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age in action

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

Case Study

Spirituality and the Cognitively Impaired

Kathy Fogg Berry, M.R.E., M.S.

Educational Objectives

1. Discuss the need to acknowledge and nurture the spirituality of older adults with cognitive impairment to enhance their health and well-being.

2. Provide tools and suggestions for use in nurturing the spirituality of older adults with cognitive impairment.

3. Review the response of one resident with cognitive impairment to spiritually-based programming and support.

Background

No one knows exactly what goes on inside the mind of someone with cognitive impairment. Neurological tangles and plaques in the brain cause cognitive deterioration unique in each individual. This deterioration affects each individual in unique ways. Despite cognitive decline cognitively impaired senior adults are spiritual beings and continue to have spiritual needs in the midst of losing ability to understand or communicate those needs, feelings and thoughts. Decline in ability to perform once familiar religious practices and disciplines does not indicate the disappearance of one's spiritual self. These declines connote a change in an individual's ability to express faith. Frustration and anxiety often accompany someone's diagnosis of dementia and increase as losses in abilities occur, such as the ability to practice and express faith, if this has been an important aspect of the person's life. Caregivers experience frustration, too, as they lose aspects of the person they love and do not know how to help. It is important to help people suffering from cognitive impairment to see that they have not lost their faith because they may no longer be able to perform religious disciplines. Helping someone who is suffering from dementia feel valued and accepted for "being" who they are rather than for being able to "do" things, affirms her as a person of great worth and embraces her spirit. "Losing" religion does not mean losing spirituality.

Kathy Fogg Berry, M.R.E., M.S. and Certificate in Aging Studies, is Director of Pastoral Care at the Masonic Home of Virginia, a not-for-profit continuing care retirement community in Richmond. She offers spiritual care to the facility's 240 residents, resident families and facility staff. Kathy is co-founder of Pastoral Eldercare Consultants -- offering education and consultation to elders, caregivers, faith communities, and long-term care facilities concerning spirituality and aging. She is also a board member of Faith in Action of Greater Richmond, an inter-faith coalition committed to mobilizing volunteers who help chronically ill and frail elderly maintain their independence for as long as possible. Kathy provides person-centered care training for the Capital Area Alzheimer's Association.

Often the words spirituality and religion are used interchangeably and/or confused with one another. Stephen Sapp, Ph.D., chair of the department of religious studies at the University of Miami, says, "The loss of cognitive ability can be taken to mean the person can no longer experience God because we think everything meaningful in human life depends on a functioning neo-cortex. Perhaps we can say that religion consists of the forms into which we put and try to capture and express our spiritual awareness/ experience. I am not willing to grant that people with Alzheimer's disease (and other forms of dementia) cannot still experience spirituality even after they may not be able to participate in religion. Who are we to say God cannot continue to speak even to the most severely demented person if God so chooses, whatever our understanding of the brain says about a person's ability to comprehend human communication" (Bonifazi, 2003).

People over 85 years of age represent the fastest growing segment of America's population. According to the National Alzheimer's Association, up to 50% of people over 85 experience some form of dementia. Thus, cognitive impairment is a rapidly advancing dilemma that a large percentage of this nation will face. As people lose the ability to function cognitively, they may experience guilt from no longer being able to practice their faith as they always have. Providing opportunities for them to express their spirituality taps into some deep reservoir of memory and enhances self-worth. According to Harold Koenig of Duke University, holistic care of aging individuals requires that attention be given not only to one's bio-psychosocial self, but also to one's spiritual self, offering bio-psychosocial-spiritual care (Kimble, 1995).

Objectives

Discovering a cognitively impaired person's spiritual needs cannot always occur from using a standard spiritual inventory tool employing a question and answer format. Obtaining information from a person's familial and clinical caregivers provides insight beyond that gained from reading charted social histories. A spiritual care plan can evolve for each individual with cognitive impairment based on learning his faith background and discerning needs. Ask the person suffering from dementia or his caregivers, if he is incapable of responding, such questions as: Is he from a particular faith background? What religious practices - Scripture reading, acts of service, prayer, meditation, music - have been important to him or her? Is a particular style of worship important to him? What religious symbols or rituals are valued? Did he enjoy hearing particular religious music or seeing works of art? Are there things in nature that hold special significance to him? What comforts him? How does he express his faith best? Discovering important personal rituals, traditions, music, and symbols is essential to meeting each individual's needs.

