1500 mg in about half the US population (compare sodium amounts in buying soups, frozen foods, etc.) and limiting consumption of saturated fats, dietary cholesterol, trans fatty acids, solid fats, added sugars, and refined grains. In contrast, increase intake of vegetables, fruits, grains, and fat-free and low-fat dairy products (half your plate should be fruits and vegetables). The Guidelines emphasize lean proteins, such as seafood, lean meat and poultry, eggs, beans and peas, soy products, and unsalted nuts and seeds. The guidelines also suggest eating foods providing more potassium, dietary fiber, calcium, and vitamin D. Check out the Guidelines at www.cnpp.usda.gov/DGAs2010-PolicyDocument.htm.

COMMONWEALTH OF VIRGINIA

Alzheimer's and Related Diseases Research Award Fund

2011-2012 ALZHEIMER'S RESEARCH AWARD FUND RECIPIENTS ANNOUNCED

The Alzheimer's and Related Diseases Research Award Fund (ARDRAF) was established by the Virginia General Assembly in 1982 to stimulate innovative investigations into Alzheimer's disease (AD) and related disorders along a variety of avenues, such as the causes, epidemiology, diagnosis, and treatment of the disorder; public policy and the financing of care; and the social and psychological impacts of the disease upon the individual, family, and community. The ARDRAF competition is administered by the Virginia Center on Aging at Virginia Commonwealth University. The grant awards for 2011-2012 are as follows:

VCU Malgorzata Dukat, Ph.D. and Galia R. Abdrakhmanova, M.D., Ph.D. "Small Molecules as Negative Allosteric Modulators of $\alpha 7$ nAChRs"

Both agonists and antagonists of $\alpha 7$ nAChRs (i.e., nicotinic acetylcholine receptors) have been shown to be of value in the treatment of AD. Agonists might desensitize the action of ACh at these receptors, thereby reducing cholinergic transmission, and antagonists block ACh transmission. An entirely novel approach is to identify negative allosteric modulators of $\alpha 7$ nAChRs that can selectively, but indirectly, block the effect of ACh at $\alpha 7$ nAChRs without acting at $\alpha 4\beta 2$ receptors. The investigators have identified one of the first small-molecule negative allosteric modulators of $\alpha 7$ nAChRs, namely MD-354. Because MD-354 is a known 5-HT₃ (serotonin) receptor agonist, the investigators propose to modify its structure so as to abolish this action and thereby develop "selective" $\alpha 7$ nAChR allosteric modulators. The structure-activity relationships for the binding of MD-354 at 5-HT₃ receptor sites are already known, so it should be relatively easy to eliminate such actions. However, the influence of these structural changes on $\alpha 7$ nAChR modulation is unknown. Thus, the investigators will synthesize a series of MD-354 analogs to determine what structural features are required and to optimize the pharmacological actions by eliminating affinity for 5-HT₃ receptors. The analogs will then be evaluated in functional assays. In contrast to current acetylcholinesterase inhibitors that are limited to symptomatic treatment of cognitive function, these new agents offer the potential for slowing the progression of AD. (*Dr. Dukat may be contacted at 804/828-5256; Dr. Abdrakhmanova may be contacted at 804/828-1797*)

GMU Jane M. Flinn, Ph.D., Nathalia Peixoto, Ph.D., and Daniel N. Cox, Ph.D. "Behavioral and Inflammatory Changes in a Mouse Model of Late-Onset Alzheimer's Disease"

Alzheimer's disease (AD) has two forms, early onset and late onset, with late onset comprising over 90% of the cases. Much of the research into this disease uses mouse models of AD, and the majority of work is done on mouse models of early onset AD. The investigators have measured inflammatory markers in isolated brain structures of normal rodents and have correlated those to electrical stimulation. This study will investigate early inflammatory responses in a mouse model of late onset AD they recently developed by cross breeding two types of transgenic mice. They will also examine circadian rhythms and memory deficits and compare these values with those of control mice. The long term goal is to measure inflammatory reaction in late onset AD mice as a response to electrical stimulation, and then to develop an engineered device which applies electric field to structures of the brain containing plaques, ultimately ameliorating AD symptoms. This proposal establishes the first steps toward that long term goal, which is to determine whether inflammatory responses are produced in AD animals upon the application of electric field to regions where plaques exist. (*Dr. Flinn may be contacted at 703/993-4107; Dr. Peixoto may be contacted at 703/993-1567; Dr. Cox may be contacted at 703/993-4971*)

