



Maine Aging News & Information Update

Maine Gerontological Society

Issue 5
Summer 2007

17th Annual Conference—"Community Mobilization Around Aging in Maine"

The 17th Annual Rural Geriatric Conference is set for May 31 and June 1 at the Atlantic Oakes by the Sea in Bar Harbor. The Conference is co-sponsored by the Acadia Health Education Coalition, The Maine Gerontological Society, The Maine Office of Rural Health and Primary Care and the University of New England. Last year, the conference began merging aging themes of practice and policy. The concept was successful and sets the agenda of all subsequent conferences.

The title of the Conference "Community Mobilization Around Aging in Maine" considers a full spectrum of programs and concepts affecting aging.

"Reauthorization of the Older American's Act and Implications for Maine" informs attendees of future trends and expectations within the OAA. As The Administration on Aging encourages the implementation of evidence based programming for elders within each State, "Healthy Choices for Maine Evidence Based Programs for Older Adults" becomes a timely topic.

For those who have always wondered what it was like to be challenged with dementia, an experiential opportunity is offered via "Virtual Dementia Tours".

Reviewing "Career Paths and Ladders in Gerontology and Geriatrics" sets the stage for future employees within the aging field.

Recognition of state

shortages of domestic employees with an increasing aging demographic becomes a discussion point in "A study of Maine's Direct Care Workforce: Wages, Health Coverage and a Worker Registration".

Because the prevalence of Alzheimer's Disease continues to increase and to incur such high costs at the grass roots and national level, facets of the disease and implications of care are discussed in "Dementia: Effective Management", "New Directions in Alzheimer's Care: An Interdisciplinary Approach" and "Speak to Me, Listen to Me: Communicating with People with Alzheimer's Disease."

Those living in a nursing home also have needs. Depression becomes a common thread for nursing home residents as discussed in "Prevalence of Depression in Maine's Nursing Home". Katrina and its travesty for the frail and elders was not lost. "Disaster Recovery in Long Term Care: Post Katrina Experiences" is offered as a workshop to provide attendees with an opportunity to contemplate disaster recovery in other natural catastrophes. "Disaster Preparedness: What you Need to Know" also offers information and expertise on effective planning for disasters.

Death is a natural occurrence of life. Workshops "Hospice House: Building a Future for Death and Dying" and "Palliative Care: Transitions for the Dying Person and the Family" discuss the life event of dying.

Other aging issues are broached including: "Recognizing and Managing Psychosis in the Elderly", "Pharmacology for the Aging Population", and "Building a Community Response to Issues of Elder Abuse".

In order to provide options for alternative forms of Practice, "TaiJiQuan for Elders" and "Herbal Medicine and

Supplements" are also being offered.

The conference is offering an exhibit area for the first time in its history. Exhibits are also varied, offering a wide array of information.

The Maine Gerontological Society is sponsoring a wine and cheese reception following its Annual Membership meeting on Thursday afternoon, May 31st. The annual meeting provides an opportunity to voice expectations of the Society, to become an MGS member, and to hear about all of the Society's accomplishments in the past year.

Please note that the location of the conference has changed in order to better serve attendees. The conference MOVED from the Bar Harbor Regency to the Atlantic Oakes by the Sea, which is on the same side of the road and directly following the Bar Harbor Regency.

Planners of the conference are hoping that attendees will enjoy the change and are anxious to hear the thoughts that attendees have regarding this move.

The conference brochure and MGS membership application can be obtained at the MGS website:

www.umaine.edu/mainecenteronaging/MGS2.htm

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From the President ...

This year marks the 17th Annual Rural Geriatric Conference. The Maine Gerontological Society is again partnering with organizations within the state to offer a conference that is diverse in scope and speaks to all disciplines that will attend.

The planning for this conference is many months in the making and members of the planning committee put much time and effort into offering speakers and workshops that speak to current issues facing Maine's aging population. This year's workshops will include a mix of educational opportunities from public policy to alternative medical treatments for older citizens.

The importance of having so many people with a similar interest in one place at the same time cannot be overemphasized. Not only are conferences like this one an opportunity to learn new emerging concepts but they are also a time to connect with others in the field who have a similar focus. Having the chance to share ideas and ask questions with others in the field is invaluable. Innovative partnering in a state like Maine is often times how we get things accomplished when faced with limited funding. Taking this time to reconnect with familiar contacts and establish new connections is vital to ensuring that geriatric initiatives move forward in our state.

This two day conference will again be set against the beautiful backdrop of Bar Harbor. This venue allows conference attendees time to enjoy one of Maine's most beautiful coastal towns. We are lucky in Maine to be able to combine an educational conference of this scope with a picturesque scenic location.

I encourage all who can attend to make the time. This conference will surely offer something special for every attendee. By focusing on integration of policy and practice this conference will touch on all levels of geriatric education. I look forward to seeing you all there.

Lenard W. Kaye



FAST FACTS

25,000 people in Maine are estimated to have Alzheimer's Disease

Nationally, one out of every eight people over 65 have Alzheimer's Disease

The number of people over 85 living with Alzheimer's Disease is expected to grow by 52% by 2020

Maine is ranked number one in the nation in the percent of people in nursing homes with dementia

(Muskie School Research and Policy Brief, Caring for People with Alzheimer's Disease or Dementia in Maine, 2007)



Treasurer's Report

By Roberta Downey, MGS Treasurer

The Maine Gerontological Society began the year with a checking account balance of \$3049.05. During the first three months of the year we had income of \$1182 and expenses totaling \$413 for a net positive change of \$769. Our balance as of March 31, 2007 is \$3,818.50.