When working with individuals with cognitive impairment, it is important to move from an empathetic, supportive style of communication that uses strong listening approaches to an intuitive-oriented method of

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communication where the caregiver supplies energy and much of the interaction (Ellor, Stettner & Spath, 1987). Care providers should focus on the individual through building relationships, using such tools as music, touch, prayer, conversation when possible, and presence (Bell, 2001). "A cognitively impaired older person may recite words of the 23rd Psalm and gain comfort and a sense of peace from the rhythm of the words even when there is little awareness of where he or she lives" (Richards, Seical, 1991).

Enabling an individual with cognitive impairment to express her faith aids her psycho-logically, as she is able to emote, experience accomplishment through active participation, and feel included in her faith community. Encourage and allow him or her to do as much as possible to express spirituality. Relationship building with individuals with cognitive impairment is in keeping with spiritual tenets such as inclusivity, openness and love. Caregivers can be encouraged to do such things as read familiar scriptures, play religious music, display religious symbols, offer one-on-one prayers with cognitively impaired individuals, enable them to be outside in creation, etc. Providing opportunities for group and individual worship experiences can also meet a person's spiritual needs. Establishing a holy place by setting up an altar containing that person's traditional religious symbols, religious scriptures, flowers, candles and other familiar elements of worship appeals to individuals' senses (Goldsmith, 2001).

Someone with a cognitive impairment who can no longer participate in congregate religious experiences in his place of worship may benefit from being offered a private worship experience in his church, synagogue or temple at a non-traditional time, thus enabling him to stay connected with his faith's roots (www.Mayo clinic.com, 2003). Worship experiences should be kept brief to accommodate short attention spans - preferably no longer than ½ hour - and consistently structured in format offering familiar songs, rote and personal prayers, scriptures readings from more traditional Bible translations like the King James Version, and the presence of religious symbols (Clayton, 1991).

Case Study

Hovered in her doorway or poised on the edge of her rocker, Mrs. G anxiously awaited passersby to assist her with pressing questions plaguing her mind: "Is it time?" And "What's going on?"

At 92, Mrs. G was physically and cognitively declining, with diagnoses of hypertension, dementia, depression and degenerative joint disease. Mrs. G lived in the Masonic Home's Richard E. Brown Memory Support Center and was a life-long Richmond resident. Her dementia caused her to ask repetitive questions concerning time and orientation. These questions exacerbated her anxious feelings and occasionally resulted in aggressive behavior toward staff and other residents.

After getting to know her spiritual background, it became apparent that her lifelong active involvement in a Protestant church led to expressions of her faith, albeit disjointed at times. Being able to express her faith was essential to Mrs. G's well-being. These expressions sometimes followed cues but were often spontaneous, as she would want to sing familiar-to-her religious songs. Even when disoriented to time and place, traditional Protestant religious symbols like a cross or Bible prompted Mrs. G to quiet down and sing or quote scripture appropriately during congregate or private worship experiences. As she was encouraged to participate in traditional Protestant worship activities, Mrs. G demonstrated diminished acting out and anxiety, as well as visible feelings of joy and well-being. Even if these positive

times were transitory, they were nonetheless, pleasurable moments for her and a departure from the anxiety she often exhibited. In her book *Creating Moments of Joy*, Jolene Brackey discusses the importance of providing such experiences for cognitively impaired seniors who live a moment at a time, not in touch with preceding or following moments.

Performing her role as song leader in a weekly support group, Mrs. G would spontaneously lead in singing her self-proclaimed favorite song, "Jesus Loves Me." Familiar-to-her religious practices elicited less agitation and enhanced calmness when Mrs. G was engaged one-on-one and sometimes in group settings. When religious scripture was read, prayers offered or songs sung in her presence, she sat attentively listening or participating as able, not typical behavior for her.

Interdisciplinary staff participation in Mrs. G's spiritual care enhanced her cooperation on other levels of care. Not all nursing home or retirement communities have chaplains or pastoral care providers on staff to prepare spiritual inventories or provide spiritual care. So, outside volunteers from various faith backgrounds may be a valuable adjunct. Moreover, providing spiritual care should not be confined to any one person. It is part of providing holistic care. In Mrs. G's case, Activities Department staff provided a CD player and Christian CDs for her to listen to. They also planned religious programs during which they provided one-on-one attention to Mrs. G as needed. Social Services and Nursing staff learned of her spiritual needs and helped her through calming touch, playing or singing music with her, and offering comfort to her in other ways. Environmental and Dietary staff also learned about Mrs. G's spiritual needs and strengths, providing similar services. Everyone worked together enabling the best possible care for Mrs. G.

