Chronicles in Aging

Interdisciplinary Center on Aging

Donald W. Reynolds Programs in Geriatrics

Discovery and Learning in Gerontology at the University of Missouri

SPRING 2007

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Volume 1, Issue 2

ELDER MISTREATMENT: OLDER AMERICANS AT RISK

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University of Missouri

Compared with child abuse, child neglect and domestic violence, elder mistreatment has received little clinical attention and research interest until recently. Most instances are unreported or undetected, and standardized definitions of elder mistreatment were not published until 1993.

Even those reaching age 65 in relatively good health on average will spend 40 percent of their remaining years receiving some form of assistance from others. Considering this potential vulnerability, along with the projected increase in the older American population, the number of older Americans at risk for mistreatment in the next 30 years will increase by millions.

Depending on definitions and sampling techniques, most incidence estimates of elder mistreatment are between 3 percent to 4 percent annually.

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ELDER MISTREATMENT

Physical Abuse: Acts of violence that may result in pain, injury, impairment or disease

Physical Neglect: Failure to provide the goods or services necessary for optimal functioning or to avoid harm

Psychological Mistreatment: Conduct causing mental anguish in an older person, or the failure to provide a dependent elderly individual with social stimulation

Financial or Material Mistreatment: Misuse of an older adult's income or resources for the financial or personal gain of the perpetrator, or failure to use available funds and resources necessary to sustain or restore the health and well-being of the older adult

Violation of Personal Rights: Disregard of the older adult's rights and capability to make decisions for himself or herself

(From AMA guidelines, Aravanis SC et al.)

from page 1

Risk factors include:

- Poor health, functional impairment;
- Cognitive impairment (recent decline in particular);
- Depression;
- Caregiver substance abuse or mental illness;
- Dependence of abuser on the victim;
- Shared living arrangement;
- Lack of contact with outside world;
- Stressful events; and
- History of violence or conflict.

The seriousness of elder mistreatment is illustrated in studies connecting it with death. In a cohort study of community-dwelling older adults, a history of mistreatment was associated with a higher risk of death (9 percent survival for those with substantiated mistreatment over a 13-year period, 40 percent survival for those without mistreatment investigations). The risk of death remained elevated after adjusting for demographics, comorbidities, functional status and social networks (OR = 3.1, 95 percent CI 1.4 - 6.7).

Any of the elements below may contribute to a higher suspicion for mistreatment:

- Inconsistency in histories, labs;
- Poorly justified delay in seeking medical attention;
- Presentation without caregiver;
- Recent or sudden behavior changes;
- Careless with money;
- Excessive and/or nonspecific physical complaints or ER visits;
- Poor medication and/or treatment adherence;
- Poor dynamic between patient and caregiver; and
- Oversedation.

A full-body surface exam may reveal burns, bruises, lacerations and scars. Particularly suspicious locations include the trunk, head, neck, genitalia or circumferential restraint marks on wrists or ankles. Pressure ulcers, malnutrition, dehydration and poor hygiene (personal and environmental) are also potential indicators of mistreatment.

Specific details from the clinical encounter, including quotes, descriptions, photos and psychosocial assessments, can be quite valuable. Depending on the circumstances, further diagnostic testing may include drug screening, blood chemistry profiles (e.g. electrolytes, albumin), skeletal X-rays and/or screening for sexually transmitted infections.

If mistreatment is suspected, the provider does not need definitive proof to report. Each state has its own protocol. Medical providers are mandated reporters in almost all states, but specific state guidelines vary.

Continued on page 3

In Missouri, mandated reporters generally include the following fields: social services, adult care (in the home or in a facility), law enforcement, ministry, medicine and nursing, state service to seniors and funeral directors. Failure to report when mandated is a class A misdemeanor. The Missouri Elder Abuse and Neglect Hotline, available 24 hours a day, is 800-392-0210. For state-by-state contact information, visit www.elderabusecenter.org/default.cfm?p=statehotlines.cfm.