The primary source of revenues for the first quarter was 2007 \$972 for annual 2007 dues and Greater Bangor Elder Abuse Consortium (GBEAC) conference registration fees of \$210 received in error. Expenses of \$413 included \$196 for a MGS banner, \$210 pass through of registration fees to the Eastern Maine TRIAD, and \$7 in bank fees.

We have no outstanding debt.



Legislation Affecting Maine Elders



STATE LEGISLATURE

STATE BUDGET:

Joint Standing Committee on Appropriations and Financial Affairs: The Joint Standing Committee on Appropriations and Financial Affairs has been holding public hearings and work sessions on LD 499, the Biennial Budget. There are still some areas of the budget on which the Committee has not made final decisions, including long-term care. Recently, Committee consideration of the budget has been temporarily on hold while the Committee considers General Obligation Bond Bills.

ACTION: M4A testified before the Joint Standing Committee on Appropriations and Financial Affairs on February 23rd, requesting the following funding issues be included in the budget:

\$75,000 in fiscal year 2007-08 and \$75,000 in fiscal year 2008-09 for reimbursement for the Meals on Wheels volunteer drivers for increased travel expenses resulting from increase motor fuel costs;

\$50,000 in fiscal year 2007-08 for direct grants to local area agencies on aging to support the volunteer medical ride network;

Approximately \$575,000 for each of the fiscal years

2007-08 and 2008-09 for homecare coordination services; and,

Funds for 3 additional case workers for Adult Protective Services.

Note: As of this date, these issues have not been included in the budget. However, M4A will continue to press forward to fund these issues. We continue to meet with the House and Senate Leadership, along with the members of the Joint Standing Committee on Appropriations and Financial Services and the members of the Joint Standing Committee on Health and Human Services. If the Appropriations Committee decides not to include our funding requests in the budget, we will then seek to get funds from the Appropriations Table at the end of the session – IF there are any funds left.

Corporate Income Tax Revenue: Already faced with a very tight budget, the Legislature received more bad news when it was recently reported that the State was going to be short \$34 million this fiscal year, and \$40 million over the biennium, based on less than anticipated corporate income tax revenue. This means that the state budget will have to be adjusted to reflect the lower corporate income tax projection. A freeze has been put on discretionary spending in all departments and, as a last resort, the Governor could tap the budget stabilization fund, currently at \$113 million.

Bond Package: Governor John Baldacci has proposed a \$397 million bond package that focuses on transportation infrastructure, land conservation, higher education, research and development. Republicans have offered a \$200 million proposal targeted exclusively for bridge, road and wastewater treatment facility upgrades. The Joint Standing Committee on Appropriations and Financial Affairs must now put together a pack-

age that can get the support of 2/3 of the Legislature, the threshold for getting bond questions onto a statewide ballot.

M4A SUPPORTED LEGISLATION:

LD 819, “An Act to Provide Supplemental Funding for Mileage Reimbursement for Volunteers for Meals on Wheels Programs” (Emergency)

Summary: Provides funds to reimburse volunteers for meals on wheels programs for increased travel expenses resulting from increased motor fuel costs. This legislation takes effect when approved. Fiscal Note: \$75,000 in FY 2007-08 and \$75,000 in FY 2008-09.

Sponsor: Rep. James Campbell

Cosponsors: Representatives Beaudoin; Connor; Finley; Grose; Lewin; Perry; Walcott; Walker and Senator Raye.

Committee: Appropriations and Financial Affairs.

Action: M4A testified on February 23, 2007 before the Appropriations Committee to request that the funding for this bill be included in the Budget. To date, the Committee has not included this funding in the budget. M4A continues to meet with Leadership and the Appropriations Committee to find the funding for this bill.

LD 818, “An Act to Provide Support for the Volunteer Medical Ride Network”

Summary: This bill makes a one-time General Fund appropriation of \$50,000 in fiscal year 2007-08 for direct grants to local area agencies on aging to

support the volunteer medical ride network. The funds will be used to support and expand a volunteer medical ride network focused on using volunteers to transport Maine’s elderly to health care services such as kidney dialysis and cancer therapy.

Sponsor: Rep. James Campbell

Cosponsors: Representatives Beaudoin; Connor; Finley; Grose; Lewin; Perry; Walcott; Walker and Senator Martin.

Committee: Appropriations and Financial Affairs.

Action: M4A testified on February 23, 2007 before the Appropriations Committee to request that the funding for this bill be included in the Budget. To date, the Committee has not included this funding in the budget. M4A continues to meet with Leadership and the Appropriations Committee to find the funding for this bill.

LD 1805, “An Act to Preserve Home Care Coordination Services for Long-term Care Consumers Served in the Community”

Summary: This bill appropriates and allocates funds on an ongoing basis for home care coordination services for consumers of state-funded and MaineCare-funded home-based care programs.

Sponsor: Rep. James Campbell

Cosponsors: Representatives Craven; Faircloth; Lewin; Pingree; Tardy and Senators Branigan; Raye; Marrache and Weston

Committee: Health and Human Services

Action: M4A testified on February 23, 2007 before the Appropriations Committee to request that the funding for this bill be included in the Budget.

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Medication Concerns in the Elderly

Janis B. Petzel, M.D.