VCU Aron H. Lichtman, Ph.D. and Laura E. Wise, Ph.D. “Targeting the Endogenous Cannabinoid System to Treat Alzheimer’s Disease”

Cannabinoids (i.e., marijuana-like drugs) have been demonstrated to inhibit or reduce the deposition of beta-amyloid plaques, a major histological hallmark of AD. Drugs that elevate naturally occurring cannabinoids (i.e., endocannabinoids) without producing psychomimetic effects and cognitive impairing actions are particularly attractive therapeutic targets. This study will evaluate whether a drug that prevents degradation of endocannabinoids will prevent the development of learning and memory deficits, as well as the neuropathological markers of AD in a well-established animal model. The investigators will treat amyloid precursor protein and presenilin (APP/PS1) transgenic mice with a drug that raises levels of endocannabinoids in the brain, test them in a battery of learning and memory tests, and quantify the extent of beta-amyloid pathology. Significant reductions of either cognitive deficits or neuropathology in the APP/PS1 mouse model will provide proof of principle that the endogenous cannabinoid system represents a potential target for medications to treat AD. *(Dr. Lichtman may be contacted at 804/828-8480; Dr. Wise may be contacted at 804/828-7264)*

GMU Robert H. Lipsky, Ph.D. “Functional Characterization of Promoter Polymorphisms of the Human GRIN2B Glutamate Receptor Gene Associated with Altered Memory Functioning in Older Adults”

Current work in the dementia field is focused on detecting ever earlier stages in the degenerative disease process, preclinical Alzheimer's disease, where even the most subtle clinical signs and symptoms are not yet manifest, and yet the pathological cascade has already begun. This project aims to determine the basic underlying genetic causes of altered memory performance in the aging human brain, as well as the molecular events underlying the pathologic processes leading to AD. In a longitudinal study of cognitively normal older adults, the investigator and his colleagues discovered that a naturally occurring single nucleotide polymorphism (SNP) of a glutamate receptor gene (GRIN2B) is associated with altered brain responses to memory functioning. The SNP occurs in a region of the GRIN2B gene that controls its expression, but the influence is unknown. This study will functionally characterize the SNP, as well as other SNPs physically linked to it, so that a future longitudinal follow-up of subjects will bring mechanistic insights into the role of genetic variation as a risk factor for late onset dementia based on well-defined biological mechanisms. *(Dr. Lipsky may be contacted at 703/993-5140)*

2011-2012 ARDRAF Awards Committee

- Paul Aravich, Ph.D.
Eastern Virginia Medical School
- Jeffrey L. Dupree, Ph.D.
Virginia Commonwealth University
- Lynne Elmore, Ph.D.
Virginia Commonwealth University
- Kathleen Fuchs, Ph.D.
University of Virginia Health System
- Wendy L. Golden, Ph.D.
University of Virginia Health System
- Tailiang Guo, Ph.D.
Virginia Commonwealth University
- John C. Hackett, Ph.D.
Virginia Commonwealth University

- Vasiliki N. Ikonomidou, Ph.D.
George Mason University
- Richard Lindsay, M.D.
University of Virginia Health System
- Manoj Patel, Ph.D.
University of Virginia Health System
- Linda Phillips, Ph.D.
Virginia Commonwealth University
- Jodi Teitelman, Ph.D.
Virginia Commonwealth University
- E. Ayn Welleford, Ph.D.
Virginia Commonwealth University

The ARDRAF Awards Committee in Deliberation, June 2011

The Alzheimer's and Related Diseases Research Award Fund (ARDRAF) relies on the generous assistance of experts across many disciplines to ensure that all proposals receive full and impartial scrutiny. The ARDRAF review process involves third party primary reviewers in Virginia who supervise the review process, as well as content experts around the world (this year, in Australia, Ireland, Italy, and Spain) who offer outside analyses of the proposals. This thoroughness has produced arguably the most effective state-funded seed grant program in the country, one that produces hundreds of research publications and returns to Virginia, in subsequent federal and foundation grants, about \$9 for every \$1 appropriated to ARDRAF.