Upon her decline toward death, Christian music playing softly, prayer, and gentle touch from caregivers at her bedside visibly eased her anxieties. As she literally took her last breaths, caregivers quietly sang her favorite spiritual song and held her hand, ushering Mrs. G from this physical world. Recognizing Mrs. G's spiritual roots enhanced her sense of well-being and calmness, even at death.

Conclusion

Anyone who cares for a cognitively impaired person can take part in helping to recognize and meet his or her spiritual needs. Offering hope to cognitively impaired individuals and their caregivers nurtures spirituality and enhances quality of life. "Caregivers can incorporate simple religious activities and guide persons with Alzheimer's disease and related disorders in such a way that their dignity and self worth remain intact … Persons possess more than memory and intellect; they also have emotion, relationship, imagination, will and aesthetic awareness" (VandeCreek, 1999).

Study Questions

1. How can discovering and meeting the spiritual needs of individuals with cognitive impairment enhance their well-being?

2. What tools might you use to help an individual with cognitive impairment continue to enhance his or her spirituality?

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From the
Executive Director, Virginia Geriatric Education Center

Iris A. Parham, Ph.D.

This quarter has been one of the most exciting and productive for the VGEC. We have fully implemented the supplemental grant focusing on Ethical Decision Making. We are also gratified to report that we are making the final push for the third consortium-based videoconference titled, *Substance Abuse in Older Adults: The Diagnostic Challenge*, to be presented in three parts on April 12, 19, and 26, 2005. Additionally, the supervisor curriculum for the Department of Medical Assistance Services contract dealing with recruitment and retention of direct care providers is in its final stages (with special thanks to Drs. Jablonski and DeLellis of the School of Nursing). The schedule for the Spring training sessions for the Department of Social Services contract is now complete. Please visit our website, http://www.sahp.vcu.edu/gerontology/html/dss/home.htm for more details including registration, sites, and schedule. Also, we are continuing the work in geriatrics mentoring with a conference for the current cadre of mentees and mentors (with presentations by Lori Hasty, Kathy Vesley, Tomaree Porter, and Dr. Jablonski). The details and schedules for the upcoming training sessions are peppered throughout the newsletter, so we urge you to attend the trainings scheduled. There have been the usual arrivals and departures of staff and we welcome new additions to the already outstanding VGEC core staff.

Kudos to the first graduates of the Virginia Beach cohort of students who were formally mentored through the VGEC core grant and who completed the graduate Certificate in Aging Studies: Shelly Dimmick, OASIS Coordinator for the City of Virginia Beach Department of Human Services and Kathleen O'Connor, Administrative Supervisor of Senior Adult Services for the Virginia Beach Department of Human Services, Mental Health/Substance Abuse Division. Both graduates are using their degrees to further their work with the Department of Human Services. Lastly, over 30 professionals will be mentored in grant writing this Spring to complete the VGEC core grant objective to train professionals to successfully access more resources for aging interventions, research and service projects, and demonstration initiatives. Overall, this should be an exciting Spring for the VGEC.

From the
Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

The meaning of "crisis"

The lesson says, "I complained about having no shoes, until I met someone with no feet." The devastating effects of the massive tsunami in Southeast Asia teach the real meaning of the word "crisis." The loss of tens of thousands of lives in a matter of minutes and the enduring homelessness of millions of people since then make pale by comparison what pundits stateside call crises: traffic jams, unemployment, even the Social Security system. The response from countries around the world to the plight of so many people in Sri Lanka, Indonesia, and elsewhere in the region demonstrates both the good heartedness of so many nations and the ability to act decisively. Refocusing on our own matters here in this country, Social Security reform seems much less "critical." Yet December was filled with discussions and debates, sometimes acidic, about this particular aspect of growing older, and the rhetoric seems to be intensifying in the New Year. The president's desire to privatize some part of the Social Security program has obliquely focused attention on the aging of our nation. The discussions, like the election campaign, however, do not so much speak to the fundamentals like the transformation of our demography, the change in the complexities of intergenerational relationships, or older adults as a resource, as to the appropriateness and affordability of changing the financing scheme of Social Security. Are we in the midst of a crisis in the Social Security System? In the tsunami sense, no. Yet there seems to be growing movement toward some change. The process of change invites, if not requires, our engagement as citizens. One may ask, why bring this up in a Virginia-oriented newsletter? Social Security reform will affect Virginians old and young, the healthy and the ill, those of means and those without. It will affect individuals, families, and agencies. Change in the national formula will inevitably mean changes in practices in Virginia. We Virginians need to be participants in the process. Elsewhere in this issue we summarize representative positions in this growing debate (see page 10). Let us study, become informed, reason and share our opinions, and help to shape the process.