The mantra for medication prescription in geriatrics is “Start low and go slow...but go.” This article will discuss the reasons why this advice is valid for our older patients. Other issues of concern such as polypharmacy, inappropriate medication prescription and medication non-compliance will also be discussed.

First, we need to review the basics of pharmacology concerning pharmacokinetics, or how medications get in and out of the body. When a medication is taken by mouth, it is absorbed into the blood either by the oral mucosa, in the stomach or in the small intestine. Once in the blood vessels serving the gut, the medication travels directly to the liver, where it undergoes what is known as *first-pass metabolism*. Any medication that remains after being processed by the liver, or any active metabolites, enter the general circulation and are absorbed into the tissues in the body, including, one hopes, into the site for the mechanism of action of the medication. Medications that are fat-soluble, or *lipophilic*, tend to soak into the fatty tissues of the body, and those that are water soluble, or *hydrophilic*, will tend to stay in the watery compartments of the body. Medications that enter the brain have to pass through a special set of membranes called the *blood-brain barrier*.

Some medications are *protein-bound*, or travel in the blood by hitchhiking on the proteins in the serum. In the bound state, they are not biologically active. There is only a certain amount of room on these proteins, so the excess medication travels as *free* or *unbound*, and is available to do its pharmacologic job. In the elderly, this may become an issue in malnutrition or illness, since the amount of these serum proteins may decrease significantly leading to an increase in the active, free form of the drug.

Medications are cleared from the body for the most part by either the liver or the kidneys or processes involving both. A lipophilic medication may be modified by liver enzymes into a hydrophilic molecule which can then be cleared by the kidney. The liver has a hugely complicated system of enzymes that metabolize or break down medications. The most infamous of these for students trying to learn them is the cytochrome P450 system. For purposes of understanding pharmacology in the elderly, it is enough to know that certain foods (such as grapefruit juice) or medications can change the way the liver metabolizes other medications, leading at times to disastrous consequences. Many of the medications that were potent inducers or inhibitors of the P450 enzymes have been taken off of the market, so the chances of accidental death from medication interactions is much less than it used to be, but care still needs to be taken when a patient is on multiple medications (as happens all too often in the elderly).

Also, lifestyle changes such as smoking cessation can have an impact on certain P450 enzymes leading to unexpected changes in medication levels. Smoking cessation may happen in an abrupt way when a person enters a hospital or long-term care facility where smoking is not allowed. Nicotine withdrawal and changes in medication levels may contribute to agitation or a change in function in these circumstances. The take-home message is not that people should continue smoking, but that their physicians need to be aware that they have quit, and response to current medications needs to be monitored. Likewise alcohol use can cause additive sedation and changes in the way the body handles prescription medications, and alcohol withdrawal may lead to delirium when a patient is hospitalized.

The time it takes for a medication to be cleared from the body is called the *elimination half-life*. The half-life is determined by the balance of all the forces that impact the medication getting in and out of the body. A rule of thumb for the time it takes a new medication to reach steady state in the body is 5 half lives. Most processes in the elderly lead to a slower clearance of medications. This means that the time it takes to reach steady state is much longer, leading to the “start low and go slow” idea. However, **as long as there are no intolerable side effects and the patient continues to gain clinical improvement**, there is no reason to avoid increasing medications into the top dosing ranges.

In the healthy elderly, the processes involving absorption of medications in the gut stay relatively intact, as do the proportions of enzymes in the liver. What may change is the gross circulation to the liver, which may decline to the point that the liver shrinks or has less volume, leading to decreased work area available to process medications. Some illnesses such as diabetes may slow gastric emptying and thus slow the process of absorption in the small intestine.

The blood-brain barrier may also change as a result of illness or injury, thus leading to a higher risk for *delirium*. Delirium is an acute confusional state brought about by illness or medications. I think of it as a form of acute brain failure, analogous to what happens to the heart in acute heart failure. Age is a risk factor for delirium, as is dementia. Delirium can be mild or severe. The person may be more quiet than usual or may be agitated or look manic and may even hallucinate. In any case, the patient’s ability to concentrate and attend to events in the present becomes impaired. The risk for death increases substantially in the months after a delirium. The treatment for delirium is to find the underlying cause and eliminate it. Urinary tract infections are a common cause of delirium in the elderly, especially those with dementia, since their brains are more fragile and have less functional reserve.

In the elderly, even seemingly benign medications such as non-steroidal anti-inflammatory pain medications have been known to cause delirium. Anticholinergic medications such as benadryl, cough syrups, or sleep medications such as Tylenol p.m. are notorious culprits. I tell my patients and their caregivers that any medication that can cause dry mouth may be a problem for this anticholinergic delirium.

The biggest physiologic change that happens as a person ages is a decline in kidney function. At the microscopic level, the plasma of the blood is filtered through the glomerulus of a kidney nephron. Molecules of pertinent substances are either secreted into the filtered fluid or reabsorbed along with water back into the body, and the waste fluid and substances are excreted in the urine. The *glomerular filtration rate*, or GFR, in a healthy young adult is around 120 ml/min. After the age of 50, most adults begin to have a decline in their GFR and by the age of 80, the rate may be one-half to one-third of what it was at age 20. In illness, the GFR may decline even further leading to acute or chronic renal failure.

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To date, the Committee has not included this funding in the budget. M4A is working with the Maine Long Term Care Ombudsman and Elder Independence of Maine on this legislation. We continue to meet with Leadership and the Appropriations Committee to find the funding for this bill.