The ARDRAF review panel in session.

Left to right: Drs. Kathleen Fuchs, University of Virginia (UVA); Wendy Golden, UVA; Vasiliki Ikonomidou, George Mason University; Manoj Patel, UVA; Paul Aravich, Eastern Virginia Medical School; and Ayn Welleford, VCU.

The Hidden Epidemic: Alcohol, Medications, and the Older Adult

September 22, 2011

8:15 a.m.–4:15 p.m.

Fairfax County Government Center, 12000 Government Center Parkway, Fairfax

The Hidden Epidemic: Alcohol, Medications and the Older Adult is a one-day conference highlighting best practices, including screening, referring, and treating older adults with alcohol and medication misuse disorders.

Conference Keynote Speaker:

Kristen Lawton Barry, Ph.D., Research Professor, University of Michigan; Associate Director, SMITREC, Department of Veterans Affairs. Dr. Barry will offer best practices for the treatment of substance abuse disorders in older adults during the morning session of this conference.

Presenters Include:

Patricia Slattum, Pharm.D, Ph.D., Virginia Commonwealth University; Constance Coogle, Ph.D., Virginia Center on Aging, VCU; and Regina Whitsett, VA ABC and Chair, Alcohol and Aging Awareness Group (AAAG).

Cost:

\$20 if registered by August 22nd; \$30 after August 22nd. Conference fee includes continental breakfast, boxed lunch, and a certificate of attendance.

For more information, please contact Regina Whitsett at Regina.Whitsett@abc.virginia.gov or (804) 213-4445.

Focus on the Virginia Center on Aging

Thelma Bland Watson



“You can take her out of the country, but you can’t...” Thelma recalls vivid images of her rural upbringing, her family’s attachment to the

land (farmers all), and the dependence on the farm’s produce as essential to the family’s survival. Her parents, the late Percy and Mattie Everson, were lifelong farmers, in addition to being state employees. The third of six siblings, Thelma thirsted for the educational rudiments that eventually led her away from “essential living” to a life with academic and social challenges.

Thelma’s first recollection of her developing a keen interest in the welfare of seniors occurred when her mother and father “farmed her out” to assist in caring for her Dad’s mom, affectionately referred to as “Sis Caddie.” Under Sis Caddie’s strict tutelage, Thelma garnered a healthy appreciation for the distinctions that define the boundaries separating senior assistance from senior interference, and suffered the indignities that occur when these boundaries are flouted.

Thelma graduated from Virginia State University in 1973 (Sociology with a concentration in Social Work), after completing two years of general studies at Richard Bland College. She was offered an internship at the Crater Planning District Commission that led to a lengthy and interesting career in public ser-

vice. Staying after the internship, she worked as a Federal Grants Coordinator, Human Services Planner, and Director of Human Services. In 1974, she helped organize the Crater District Area Agency on Aging, where she eventually became the assistant to the Executive Director, retired Army Colonel Richard T. Bull, and held the position from 1980 to 1988.

From 1988 to 1997, Thelma had the honor of serving as Deputy Commissioner and then Commissioner of the Virginia Department for the Aging (VDA). As Commissioner, Thelma provided leadership for several innovative initiatives, including the Public Guardianship Program, Coordinated Transportation Services, and Cooling Assistance through the Fan Care Program, generously funded for the past 21 years by Dominion (Virginia Power). During her tenure at VDA, she successfully led two Governor’s Conferences on Aging to address the needs of family caregivers, develop strategies to prevent elder abuse and exploitation, and establish viable collaborations with other agencies in Virginia’s Aging Network. She also traveled to South Korea to exchange best practices for senior services with the Health Ministry there. Most notably, she enjoyed traveling around Virginia to see the success of local programs and to engage with older citizens. She learned much from these encounters and treasures the long lasting friendships that she forged.