From the
Commissioner, Virginia Department for the Aging

Jay W. DeBoer, J.D.

The Secretary of Health and Human Resources Aging Agenda Task Force's Report on Virginia's Assisted Living Facilities (ALFs)

Virginia is rapidly becoming one of the primary magnets for aging members of the U.S. population. Secretary of Health and Human Resources Jane H. Woods formed a Task Force to examine Assisted Living Facilities (ALFs) in Virginia. The goal of the Task Force was to create a plan so that, in the future, state and local governments would not be overwhelmed by the number of older Virginians needing assistance and services.

One of the first problems the Task Force encountered in addressing ALFs is that there is no standard definition that is used nationwide. Each state is, therefore, obliged to make up its own definition. In Virginia, §63.2-100 of the Code of Virginia defines ALFs as:

"*…a congregate residential setting that provides or coordinates personal health care services, 24-hour supervision and assistance (scheduled and unscheduled) or the*

maintenance of care of four or more adults who are aged, infirm or disabled and who are cared for in a primarily residential setting…"

This broad definition allows ALFs to exist in diverse settings, ranging from small apartment houses with a "resident advisor" to large nursing homes or psychiatric hospitals. Often, these places market the ability of their residents to "age in place," implying a reduction (but not an elimination) of the need to relocate individuals as their care needs increase.

The Task Force split into three work groups to address key issues, as follows:

1. Admission Criteria/ Special Populations/Levels of Care
2. Oversight/Enforcement/ Staffing/Credentialing
3. Reimbursement/Funding Streams

These issue-specific work groups looked at ALFs, taking into consideration the impact on other service providers and community-based support services. The following are the recommendations made by each of the work groups.

<u>Admission Criteria/Special Populations/Levels of Care</u>

1. Develop uniform, comprehensive training for staff completing the UAI (Uniform Assessment Instrument), including Mental Health (MH) assessments.
2. Create a MH assessment tool to be completed by MH professionals.
3. Educate ALFs about Medicaid Mental Health Rehabilitation Services.
4. Evaluate admissions process for residents with MH issues.
5. Revise ALF level of care criteria to include Alzheimer's disease or other dementia.

<u>Oversight, Enforcement, Staffing & Credentialing</u>

1. Have the Department of Health Professions (DHP) license ALF Administrators.
2. Require additional training for CNAs who administer medications.
3. Expedite suspensions of facility licensure in cases of imminent danger.
4. Strengthen disclosure requirements.
5. Standardize training for DSS licensing inspectors.
6. Increase civil penalties from $500 to $10,000 per inspection cycle.
7. Use civil penalties to provide education and technical assistance to improve the standard of care.
8. Provide additional funding for 22 new DSS licensing inspectors.
9. Provide additional funding to expand the Long-Term Care Ombudsman program.

<u>Reimbursement & Funding Streams</u>

1. Strengthen care coordinator role of ALFs.
2. Provide GF for special services for persons with dementia.
3. Provide GF for a pilot program allowing persons with mental illness to use Auxiliary Grants for supported living in apartments.
4. Hold a "Best Practices Session" for providers who want to offer housing and services.
5. Double the current Auxiliary Grant Rate of $894 per month.

The information in this article, along with other details, is available on VDA's web site at: http://www.vda.virginia.gov/AATF%20Files/AATF.htm.

You can also contact Ms. Carolynne Stevens, Director of the Division of Licensing Programs at the Department of Social Services (DSS) at (804) 726-7156, or e-mail address, carolynne.stevens@dss.virginia.gov or contact Ms. Lynne Williams, the Assistant Director of the Division of Licensing Programs at DSS, at (804) 726-7147, or e-mail address at lynne.williams@dss.virginia.gov

Focus on the Virginia Geriatric Education Center

Tracy Evans

Tracy Evans joined the Virginia Geriatric Education Center in December 2004. Ms. Evans is responsible for maintaining the statewide database for the Medication Management training program, providing assistance with implementing trainings for licensed assisted living facilities and adult day care centers, and performing daily task that keep the office running smoothly.