Preventing mistreatment

Prevention methods include:

- Involvement of Adult Protective Services;
- Provision of home services;
- Frequent home visits;
- Caregiver respite (adult daycare, intermittent relief of caregiver responsibilities); and
- Legal options (restraining order, arrest) if caregiver is a persistent danger.

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Web resource: Department of Health and Senior Services: http://www.dhss.mo.gov/ElderAbuse/

Web resource: National Center on Elder Abuse: http://www.elderabusecenter.org

Upcoming Elder Abuse Conferences

April 12: Washington, DC

Breaking the Silence: Responding to Elder Sexual Abuse
This event, scheduled for 9:30 a.m.-12 p.m., is open to LTC residents, nursing home and senior group home staff, social workers, administrators and advocates. Co-sponsors: DC Rape Crisis Center and DC Office on Aging's Adult Abuse Prevention Committee. Register by April 5.
Contact: Shiwali, (202) 232-0789
www.aarp.org/states/dc/dc-lce/

April 12-14: Colorado Springs, CO

NASW Colorado 2007 Conference: "Creating Safer Communities Through Empowerment and Prevention"
Elder abuse, domestic violence, sexual assault and disaster/emergencies are among topics on agenda.
Contact: National Association of Social Workers, Colorado Chapter; www.naswco.org/displayconvention.cfm

April 30-May 1: Oakland, CA

3rd Annual Elder Abuse Conference
Presented by Legal Assistance for Seniors, Alameda County
Phone: (510) 832-3040 x323; E-mail: confreg@lashicap.org
www.lashicap.org/events.htm

May 7-11: San Francisco, CA

California Attorney General's Fourth Biennial Training Conference: "Elder Abuse: The Best in Detecting, Investigating & Prosecuting Elder Abuse"
Phone: (916) 274-2907
www.safestate.org/documents/Elder_Abuse_AG_Training_May_2007.pdf

June 15: World Elder Abuse Awareness Day

July 29-Aug. 1: San Francisco, CA

n4a 32nd Annual Conference and Tradeshow: "Gateway to the New World of Aging"
Contact: National Association of Area Agencies on Aging
www.n4a.org/2007conf/sanfran2007.cfm

Sept. 5-7: Atlanta, GA

18th Annual National Adult Protective Services Association Conference: "APS: Protecting Adults and Embracing Change"
Contact: Anne Kincaid, (720) 565-0906
E-mail: Anne.Kincaid@apsnetwork.org
www.apsnetwork.org/Training/conference.htm

See calendar on page 9 for more geriatrics conferences.

Systems-based practice to improve care of the elderly: The Hip Fracture Pathway at MU

Steven C. Zweig, MD, MSPH
for the Hip Fracture Pathway Team
Director, MU Interdisciplinary Center on Aging

Hip fracture is a prevalent and potentially devastating problem affecting primarily the oldest members of our community. There are more than 350,000 hip fractures annually in the United States with a lifetime risk of 18 percent in women and 6 percent in men. With an in-hospital mortality of 4 percent, 10 percent to 35 percent more die within a year. Of those who do not die, 32 percent are re-admitted within six months. Those with advanced dementia and a hip fracture have 50 percent mortality by six months.

Furthermore, management of hip fractures is commonly complicated. Delirium affects 35 percent to 65 percent of patients. Pressure ulcers are present in 7 percent at discharge. Deep vein thrombosis (DVT) and pulmonary embolism are common without prophylaxis. Infections, including pneumonia and urinary tract infection, are frequent. Delays in surgery are also associated with poor outcomes.