Thelma served as Executive Director for Field Services for the National Committee on Social Security and Medicare between 1997-2002, working in Washington,

D.C. while living in Fredericksburg. She worked with a group of retirees from the Social Security Administration who served as volunteer advocates throughout the United States. She considered this the opportunity of a lifetime, for early in her career she had declined an offer from the Social Security Administration due to her activities with the Planning District Commission. She says that she learned valuable lessons about the importance of Social Security, not only as a benefit for retirees, but also as an often overlooked safety net for people with disabilities, and surviving children and spouses. Serving on the Political Action Committee (PAC) for the organization, she met aspiring and current members of Congress, learning first hand their political philosophies and public policy concerns. She was also able to advocate with the White House on senior issues during her time with the Committee.

Thelma earned two degrees from Virginia Commonwealth University (VCU) during this time, taught classes at VCU and Troy State University, and directed a family child care business. She earned a Ph.D. in Public Policy and Administration, and an MS in Gerontology (concentration in Human Resources), both of which have strengthened her initiatives as Executive Director, since 2002, of Senior Connections, The Capital Area Agency on Aging, a private nonprofit organization that has served the Richmond Region since 1973.

Past honors for Thelma include alumni recognition from RBC, VSU and VCU. In 1993, she was

recognized by her peers with the Applied Gerontologist Award from The Southern Gerontological Society. In 1994, she received the YWCA Outstanding Woman Award for Government and Politics, in recognition of her achievements as VDA Commissioner and advocacy on improving policies for long term care services in the Commonwealth. She served on the Board of Directors for the National Association of State Units on Aging during her tenure as the VDA Commissioner. Currently, she serves on the Boards of Directors for the Richmond Chapter of the Alzheimer's Association, Covenant Woods Retirement Community, VHQC (formerly the Virginia Health Quality Center), the Capital Area Health Education Center, Legal Services Corporation of Virginia and ElderHomes. She is also a gubernatorial appointee to the Virginia Public Guardian and Conservator Advisory Board.

As a gerontologist and public administrator, Thelma's vision is a world where people know how to find and use resources in order to cope with health issues as they age successfully like her Grandmother did so many years ago. In addition to her work, she enjoys her family. She is the grandmother of three, the mother of a daughter and two stepchildren, has two sons-in-law, and is the wife of Walter H. Watson, Jr. She and her husband are residents of Petersburg and members of Union Branch Baptist Church in Prince George County, where they both previously served as pioneering Chairs of the Church Council. She is a valued member of VCoA's Advisory Committee.

Bert Waters Chosen Alumnus of the Year



VCoA's Bert Waters received special recognition this spring, being named the Alumnus of the Year by VCU's Department of Gerontology. Celebrating its 35th anniversary at a festive and well-attended event held at the Virginia Historical Society in Richmond this April, the Department honored Leland (Bert) Waters "in recognition of outstanding contribution to the professional field of gerontology." We are all proud.

2011 – 2012 Geriatric Training and Education Request for Proposals

Virginia institutions of higher education, community-based organizations, and other not-for-profit groups with a strong history of adult and aging-related experience may apply for Geriatric Training and Education (GTE) funds. These funds are intended for workforce training and education initiatives that can be completed within the fiscal year. Applications for training projects, conferences, or similar educational programs are appropriate.

Applicants may seek GTE awards in any amount from \$1,000 to \$25,000, so long as this request is justified. We have established two application deadlines: August 1, 2011 and November 1, 2011. Awards will be made until such time as the appropriation from the General Assembly has been fully allocated to successful applicants. The Request for Proposals can be downloaded from www.sahp.vcu.edu/vcoa/program/training.html.

Save the Date: December 7-9, 2011

Virginia Rural Health Association's Annual Conference

Featuring Aging in Place and Five Additional Themes

Staunton, Virginia

For information, contact Beth O'Connor at boconnor@vcom.vt.edu or (540) 231-7923.