LD 1407, “Resolve, To Address Issues Concerning the Employment of Senior Citizens”

Summary: This bill directs the Commissioner of Labor to convene a stakeholder group to study barriers to senior employment and how to promote best practices in senior employment, to review benefit reductions for senior workers and to undertake a public education campaign to promote the value of senior citizens in the workforce.

Sponsor: Rep. James Campbell.

Cosponsors: Representatives Beaudoin; Faircloth; Finley; Grose; Lewin; Perry; Walker and Senators Raye and Sullivan.

Committee: Labor

Action: A public hearing was held for this bill on Wednesday, April 4, 2007 before the Labor Committee. M4A did testify. A work-session for this bill was held before the Labor Committee on Wednesday, April 11, 2007.

LD 1661, “Resolve, To Support Community Planning for the Aging of the Population”

Summary: This bill directs the Commissioner of Health and Human Services to convene a stakeholders group to study community plans in Maine and to ensure the plans include a component addressing the elder population.

Sponsor: Rep. James Campbell

Cosponsors: Representatives Connor; Finley; Grose; Lewin; Miller; Walcott; Walker and Senators Brannigan and Raye.

Committee: Health and Human Services

Action: A public hearing for this bill was held on Monday, April 9, 2007 at 9:00 a.m. before the Health and Human Services Committee. M4A did testify. A work-session is scheduled for this bill was held immediately after at 1:00 p.m.

“The Maine Homeowners Protection Act” (No LD number yet)

Summary: This bill will prohibit equity-stripping practices in mortgage lending and ensure that mortgages made to Mainers are fairly underwritten, so that they will be able to repay back their debt

Sponsor: Speaker Glenn Cummings

Cosponsors: pending

Committee: pending

Action: M4A continues to work in coalition with other interested groups to support this legislation.

OTHER BILLS OF INTEREST:

LD 519, “An Act to Provide Assistance to Family Members, Friends and Neighbors Who Provide Home Health Care for Senior Citizens”

Summary: This bill allows family members, friends or neighbors to receive payment for providing personal care and health maintenance services to persons who receive Medicaid.

Sponsor: Rep. James Campbell.

Cosponsors: Speaker Cummings; President Edmonds; Representatives Finley; Grose; Lewin; Perry; Saviello, Walker and Senators Brannigan; Gooley and Raye.

Committee: Health and Human Services.

Action: A hearing was held on Friday, March 30, 2007 at 9:00 a.m. in room 209 of the Cross Building before the Health and Human Services Committee. At that hearing, the bill's sponsor, Rep. James Campbell, requested and the Committee agreed, that consideration of the bill be “carried over” to next session so that more study could be done. My understanding is that much of what the bill calls for is already being done. It was suggested by the Maine Long Term Care Ombudsman that a demonstration project be done to focus on consumers who are waiting for care, because they are most at risk. The Long Term Care Oversight Committee could hold public hearings with home care consumers and their families. M4A will continue to track this effort.

LD 1714, “Resolve, To Expand the Maine Registry of Certified Nursing Assistants”

Summary: This bill requires that the Department of Health and Human Services develop a plan to improve and expand the Maine Registry of Certified Nursing Assistants, established in the Maine Revised Statutes, Title 22, section 1812-G to include unlicensed assistive personnel, and present the plan to the Joint Standing Committee on Health and Human Services no later than December 1, 2007.

Sponsor: Rep. Hannah Pingree.

Cosponsors: President Edmonds; Representatives Campbell; Lewin; Miller; Perry; Walcott; Walker and Senator Raye.

Committee: Health and Human Services.

Action: This bill was referred to the Health and Human Services Committee on March 27, 2007. No further action has been scheduled as of this date. M4A is working with a coalition on this issue.

LD 1687, “An Act to Increase Health Insurance Coverage for Front-line Direct Care Workers Providing Long-term Care”

Summary: This bill allows providers of long-term care services with more than 50 employees to participate in the DirigoChoice health insurance plan. The bill also allows uninsured direct care workers who work an average of 10 or more hours per week to participate in the DirigoChoice health insurance plan. The bill also requires the Department of Health and Human Services to establish a demonstration project for long-term care providers who provide health insurance coverage to their full-time and part-time employees.

Sponsor: President Beth Edmonds

Cosponsors: Representatives Beaudoin; Campbell; Connor; Miller; Perry; Pingree and Senator Marrache.

Committee: Health and Human Services

Action: This bill was referred to the Health and Human Services Committee on March 27, 2007. No further action has been scheduled as of this date. M4A is working with a coalition on this issue.

LD 1544, “An Act to Enact the Home Care Consumer and Worker Protection Act”

Summary: This bill creates the Home Care Consumer and Worker Protection Act. The purpose of this bill is to ensure that both the consumer and the home care services worker are given the ability to make informed, knowledgeable decisions regarding their status as employees, independent contractors and employers.

Sponsor: Rep. Wesley Richardson.

Cosponsors: Representative Cebra.

Committee: Labor

Action: No hearing has been scheduled yet.

LD 1764, “An Act to Increase the Wages of Direct Support Professional Staff Based on Increases in the State Minimum Wage”

Summary: This bill requires the Department of Health and Human Services to increase the rate of reimbursement for direct support professional staff costs by 3.8% effective October 1, 2007. It also requires the Department to increase the wage component for direct support professional staff whenever the State's minimum wage is increased.