Ms. Evans recently relocated from Northern Virginia, where she worked at Vance Securities assisting with new employee applications, interviewing, and hiring. She has also attended both Virginia State University and Northern Virginia Community College majoring in Criminal Justice.

In her spare time, Ms. Evans teaches defensive driving, runs marathons (currently, she is training for the upcoming Ukrop's marathon held later this spring), spending time with her 8 year old Maltese, Molly, and attending church.

Focus on the Virginia Center on Aging

Tara Livengood

Tara Livengood joined the staff of the Virginia Center on Aging in March 2004. A native Texan from Austin, she says that everything is "big" in Texas. She thinks that half of the Chevy and Ford pick-up trucks in the United States are in Texas, that cows and horses occupy about half of the land in Texas, and that the other half is used for farming hay for the horses. While she admires Virginia's rural areas, she thinks that Texas Country will always hold her heart. She has enjoyed living in Richmond for over three years, but travels regularly to visit her friends and family.

Tara is completing her senior year at Virginia Commonwealth University, earning a Bachelor of Science in Psychology with a double major in Criminal Justice. She will graduate in May and begin a Master's Program in Forensic Psychology at Argosy University in Arlington, Virginia in Fall 2005. Tara hopes to work in criminal justice and to help improve the criminal justice system.

Tara has already expanded the scope of her responsibilities at VCoA, adding research assistance and administrative duties to her primary work in Elderhostel. She has expressed interest in VCoA's initiatives in aging with lifelong disabilities and would like to participate in the forthcoming work of the Area Planning and Services Committee (APSC) operating in metropolitan Richmond.

In her free time, Tara enjoys the outdoors, especially visiting the gardens and animals at Maymont, as well as other parks in and around Richmond, since "Virginia has so many wonderful parks." Tara, an avid reader, makes great use of her VCU and Henrico County library cards. She also enjoys traveling, favoring the Virginia mountains, but has also visited New York City, Montreal, and, of course, Texas and the southwest. She hopes to be travel to Paris after she graduates in May as a graduation present to herself.

CALL FOR PROPOSALS

COMMONWEALTH OF VIRGINIA

Alzheimer's and Related Diseases Research Award Fund

THE VIRGINIA CENTER ON AGING
VIRGINIA COMMONWEALTH UNIVERSITY

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

Funding: **The size of awards varies but is limited to $25,000 each. Number of awards is contingent upon available funds.**

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

Schedule: **We request a non-binding letter of intent with tentative title, non-technical abstract, and a 4-5 sentence description of the project in common, everyday language for press release purposes by March 3, 2005. Applications will be accepted through April 1, 2005, and applicants will be notified by June 22, 2005. The funding period begins July 1, 2005 and projects must be completed by June 30, 2006.**

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

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

Constance L. Coogle, Ph.D.
Alzheimer's & Related Diseases Research Award Fund
Virginia Center on Aging
P. O. Box 980229
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Social Security Reform: The Great Debate

Edward F. Ansello, Ph.D.
Virginia Center on Aging

While the presidential and vice presidential candidates said little about the unprecedented aging of the nation before the election, December has been filled with discussions and impassioned exchanges about one particular aspect of growing older, namely, Social Security. The president's desire to privatize some part of the Social Security program has triggered considerable debate and, obliquely, has focused attention on the aging of our nation. In the interest of engaging our readers thoughtfully in this process whose outcomes will affect them, we offer several syndicated commentaries on the appropriateness and affordability of changing the financing scheme of Social Security. Note that several versions of the reform plan have been floated, so some analysts may be arguing about apples and oranges. Even the definitions of "in the red" and "insolvency" vary. This creates enormous differences in opinion about the costs of transitioning to a partially privatized plan. Note also that those who advance certain reform plans are "financing" them on assumed cost savings and growths in the economy that, at this point, are only speculative. The following contains long quotations of analysts' opinions.

Leanne Abnor and Tim Perry, writing an opinion piece for the *San Francisco Examiner* (December 8, 2004), offer an insider's perspective. Both served on the President's Commission to Strengthen Social Security, and both argue that there is misinformation about their recommendations. While the Commission submitted three recommendations, it apparently favored Plan 2. (However, it did not know which, if any, the president would advance).