VGEC Preventing the Recurrence of Falls

The Virginia Geriatric Education Center (VGEC), a consortium of health care professionals from the University of Virginia, Eastern Virginia Medical School, and VCU, launched its first initiative to decrease falls by older adults, by training staff at the Richmond PACE sites. PACE, which stands for Program of All-inclusive Care for the Elderly, is a highly effective project for community-based care of older adults, one that mixes interprofessional care, various funding streams for payment, and a philosophy of preventative health care. So, it was a logical partner for the VGEC's evidence based program (EBP) to reduce the recurrence of falls.

The VGEC conducted this 24-content hour EBP on site during May and June for more than two dozen dedicated professionals, including therapists, physicians, pharmacists, nurses, social workers, clinical care managers, and others. Each of six training days began in the afternoon, once PACE clients had departed. Training content included discussion of the rationale for employing an EBP approach; risk factors for falling; clinical assessments used by nursing, medicine, physical therapy, social work, and pharmacy; interventions to address intrinsic and extrinsic contributors to falling; team work; and care planning.



Peter Boling, MD, geriatrician (top left photograph), Emmy Wheeler, PhD, physical therapist (top right photograph), and Bonita Hogue, MSW, clinical social worker (bottom photograph), interacting with participants at the PACE Manchester site.

Ageing Rocks!

**September 25-28, 2011
Memphis, TN**

The 2011 Southeastern Association of Area Agencies on Aging (SE4A) Annual Training Conference is a great opportunity to network with aging professionals from across the Southeast and beyond. The SE4A's purpose is to promote sharing of information among members and to encourage the development and enhancement of a coordinated and unified network on aging in the Southeast. Member states include: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee.

Workshops at this year's event will include Senior Center/Focal Points; Nutrition/Transportation; Elder Rights; Long Term/Caregiver Support; Agency Management/Professional Development; and Promoting Healthy Aging.

Sponsors of the conference include the Tennessee Commission on Aging and Disability, Oxford HealthCare, Help at Home, Inc., HUMANA, Valley, United Health-care, National Association of Area Agencies on Aging, Tennessee Development District Association, Golden Cuisine, peerplace, MERTAN, Tennessee Association of Human Resource Agencies, GA Food Service, Inc., Amerigroup, and Bateman Senior Meals.

For more information, or to register for this conference, visit the SE4A website at www.se4a.org.

The Downside of Medicare

by Saul Friedman

(Saul Friedman, Pulitzer Prize winner, whose columns reached many people, including readers of Age in Action, over his decades of passionate journalism, died this past December 24th. He was an unabashed advocate for people, especially the disadvantaged. His commentaries seldom pulled punches and he aroused readers on every side of the political spectrum. The following column, abridged here, appeared in late August 2010. With Saul's permission, Age in Action will be publishing abridgements of some of his last columns in our 2011 issues.)

Those of us of a certain age sing the praises of Medicare which, thanks to the recently passed health reforms, according to the latest report of the trustees, has a new lease on life. It will serve the needs of upwards of 45 million disabled and people over 65 for longer than some banks and businesses will be around.....

But Medicare, which was passed 45 years ago, is far from the universal health care that we one day hope to have. Unless a beneficiary has supplementary coverage from a former employer, Medicare's deductibles and premiums or the Medigap policies to cover those costs have gotten expensive.....

We could have done better than Medicare or the cumbersome health reforms, most of which won't take effect until 2014, if the nation was-

n't so stuck in an ideological rut.

One great alternative is called socialized medicine and it's practiced right here in the U.S. - the Veterans Administration hospitals and health services. And its beneficiaries, non-socialists all, have included the four star generals now running our wars, as well as Senator John McCain and many members of Congress.

Although they are not run by the VA, among the socialized institutions that have tended to the needs of presidents, as well as lawmakers, are Walter Reed Hospital, in Washington, D.C., run by the Army, and the Bethesda Naval Hospital in the Maryland suburbs.

A few years ago, millions of Americans and I were beneficiaries of the VA health system when it developed, along with Merck and California researchers, an effective vaccine for the dreaded shingles. That was just one of the innovations credited to the VA in a new edition of a book, *The Best Care Anywhere*, with the subtitle, "Why VA Healthcare Is Better than Yours."

Written by Phillip Longman, a professional demographer, and a fellow at the New America Foundation and the *Washington Monthly*, the book tells the story of the quality revolution launched by Dr. Ken Kizer when he took over the VA health system in 1994.