Sponsor: Senator Joseph Perry

Cosponsors: None

Committee: Health and Human Services

Action: No hearing has been scheduled yet.

LD 1699, “Resolve, To Improve Maine’s Homemaker Services Program”

Summary: This bill directs the Department of Health and Human Services to increase the pay rate of the homemaker services providers who assist lower income senior citizens from \$17.00 to \$18.75 per hour.

Sponsor: President Beth Edmonds

Cosponsors: Senator Marrache and Representative Pingree

Committee: Health and Human Services

Action: No hearing has been scheduled yet.

LD 1310, “An Act to Make Unemployment Compensation Law More Fair to Seniors”

Summary: This bill eliminates the pension offset against unemployment benefits for persons who receive Social Security and rewrites the remaining statutory language of the offset to clarify it.

Sponsor: President Beth Edmonds.

Cosponsors: Rep. Haskell

Committee: Labor

Action: No hearing has been scheduled yet. AARP is a strong supporter of this bill.

LD 1055, “An Act to Establish the Hearing Assistance Program for Low-Income Persons Who Are Elderly or Disabled”

Summary: This bill establishes the hearing assistance program within the Department of Labor, Bureau of Rehabilitation Services to provide grants to low-income persons who are deaf or hard-of-hearing and elderly or disabled for the purchase of hearing aids and subsidies for cap-tel service. The program is funded through the state universal service fund, which is administered by the Public Utilities Commission.

Sponsor: Rep. David Webster.

Cosponsors: Representatives Adams; Miller and Priest

Committee: Labor

Action: A hearing was held on March 28th, but was immediately recessed because the needed equipment was not available. A new hearing will be scheduled soon.

LD 416, “An Act to Protect Seniors and the Public from Unfair Health Insurance Sales Practices”

Summary: This bill expressly defines certain marketing practices as unfair trade practices when used to market health insurance products.

Sponsor: Rep. Sharon Treat

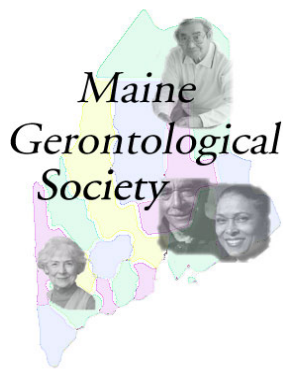
Cosponsors: Representative Canavan and Senator Schneider

Committee: Insurance and Financial Services

Action: This bill was passed to be engrossed by the House on March 27. The Senate still has the bill under consideration.

N4A LEGISLATIVE CONFERENCE: N4A held its Legislative Conference in Washington, D.C. March 26-28. The message was clear; now that the Older Americans Act has been reauthorized, we must work to ensure effective implementation of the Act and appropriate funding as well. N4A is calling for at least a 5.24% increase in funding for the Older Americans Act in FY 2008, to help older adults remain in their homes and communities, accessing a wide range of services and supports.

ACTION: M4A attended the N4A Conference and contacted Senator Collins' office while in Washington, D.C.



Scholars Section

An error of omission occurred in the last newsletter while offering information on *Fierce with Reality*. The publisher of this anthology of literature on aging is Just Write Books of Topsham, Maine. The book is available for \$20.00 for MGS members. There is a four dollar postage and handling fee. The website to obtain the book is www.jstwrite.com and the phone number is 207 729 3600.

The Editor of the book is Margaret (Peggy) Cruikshank who teaches women's studies at the University of Maine, where she is also affiliated with the Center on Aging. Margaret is also a member of MGS.

OLDER AMERICANS ACT: The Older Americans Act has been reauthorized, but now the focus is on ensuring that there is adequate funding for the Act. The N4A supports the following action:

Hold harmless Older Americans Act programs by increasing total funding for these programs by at least 5.24%, or \$94 million, to allow them to keep pace with projected population growth and price increases in FY'08.

Give special attention to two Older Americans Act programs, Title III B Supportive Services and Title VI Grants for Native Americans.

Allocate \$2 million in Older Americans Act Title IV funding for state and local planning to assist our nation's communities in meeting the challenges and opportunities of the coming "age wave".

Direct not less than \$43 million to the AAAs, Title VI Native American aging programs and SHIPs, or approximately one dollar for every person with Medicare, to support ongoing Medicare Part D enrollment assistance and one-on-one counseling. These funds should be set aside under the allocation to the Centers for Medicare and Medicaid Services (CMS). (Note: M4A is working with the Maine Congressional Delegation to move this effort forward).

ACTION: M4A is working with the Maine Congressional Delegation to implement these requested actions. (Note: April recess presents a great opportunity for meetings with the Congressional Delegation)

FISCAL YEAR 2008 APPROPRIATIONS: The annual appropriations process has begun for fiscal year 2008. Both House and Senate are finalizing budget resolutions, which will determine how much funding the Appropriations Committees get to work with. So far, both Chambers have proposed discretionary spending levels for FY 2008 higher than President Bush's proposed discretionary spending level. (House \$24 billion higher, Senate \$18 billion higher).

ACTION: M4A will continue to work with the Maine Congressional Delegation to ensure adequate funding for the programs so vital to Maine's seniors.

MEDICARE PART D ENROLLMENT ASSISTANCE FUNDING: A bi-partisan letter signed by 28 members of the House of Representatives has been sent to the Appropriations Committee leaders asking them to direct CMS dollars towards AAAs, Title VI aging programs and SHIPs for Medicare Part D enrollment assistance and one-on-one counseling. An identical request letter is being planned for the Senate Appropriations Committee. At this time, we anticipate that Senators Blanche Lincoln (D-AR) and Susan Collins (R-ME) will be the sponsors of that request.