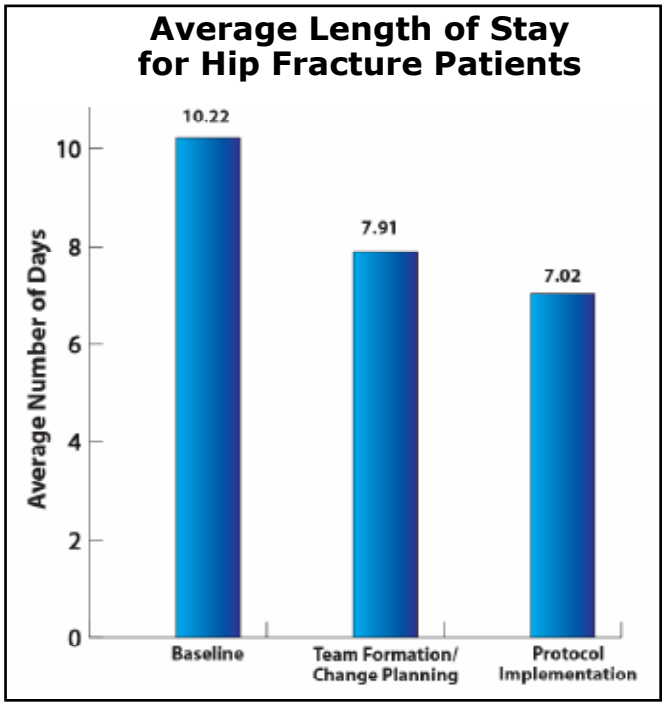
Following a grant from the Donald W. Reynolds Foundation to improve geriatric medicine education at MU, we convened a multidisciplinary group concerned about the care of patients with hip fracture. Included were physician faculty from the departments of Orthopaedic Surgery, Family Medicine (Geriatrics), Internal Medicine, Emergency Medicine, Anesthesiology, Physical Medicine and Rehabilitation, as well as representatives from nursing, social work, physical and occupational therapy, and the Office of Clinical Effectiveness at University of Missouri Health Care.

A unique aspect of the pathway was co-management of the patients who were admitted to either the medicine or family medicine hospital service with orthopaedics as the consulting surgeons. Starting with existing guidelines, we agreed on principles of care, drafted a protocol incorporating these principles and created order sets written for the emergency department, admission, post-op care and discharge.

At minimum, the medical evaluation includes mental status and cardiac risk assessment, co-morbid conditions needing pre- or post-operative management, estimation of renal function and identification of goals of care and a decision-maker if the patient has limited capacity. Medical and orthopaedic teams reach a common plan on timing of surgery, and anesthesiology is involved early if questions remain prior to surgery.

Pre-operative treatment includes pain management, DVT prophylaxis (if more than 24-hour delay) with the use of sequential compression devices in all cases, beta blockers unless contraindicated, pressure ulcer prevention and antibiotic prophylaxis.

Post-operatively, medical and orthopaedic teams both follow the patient with guidelines on DVT prophylaxis, monitoring electrolytes, fluids, and hemoglobin, and pressure ulcer prevention. Pain medications are scheduled and used as needed with frequent reassessment. We emphasize early mobilization (physical and occupational therapy), early removal of indwelling urinary catheter and delirium prevention/management (including the avoidance of high-risk drugs).



The discharge plan stresses the importance of good communication at transition, DVT prophylaxis for 28-35 days in most cases, and osteoporosis therapy. Most patients are discharged to their local Skilled Nursing Facility or to inpatient rehabilitation.

We have emphasized quality improvement and education with monthly hip fracture team meetings, bimonthly multidisciplinary case conferences and a comprehensive geriatric medicine seminar series for orthopaedic resident physicians. Each of these interactions has resulted in pathway improvements.

Preliminary outcomes have demonstrated decreased patient length of stay, fewer ICU days, and reduced costs and better patient outcomes regarding appropriate use of pain meds, DVT prophylaxis and use of therapists. Medical residents are learning important peri-operative care, and orthopaedic residents are learning principles of geriatric medicine. Medical students from all services are training in an environment that emphasizes collaboration, systems-based practice and high-quality care for patients.

Donald W. Reynolds Programs in Geriatrics

Inspiring future physicians to care for aging patients

GIG motivates Missouri medical students

"There are new challenges in meeting the social, economic and health-care needs of older Americans," said Erik Lindbloom, MD, MSPH, during the first meeting of the MU School of Medicine Geriatrics Interest Group (GIG) in the fall of 2003.