According to the Century Foundation's Health Beat blog, Longman's book includes "eye-popping evidence" based on peer-reviewed research "...that when it comes to everything from outcomes to

patient satisfaction and patient safety, the VA out performs. Most people don't associate the VA with innovation. But a majority of its doctors have faculty appointments at academic institutions, one reason that the VA is on the cutting edge of evidence-based, patient centered medicine."

Over the years, Longman reports, "the VA has been responsible for developing the CT-scanner, the first artificial kidney, the cardiac pacemaker, the first successful liver transplant, the nicotine patch, and the shingles vaccine."

The VA installed the VistA software program, the centerpiece of the VA's electronic medical record system, which is now used elsewhere. With the use of the software, Longman writes, the VA system, (including its) doctors, researchers, nurses and technicians who work for the VA, "...is the only health care provider in the U.S. whose cost per patient has been holding steady in recent years."

Dr. Donald Berwick, the new head of the Centers for Medicare and Medicaid Services wrote on the back cover of Longman's book: "The improvement of the VA health care system in the past decade is one of the most impressive stories of large-scale change."

Who says government can't do anything right?

In this case (as in many civilized nations), socialized medicine works, but it's doubtful that the VA system will serve as a model for health reform in the U.S. We blindly reject "socialism" without know-

ing what it is. But we veterans know how it can be helpful in obtaining good treatment and cheap prescription drugs. Unfortunately, budget cuts over the last eight years have forced the VA to sharply limit eligibility for its health system.

While searching for alternatives to Medicare and the inadequate health reforms, I came across a paper published earlier this month on “the impact of universal national health insurance on population health” in Taiwan, of all places, a successful bastion of free enterprise on the doorstep of communist China. Taiwan established its National Health Insurance in 1995, which covers more than 98 percent of Taiwanese, at the cost of small co-payments. In the years after the system became effective, the paper reported, deaths from “...causes amenable to health care” declined by nearly six percent a year. The decline was highest among the young and the old and was “associated with substantial reductions in deaths from circulatory disorders for men, whilst an earlier upward trend in female cancer deaths was reversed.”

The U.S. might have had something similar to Taiwan’s NHI, Medicare For All, except for the timidityand the ignorance of (politicians) who worried more about their political futures than the health care of their constituents.....We pay for this ideological narrowness with lives; in contrast to the good news of Taiwan’s NHI, the U.S. has the worst rate of amenable mortality among 19 industrialized nations, with more than 100,000 deaths per year from disorders amenable to health care.

Senator Mary Margaret Whipple and Delegate Patrick Hope Receive the Virginia Elder Rights Coalition’s 2011 Elder Rights Award

The Virginia Elder Rights Coalition (VERC) selected Senator Mary Margaret Whipple and Delegate Patrick Hope to receive its 2011 Annual Elder Rights Award, named after longtime Arlington County resident and elder rights advocate, Erica F. Wood. Senator Whipple and Delegate Hope were both honored for sponsoring two bills in the 2011 General Assembly aimed at strengthening the rights of nursing home residents. Kathy Pryor, VERC Chair and Joani Latimer, State Long-Term Care Ombudsman, presented the awards at the May 17th meeting of the Northern Virginia Aging Network.

Delegate Hope stated, "I am so honored to be recognized by the Virginia Elder Rights Coalition. As Virginia’s population ages, we will rely much more heavily on our nursing homes to provide care and it is important we take measures to protect the rights and safety of residents."

Kathy Pryor, chair of the Virginia Elder Rights Coalition (VERC), said “Both Delegate Hope and Senator Whipple were perfect patrons because they cared about the issue and they were articulate advocates for the bills.” She remarked that both are “The epitome of a legislator who is in the business for all the right reasons, because they want to make Virginia a better place for all

its inhabitants.”

Delegate Hope concluded, “To receive an award named after my dear friend, Erica Wood, who has devoted her entire life to ensuring the protection and safety of older adults across the Commonwealth, makes this honor even more special.”