ACTION: M4A spoke with Maine's Representatives and they are both on the House letter. We are now working with Senator Collin's office and n4a to support efforts to circulate the letter and send it to the Appropriations Committee.

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Healthy Choices

FOR ME!

Program Description:

The U.S. Department of Health and Human Services is supporting a \$13 million effort over three years in 16 states to support the delivery of evidence based programs for senior aging services provider organizations, such as senior centers, nutrition programs, senior housing projects and faith-based organizations. This collaboration, called **Choices for Independence**, is led by the Administration on Aging (AoA) and will empower older people, who are disproportionately affected by chronic disease, to take more control of their own health through life style and behavioral changes. Chronic disease and conditions such as arthritis, diabetes and heart disease as well as disabilities resulting from injuries such as falls, account for seven out of every 10 deaths, and more than three quarters of all health expenditures in the United States.

According to Assistant Secretary for Aging, Josephina Carbonell, "It will make it easier for seniors to learn about and take advantage of low-cost evidence-based prevention programs that have proven effective in reducing the risk of disease, disability and injury among the elderly. These interventions involve simple tools and techniques seniors can use to better manage their chronic conditions, reduce their risk of falling, and improve their nutrition and their physical and mental health. This approach holds great potential for improving the quality of life for millions of seniors and reducing health care costs. It gives our providers an important and unique role in health, and it complements the increasing emphasis being given to prevention under Medicare."

Maine's Office of Elder Services has been awarded one of these competitive 3 year grant awards to build upon current efforts to advance evidence-based prevention and wellness programs in Maine. In collaboration with MaineHealth's Partnership for Healthy Aging, the area agencies on aging, and other community partners, OES will implement and disseminate four evidence-based programs statewide during the next three years. The programs selected for implementation in Maine include the following:

The **Chronic Disease Self-Management Program**, or **Living Well**, is a workshop given two and a half hours, once a week, for six weeks, in community settings such as senior centers, churches, libraries and hospitals. People with different chronic health problems attend together. Subjects covered include techniques to deal with problems such as frustration, fatigue, pain and isolation; appropriate exercise for maintaining and improving strength, flexibility, and endurance; appropriate use of medications; communicating effectively with family, friends, and health professionals; nutrition; and, how to evaluate new treatments. Program participants demonstrate significant improvements in exercise, cognitive symptom management, communication with physicians, self-reported general health, health distress, fatigue, disability, and social/role activities limitations.

A Matter of Balance/Volunteer Lay Leader (MOB/VLL) program, specifically designed to reduce fear of falling, stop the fear of falling cycle, and improve activity levels among

community-dwelling older adults. The program includes eight two hour classes where participants learn to view falls and fear of falling as controllable; to set realistic goals for increasing activity; to change their environment to reduce fall risk factors; to promote exercise to increase strength and balance. MOB/VLL is designed to benefit community-dwelling older adults who are concerned about falls, have sustained a fall in the past, restrict activities because of concerns about falling, are interested in improving flexibility, balance and strength, are age 60 or older, ambulatory and able to problem-solve. Participants have found significant improvement regarding their level of falls management; falls control; level of exercise; and social limitations with regard to concern about falling.

EnhanceWellness is an effective, participant driven, health promotion and management program that helps older adults with chronic conditions achieve their personal health goals through health action plans, and has demonstrated significant results in the utilization of health care services. Core components include nursing and social work support, a health review and functional assessment, development of a personal health action plan, motivational interviewing and peer Health Mentors and Support Groups.

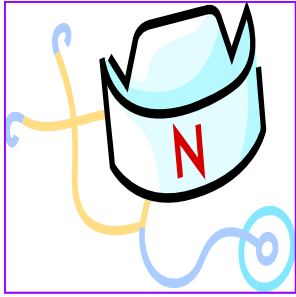
EnhanceFitness is an exercise program for seniors that offers low-cost fitness classes taught by certified fitness instructors. The one-hour classes meet three times per week in ongoing, five-week sessions. The classes include strength training with wrist and ankle weights, as well as aerobics, stretching, and balancing exercises. The program is designed to be safe and effective for seniors with a wide range of physical abilities. Studies have shown a marked improvement in participants' physical and social functioning, as well as a decline in areas such as pain, fatigue, and depression. The program is designed to be safe for physically unfit seniors, including the "near frail," yet still challenging for more active seniors.

These four programs will be disseminated throughout Maine during the next three years in collaboration with community based partners.

For more information contact: Partnership for Healthy Aging, 775-1095, pfha@mmc.org

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Submitted by Peggy Haynes



MGS Clinical Corner

Shingles – Why the Worry for Older Adults?

By: **Amy E. Cotton MSN, APRN, BC, FNGNA**

Shingles, also called herpes zoster or zoster, is a painful skin rash more commonly affecting people 50 years and older. The risk of getting shingles increases as a person ages.

Anyone who had chickenpox can develop shingles. Individuals who have immune system compromise, such as cancer, leukemia, and human immunodeficiency virus (HIV) or those people who take immunosuppressive drugs such as steroids are also at greater risk of getting shingles.