They ask, *"What did Plan 2 recommend? First, consistent with one of the president's principles, everyone who is age 55 or older should receive their promised Social Security benefits, inflation adjusted. No exceptions. This means that all AARP members can be assured that their benefits will not be changed as a result of any other reforms. Second, we recommended that Social Security's safety net be strengthened by increasing the benefits paid to low-wage workers. It is disgraceful that under the current system, a low-wage worker receives a benefit that keeps him or her below the poverty line. The Social Security actuaries told us that, if implemented immediately, this would raise at least 700,000 of today's elderly out of poverty. In addition, we recommended that widows' benefits be raised.*

"Third, because Social Security's benefit formula increases the benefits of future retirees beyond the amount received by today's retirees, even after inflation, we recommended that the growth in benefits be cut. The result is that every future retiree would get a benefit slightly larger than the benefit received by today's retirees, but less than they are promised by a system that can't pay those increased benefits. Critics have ferociously attacked this recommendation, misleading people into believing that future retirees would get a benefit less than today's retirees receive. This is completely false. Last, we recommended that younger workers be given the choice to invest 4 percent of their income -- or up to $1,000 per year, to allow lower-wage workers to invest more -- in a government-regulated Personal Retirement Account. Their money would be invested in funds similar to that in which all federal workers are allowed to invest -- just five large mutual funds. The accounts would be individually owned, controlled and inheritable. The worker would still receive a Social Security benefit, but proportionately less than he or she would have, had all of their taxes continued to flow into Social Security. The Social Security actuaries said that for those workers who chose a PRA, they could expect to receive a benefit that is higher than the existing system can pay.

Added together, this plan would cost 68 percent less in general revenues than it would cost to maintain the current system, and the system would be permanently solvent. The so-called "transition costs" -- resulting from a timing issue -- would be considerably less than has been alleged. The Social Security actuaries' analysis said that this plan would cost $700 billion over the next 10 years, not the $2 trillion figure that was pulled out of thin air during the recent campaign."

The transition costs are a key target of critics. A four-panel political cartoon in *USA Today* (December 27, 2004) shows an elephant saying, "We want the government to borrow on a massive scale…. To reform Social Security…. And prevent a crisis many years from now…. That would require borrowing on a massive scale."

Thomas Oliphant, in a *Boston Globe* column (December 14, 2004), attacks the economic assumptions of two reform plans offered by prominent Republican legislators, Senators John Sununu and Lindsay Graham, for he notes that the president has not yet said how he would finance the transition to privatization. Oliphant criticizes the assumptions underlying the financial feasibility of reform.

Oliphant says, *"For more than four years, President Bush has trumpeted the idea of personal investment accounts grafted onto the best retirement safety net we've ever had. He has yet to utter a syllable about how he would finance the transition once tax revenue intended to fund current benefits is diverted to create such accounts. He's happy to emphasize the free lunch aspects -- no benefit cuts for those 55 or younger, an all-voluntary scheme, a benefits floor, and even no increase in payroll taxes (though his spokesmen resist saying whether that applies to increasing the income ceiling of $87,700)."*

Oliphant then assesses the Sununu and Graham plans. *"What he (Sununu) doesn't emphasize are the assumptions on which this nirvana is based. To make it work, the scheme assumes that federal spending growth is cut by more than a third across the board, on average, for each of the next eight years. It then assumes that every dollar of what is now a surplus is kept within Social Security to help fund the transition costs for each of the next 14 years -- instead of being in effect embezzled to mask the true size of the government's massive and growing operating*

budget deficits. Needless to say, Sununu doesn't emphasize the debt explosion that will occur on the operating side."

Oliphant continues, *"Graham gets credit for being willing to discuss raising the ceiling on income subject to the payroll tax to help fund transition costs, which he says should not be funded with additional debt. In general, he has been suggesting a willingness to talk about a near-doubling of the ceiling to around $150,000. However, Graham does not emphasize that the proposal he made at the end of 2003 does not include this at all. Moreover, he has used a figure of $1 trillion for the transition costs over a decade, not emphasizing that all current discussions involve estimates double that figure.*

"Graham also does not emphasize that he is assuming, without specifics, major federal spending cuts to make his idea financially workable. In particular, he doesn't emphasize that his legislation assumed cuts in spending to the tune of tens of billions of dollars every year (at least 1.5 percent of payroll revenue) to be identified by a commission. Finally, while Graham like all would-be "reformers" stresses voluntarism as a key selling point, he does not emphasize that his proposal would increase payroll taxes for those who choose not to play the equities markets with any of their Social Security tax dollars. There would be a 2-percentage point increase in the payroll tax that would escalate over time. All these things are not emphasized because they detract from the attractiveness of partially privatizing the system. These nonemphasized facts have one thing in common: They impose hidden costs that may be greater socially, and are certainly greater politically, than the benefits of privatizing."