House Bill 1818, to provide information to family members of nursing home residents about family councils, passed both houses and was signed into law by the Governor on March 23, 2011. House Bill 1486, to improve the nursing home complaint resolution process, resulted in a stakeholders group convened by the Office of Licensure and Certification on complaint investigation issues, which offered a significant opportunity for a “win” for resident rights.



Joani Latimer, Kathy Pryor, and Erica Wood of VERC with Delegate Hope.

Calendar of Events

July 26, 2011

Veterans Benefit Seminar. 10:00 a.m. Sunrise at Bon Air, 2105 Cranbeck Road, Richmond. For information, call (804) 560-7707.

July 28, 2011

The Greater Richmond Regional Age Wave Initiative: Building a Ready Community. Learn about the development of the Greater Richmond Regional Age Wave Plan to prepare for regional changes in our growing aging demographic and its impact on communities. 9:00 a.m. - 10:00 a.m. Lucy Corr Village, 6800 Lucy Corr Boulevard, Chesterfield. For information, call (804) 768-7878.

August 4 & September 1, 2011

Grandparent Connection. A support group for grandparents who are raising a grandchild. Child care is provided. 4:15 p.m. - 6:00 p.m. Juvenile and Domestic Relations Courts Building, 7000 Lucy Corr Boulevard, Chesterfield. For information, call (804) 768-7878.

September 22, 2011

Virginia GrandDriver. The program gives senior Virginians and their families suggestions to improve driving skills and provides web-based resources that help senior drivers. 9:00 a.m. - 10:00 a.m. Holiday Inn Express, 5030 W. Village Green Drive, Midlothian. For information, call (804) 768-7878.

October 6, 2011

Fun at the Fairgrounds. A free health and wellness festival for older adults age 50+, featuring friends, fun and food. Join us for health screenings, karaoke, crafts, games, entertainment, competi-

tions, door prizes, vendors and more. 9:00 a.m. - 1:00 p.m. Chesterfield County Fairgrounds, 10300 Courthouse Road, Chesterfield. For information, call (804) 768-7878

October 29, 2011

Community Opportunity Fair and Forum. Co-hosted by the VCU Department of Gerontology and Lift Caregiving. The event will showcase an array of Central Virginia aging services providers, as well as open forum discussions on aging and caregiving healthcare related issues. Glen Allen Cultural Arts Center. For information on exhibition space and partnership opportunities, contact Jay White at (804) 828-1565 or whitejt2@vcu.edu.

November 3, 2011

Conference on Dementia. Presented by the Alzheimer's Association Greater Richmond Chapter. Family caregivers: \$35. Professional caregivers: \$70. Professional caregivers pay \$50 each for groups of four or more from the same organization. 9:00 a.m. - 4:30 p.m. Ramada Plaza Richmond West. To register, call (800) 272-3900 or e-mail fran.foster@alz.org.

November 3, 2011

Best Practices for Tobacco Control and Prevention. Annual conference hosted by The Virginia Department of Health Tobacco Use Control and Healthy Communities Projects and the American Cancer Society. 8:30 a.m. - 4:30 p.m. Westin Hotel, Richmond. For information, visit www.cleartheairva.org.

November 4-5, 2011

Improving Transitions of Care for Older Adults. Hotel Roanoke. Friday's presentations focus on family caregivers as key drivers for transitions in care settings and Saturday's presentations provide strategies that promote effective care coordination for health care professionals. For information, call the Carilion Center for Healthy Aging at (540) 981-7653.

November 8-9, 2011

Virginia Association for Home Care and Hospice Annual Conference and Trade Show. The Boars Head Inn, Charlottesville. For information, call (804) 285-8636 or visit www.vahc.org.

Age in Action

Volume 26 Number 3
Summer 2011

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James A. Rothrock
Interim Commissioner, VDA

Kimberly S. Ivey, M.S.
Editor

Age in Action is published quarterly. Submissions, responses to case studies, and comments are invited and may be published in a future issue. Mail to: Editor, *Age in Action*, P.O. Box 980229, Richmond, VA 23298-0229, fax to (804) 828-7905, or e-mail to kivey220@yahoo.com.

**Fall 2011 Issue Deadline:
September 15, 2011**



Virginia Center on Aging

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

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