Shingles usually starts as a painful sensation on an area of skin. The rash may not be visible for several days, making it difficult to diagnose early. The rash starts with daily outbreaks of blisters that scab after 3 or 4 days, usually clearing within 2 to 4 weeks. For about 1 in every 5 persons, severe pain can continue even after the shingles outbreak clears. This pain is called post-herpetic neuralgia. As a person gets older, there is increased risk of developing post-herpetic neuralgia, resulting in severe long term pain and negatively impacting both quality of life and health.

Several medicines have been approved for use by the Food and Drug Administration (FDA) to treat shingles, including acyclovir, valacyclovir, and famciclovir. These medications need to be started as soon as possible when the shingles blisters appear to be most effective. Pain medications can help with the acute outbreak of the skin rash also.

In May, 2006, the FDA licensed a varicella zoster virus vaccine, Zostavax for use in persons 60 years old and older to prevent shingles. The federal Advisory Committee on Immunization Practices (ACIP) provided a provisional recommendation for the use of varicella zoster virus vaccine for prevention of shingles and post-herpetic neuralgia in October, 2006. Most common side effects have included redness, soreness, swelling or itching at the injection site.

Many primary health care providers are reluctant to recommend the varicella zoster virus vaccine to their older patients until more evidence is produced about the safety and efficacy of the vaccine. Current studies indicate the vaccine prevents shingles in about half of the people and prevents post-herpetic neuralgia in about two-thirds of study participants (*The New England Journal of Medicine, A Vaccine to Prevent Herpes Zoster and Postherpetic Neuralgia in Older Adults, June 2, 2005; American Family Physician, Herpes Zoster and Postherpetic neuralgia: Prevention and Management, September 15, 2005*). The vaccine has proven most effective in persons aged 60 – 69 years old. Currently, Medicare Part B does not cover the cost of the vaccine.

Instead, the cost of the vaccine is reimbursable under the Medicare part D program.

Increased awareness of and additional research about treatment and prevention of this painful skin rash is needed. Older adults afflicted with shingles not only have significant pain from shingles, but experience a negative impact on their quality of life. Each older adult is encouraged to talk with their trusted health care provider about risks and benefits of the varicella zoster virus vaccine. All gerontology professionals are encouraged to become more informed about shingles treatment and prevention.



Did You Know That....



Between 1980 and 1992, the infectious disease mortality rate in patients sixty five and older actually rose by 25%. That comparative mortality rate is nine times the rate in patients 25 and 44.

-American Family Physicians

January 15, 2001



Medication Concerns in the Elderly

Janis B. Petzel, M.D.

(con't from page 4)

As the kidneys lose their speed in filtering the blood, the elimination half-life of medications becomes much longer and toxic levels of medications or active metabolites may build up leading again to delirium.

Because of what we understand about the complex pharmacokinetics in the elderly, a consensus panel of experts has been working on a list of medications to avoid or to use with extreme caution in older adults. This list is known as the Beers List or Beers Criteria (named after one of the senior authors of the papers from this consensus panel). The list has been periodically updated (see *Annals of Internal Medicine*, 2003). Many of the medications on the list are older medications, or are medications known to cause sedation, falls or delirium. Despite nursing home oversight, a high number of elderly still receive these medications (over 40% in one study using Medicare data). Community-dwelling elderly are at even higher risk. As the number of prescribing physicians increases and the number of illnesses and prescriptions rises, the likelihood of being given one of the meds from the Beers List also increases. Research takes a long time to catch up with clinical hypotheses, so at this point, there is not a lot of hard data about the health impact of prescribing Beers' List drugs. However, given what we know about susceptibility to delirium and drug-drug interactions, common sense tells us that polypharmacy puts an elder at risk for an adverse outcome. Families and caregivers can help avoid problems with polypharmacy by making sure that all of their loved one's doctors are aware of the medications prescribed by the others.

Our current health care system makes polypharmacy more likely. Primary care doctors get very little time with each patient and are less likely these days to be the treating physician if a patient enters the hospital. All physicians, whether primary care or specialist, are under pressure to see as many patients as possible in the shortest amount of time possible, so doctor-to-doctor communication suffers. Hospital stays are short and are frequently followed by a stay in a rehabilitation facility, which means that the patient may have been seen by several doctors who don't know the patient well, at different facilities over a short period of time. If the patient was non-compliant with his/her outpatient treatment and the primary care doctor was not aware of it, dosages of medications may have been increased because the doctor was trying to achieve a clinical response. When the patient gets into the hospital, s/he is given the full dose of medications which s/he wasn't really taking at home, and delirium may ensue.

If a patient experiences a delirium in the hospital for whatever reason, antipsychotic medications may have been started to treat the agitation. As a patient gets transferred from one facility to another and the current medication lists are passed along, it can be very difficult for the next physician to tell which medications are new and which ones were well-established in community treatment. Doctors who are only going to be treating patients for a short time may be reluctant to take away a medication. When the patient gets back to his/her primary care doctor, the medication list may be much longer but the PCP only has a few minutes with the patient and may not have time to do a thorough analysis of which meds are truly needed in a complex regimen, and so the medication list becomes hardened in stone. Continued on Page 11



UPCOMING Conference

The Maine Association of Area Agencies on Aging announces the June 21, 2007 Conference and Annual Meeting: ***Developing Strategies For An Aging Maine.***

This full day conference will be held in Portland, Maine at the Doubletree Hotel. Session workshops blend health and aging policy discussions to include: *Healthy Aging, Emergency Preparedness, Elder Abuse, Community Planning, Elder Transportation, Elder Housing, and Long Term Care Insurance.*

Confirmed speakers include:

Diana Scully, Director of the Maine Office of Elder Services

Laurie Lachance, President/CEO of Maine Development Foundation

John Richardson, Commissioner: Maine Department of Economic and Community Development

Steve Rowe, Attorney General – State of Maine

For more information, contact pgroves@seniorsplus.org or call Patricia Groves: 207-795-4010 x132



Employment in the Field of Aging

Shanna Siegel, who earned an MSG degree from USC this year, has found that companies seem to be increasingly open to hiring gerontologists—after learning what a gerontologist is. Job seekers with a gerontology degree may need to educate prospective employers about the value of a degree that provides a broad understanding of the aging process, with more training in administration and policy than in most related disciplines.