Paul Krugman, in a syndicated column (*Richmond Times-Dispatch*, December 19, 2004) cites the experiences of other countries with privatization, in criticizing the Bush administration's plans. He notes that a large fraction of workers' contributions goes for brokerage fees to investment companies that cut into the returns that individuals realize; even after the government imposed a "charge cap" in Britain, for instance, he claims that fees erode retirement savings.

Krugman says, *"A reasonable prediction for the real rate of return on personal accounts in the United States is 4 percent or less. If we introduce a system with British-level management fees, net returns to workers will be reduced by more than a quarter. Add in deep cuts in guaranteed benefits and a big increase in risk, and we're looking at a "reform" that hurts everyone except the investment industry."*

Finally, economist Robert Samuelson broadens the debate (*Washington Post*, December 15, 2004), questioning both the costs of federal spending on retirement benefits and legislators' resolve to take unpopular stances. Using the recent passage of Medicare drug benefits as an exemplar, he raises the prospect that privatizing Social Security may be more politically than economically motivated. He begins by decrying out-going Secretary Tommy Thompson's declared accomplishment in establishing a drug benefit.

Samuelson says, *"Here is thunderous doublespeak: Far from a triumph, the Medicare drug benefit is one of the worst pieces of social legislation in decades. Let's see. Even before the drug benefit, the combined costs of Social Security, Medicare and Medicaid (which covers some nursing home care) were projected to grow by about 80 percent, as a share of national income, by 2030. This implies huge tax increases, immense budget deficits or dramatic cuts in other government programs. The drug benefit merely adds to the costs. In 2006 Medicare will spend an average of $2,069 on drug bills for each recipient, say Medicare's actuaries. By 2013, that reaches $3,367.*

"As baby boomers retire, Medicare drug spending rises rapidly. Without the drug benefit, Medicare spending was projected to grow from 2.6 percent of national income

(gross domestic product) in 2003 to about 5 percent of GDP in 2030. Adding the drug benefit, total Medicare spending jumps to almost 7 percent of GDP in 2030 -- a huge increase. In today's dollars the extra drug spending would amount to $200 billion annually in 2030. What motivated this legislative atrocity? Here's Thompson's answer: "Seniors from Alaska to Florida demanded that we provide them a prescription drug benefit . . . and I'm happy to say we have delivered." Another interpretation would be that the Bush administration was trying to buy the support of retirees with hundreds of billions of dollars of new handouts. Either way, it's the politics of "yes." One narrow lesson: Be suspicious of the Bush administration's forthcoming proposals for Social Security "personal accounts." If the drug benefit is any guide, the motives are mainly political. The larger lesson is that Americans are living in a self-created culture of delusion. The central truth about retirement "entitlements" is this: The only guaranteed way to cut spending growth is to cut benefits. But this truth is unspeakable, so no one speaks it."

Already there are, indeed, several proposals that may serve as alternatives to or supplements of privatization. These include postponing the age of eligibility for benefits to correspond with the number of years of life remaining at age 65 when Congress enacted Social Security in 1935, and indexing benefits to the amount of worker-employer earnings contributed to Social Security plus inflation since the contributions. We hope that the debate will continue and will engage more citizens in thoughtful discussion. How will we as a nation balance the needs of older Americans and the needs of the nation (are they one or separable)? How will we balance our budget? What needs and services will we cut if the budget costs continue to rise? How will we balance the costs of a war oversees with the realities of an aging, multigenerational nation at home? What will we prioritize?

This last question leads inevitably to the fundamental question: What is the "good" to be achieved in whatever Social Security-related action that is undertaken? This begs the question of the values at play. A pooled-risk social system or an individual-risk personal system? What are the goals to be achieved? Savings in federal government expenses? Exit from entitlements? Taxpayer choice? What are acceptable costs (monetary and otherwise) to achieve these goals? Virginians old and young will want to engage in this policy-making process and make their opinions known.