Jobs for "Gerontologists" Hidden Job hunting may lead to challenging opportunities for gerontology graduates. Job bank websites typically do not have a category for "gerontologist," according to Dr. Peterson, presenting an opportunity for GSA and AGHE to help fill this need.

Gerontology alumnae can help by forwarding information on job openings or simply keeping in touch with their home institutions with information about their own career experiences. Job seekers may also benefit from networks outside of gerontology, such as organizations for marketing professionals or other local, regional or national professional associations. The Association for Gerontology in Higher Education (AGHE) offers a wealth of resources for students, faculty and employers (visit their web page: <http://www.aghe.org/publist.htm>)

Medication Concerns in the Elderly

(con't from page 10)

Patient non-compliance with medications also becomes more of a problem with polypharmacy or frequent medication changes. Anyone working in direct patient care with the elderly has seen the shopping bags full of prescription medications, vitamins and over-the-counter products that our patients are using. Given that many of our community-dwelling patients or their spouses/caregivers have mild cognitive impairment, over- or under-use of prescribed medications or mistaken use of old medications is a significant worry. Pharmacies are sometimes able to pack medications in bubble packs that make it easier to track medication doses and timing, but insurance companies do not like to pay for this service and elders on a restricted income may not be able to afford it.

There are many factors leading to patient non-compliance with medications. Some people don't understand the purpose of the medication or feel that they don't really need it. Some people are fearful of or experience side effects. Some people intend to take the medication as prescribed but are cognitively unable to stay organized enough to do it properly. Financial constraints are certainly important. It's not clear yet how the Medicare Part D "donut hole" will impact the ability of patients to afford their medication, but I suspect that for many, the donut hole is going to be a huge financial barrier and that people will either stop taking their medications, or ration them by taking smaller, less frequent doses.

Pharmacology in the elderly is a double-edged sword. We are blessed with an ever-expanding pharmacopeia that offers relief of symptoms and prevention of damage from chronic illnesses that was not available to previous generations. The complexity of proper use of these medications is made even more complicated by the changing physiology of normal aging and of disease states, as well as by the limitations of our social and medical institutions. I hope this article has given you some insight into how medications are handled by the body, and where trouble may happen so that you can work with your patients and family members to prevent problems.

Janis B. Petzel, M.D. is a board-certified geriatric psychiatrist in private practice in Hallowell, ME. She is the geriatric psychiatrist at the Togus VA and teaches at the Maine-Dartmouth Family Practice Residency Geriatric Fellowship Program



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MGS Student Chapter

Finding a Job in the Field of Gerontology

By: Amy Fiske

Gerontological Society of America Emerging Scholar and Professional Organization (ESPO) Secretary

Graduates with gerontology degrees are likely to secure employment in aging, have high levels of satisfaction, receive a reasonable salary, and have opportunities for advancement. This is the message from David A. Peterson, Ph.D.,

Director of the Leonard Davis School of Gerontology at the University of Southern California. In a survey of USC gerontology graduates from 1976 to 1995 (Masunaga, Peterson & Seymour, 1998), Dr. Peterson and colleagues found that 66% of respondents reported employment in the field of aging and 68% were very satisfied with their jobs.

The employment success of these alumnae is not surprising. Approximately 6,000 students graduate annually from gerontology programs, according to a 2004 survey by USC and AGHE, yet the population of older Americans is over 30 million and climbing. Gerontology-trained graduates will be needed to meet the rapidly growing demand for services for an aging population.

Prospects may also be bright for students graduating in other disciplines who received gerontology training. The national Bureau of Labor Statistics' Occupational Outlook Handbook for 1998-2008 cites the aging of the population as a key factor in projecting faster than average growth in the demand for social and health services occupations, including much faster growth in the need for physicians, nurses, social workers and speech-language pathologists, among others. Although much faster than average growth is also expected for biological, medical and social scientists, competition for research jobs is likely to be considerable.

Where Do Gerontology Graduates Go?

For graduates with a degree in gerontology, the career path may be less obvious than for their counterparts who receive a degree in another discipline with an emphasis on aging. Alumnae with gerontology degrees from USC have been employed in a variety of settings, including health facilities, mental health facilities, social service agencies, corporations, residential facilities, government agencies, community agencies and advocacy groups. Entrepreneurial gerontology graduates have also worked as self-employed consultants. Dr. Peterson has observed that current graduates are more likely to enter the private, for-profit sector than were gerontology graduates of a decade ago, and their jobs are more likely to have a marketing focus.

Students today are able to "contribute to the welfare of older people...and have a reasonable income." He projects increasing demand for gerontology graduates in the health services field, particularly in administration, planning and policy.