"Substance Abuse in Older Adults: The Diagnostic Challenge"

"Substance Abuse in Older Adults: The Diagnostic Challenge," a three-part national videoconference will air on three consecutive Tuesdays in April 2005: April 12, 19 and 26 at 1:00 p.m. Eastern Standard Time. This program will address the specific challenges to medical professionals treating older adults who abuse substances such as drugs or alcohol, including recognition, diagnosis and treatment.

This program is a joint effort of the Veterans Administration Employee Education System (EES) and a consortium of four Geriatric Education Centers: Virginia GEC, Mountain State GEC, Western Reserve GEC and the GEC of PA. Each hour-long broadcast will be followed by a conference call that will allow for discussion between audience members and conference faculty. Continuing Medical Education Credits (CME), as well as other CE credits, will be available for attendees.

For information on viewing sites in Virginia, or if you are interested in hosting a viewing site, please contact Kathleen Watson at the Virginia GEC at (804) 828-9060 or kdwatson@vcu.edu

Calendar of Events

January 26, 2005
Virginia Center on Aging's Annual Legislative Breakfast, St Paul's Church Parish Hall, Richmond. For information, call (804) 828-1525.

February 24-27, 2005
Careers in Aging. 31st annual meeting and educational leadership conference presented by the Association for Gerontology in Higher Education to be held at the Renaissance Oklahoma City in Oklahoma City, OK. For more information, go to www.aghe.org

March 30 - April 2, 2005
Strengthening the Bridge: Informing Research and Practice. 26th Annual Meeting of the Southern Gerontological Society to be held at the Rosen Center Hotel, Orlando, FL. For more information, go to www.wfu.edu/academics/Gerontology/sgs

April 1-3, 2005
16th Annual Virginia Geriatrics Conference to be held at the Jefferson Hotel in Richmond, VA. For more information, contact Lucy Lewis at (804) 828-9060 or by email at lblewis@vcu.edu

April 4-5, 2005
Joint Conference of the Virginia Guardianship Association and the Virginia Elder Rights Coalition, Woodlands Hotel and Suites in Williamsburg. For more information, contact Joy Duke at (804) 261-4046 or joyduke@msn.com

April 13, 2005
Who will Care? Elder Caregiving in the New Political Reality. Conference sponsored by the Virginia Quality Healthcare Network, the Virginia Association for Home Care, and the Virginia Center on Aging to be held at The Place at Innsbrook, Richmond. For more information, contact Becky Rice at (804) 649-7238.

June 2-3, 2005
11th Annual Conference of the Virginia Coalition for the Prevention of Elder Abuse to be held at the Virginia Beach Resort and Conference Center. For more information, call Joyce Walsh at (757) 382-6883.

Virginia Guardianship Association and the Virginia Elder Rights Coalition Joint Conference

April 4-5, 2005
Woodlands Hotel and Suites
Williamsburg, VA

The Virginia Guardianship Association and the Virginia Elder Rights Coalition will offer their 2005 joint conference on April 4 and 5 at the Woodlands Hotel and Suites in Williamsburg. The conference will include a Community Living Track of workshops sponsored by the Virginia Board for People with Disabilities. The conference overall will consist of twenty workshops and three plenary sessions on a wide variety of guardianship and elder rights issues.

Keynote speaker will be A. Frank Johns, JD, CELA, RG, a nationally recognized legal authority in Elder Law, Guardianship, Disability Rights, Special Needs Trusts and Legal Ethics. Mr. Johns is a charter partner in Booth Harrington & Johns, LLP . He is former chair of the North Carolina Bar Association Elder Law Section. A frequent speaker on Elder Law, Guardianship, Special Needs Trusts and Legal Ethics, he is also a well-published author and past editor of the *NAELA Quarterly*.

Virginia Center on Aging

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www.vcu.edu/vcoa

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16th Annual Virginia Geriatrics Conference

April 1-3, 2005
Richmond, VA

Plan now to attend the 16th annual Virginia Geriatrics Conference at the Jefferson Hotel in Richmond. The conference will feature 18 - 20 Master Teachers addressing topics that are critically important to the care of older adults. Continuing Education credits will be awarded for physicians, nurses and pharmacists. The conference is co-sponsored by the Virginia Geriatrics Society, the Virginia Geriatric Education Center, and the VCU/Reynolds Partnership in Geriatric Education.

Registration is available on-line at http://www.vageriatrics.org/

For more information or to receive a brochure, contact Lucy Lewis at (804) 828-9060 or lblewis@vcu.edu.

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