Lindbloom, GIG co-faculty director, told the group of 17 students gathered at that inaugural meeting that "with the exception of pediatricians, all physicians graduating in the upcoming years can expect to treat a large number of elderly. Even pediatricians will deal with grandparents and elderly caretakers of children."

Several of the students Dr. Lindbloom spoke with during that inaugural meeting have since graduated from medical school and know from firsthand experience how true that is. Apparently our current students are aware, too, for in 2007, GIG is thriving. More than 35 students at the School of Medicine are actively enrolled in the program, and the regularly scheduled meetings, held about every six weeks during the academic year, often attract more than 50 student participants.

"We think the speakers have been a big draw," reports Karli Echterling, second-year medical student and GIG president. This year a series of special-interest speakers have talked to students about topics related to the physical, psychological and spiritual aspects of aging, including Medicare, sex and aging, elder abuse and breaking bad news.

GIG President Karli Echterling plays "Tag-Team Bingo" at a GIG event held at an assisted-living facility.

"The students in GIG realize there will be a growing number of elderly patients in their future practices," Echterling says. "GIG provides medical students the opportunity to learn how to better care for this generation, regardless of their future specialty."

GIG is sponsored by the Donald W. Reynolds Foundation, a national philanthropic organization founded in 1954 by the late media entrepreneur for whom it is named. Headquartered in Las Vegas, the Donald W. Reynolds Foundation is one of the 50 largest private foundations in the United States.

DONALD W. REYNOLDS MU Programs in Geriatrics

Geriatricians: A critical need

By 2030, 20 percent of the population will be 65 or older — making for 70 million elderly Americans.

Based on current figures, the John A. Hartford Foundation estimates that by 2030 we will have a shortfall of 26,000 geriatricians. Of the more than 400 geriatric fellowship slots open in the U.S. last year, less than 70% were filled, according to the American College of Physicians.

Only seven of the nation's 125 medical schools have departments of geriatric medicine.

South Carolina recruitment successful

South Carolina is recruiting much-needed geriatricians through an innovative program that forgives medical school debt in exchange for geriatric training and a five-year commitment to practice in the state. Under the Geriatrician Loan Forgiveness Act, South Carolina repays up to $35,000 for each year of fellowship training for physicians who specialize in geriatrics or geropsychiatry.

The state only has 30 geriatricians to serve 510,000 people 65 or older. Nationwide, only about 6,000 geriatricians are certified.

For more information, contact Linda Danielson at (803) 734-9889 or via e-mail at danielse@aging.sc.gov.

Reflections of Aging

Contest deadline April 13

The April 13 deadline for the 2007 Reflections of Aging Photo Contest, sponsored by the Geriatrics Interest Group, is quickly approaching. The purpose of the photo contest is to capture the character and experience of older adults and provide images that challenge stereotypes of the elderly.

The contest is open to all Missouri residents. Prizes will be awarded ($100, $75 and $50 gift certificates). For more information, visit http://reynolds.umh.edu/photocontest3.htm.

Concerns about elderly drivers grow after recent accidents

After an 84-year-old woman plowed her car through a school building in Belleville, IL, in January, killing an 8-year-old boy, nationwide attention focused on the abilities of elderly drivers. The parents of the boy suggested laws restricting the elderly from driving past a certain age, a measure lawmakers said was unlikely. However, older drivers do face extra requirements, including vision tests and more frequent renewals, in at least 21 states.

In Missouri, drivers 70 and older must renew their licenses every three years, as opposed to six for younger drivers. To renew, drivers must pass vision and road-sign recognition tests. Missouri also has a confidential system in which people can report unsafe drivers — young or old — who then may be required to pass a driving test or physical examination.

In Illinois, drivers 75 and older must pass both vision and driving tests to renew. Once a driver reaches 81, they must renew every two years, and after 87 they must renew annually.

Elderly Drivers in Missouri

In the past three years, 567 people were killed and 3,341 were seriously injured in traffic crashes involving an older driver.

In 2005, people 65 years of age and older accounted for nearly 15 percent of licensed drivers.

Older drivers were involved in 16 percent of the fatal traffic crashes and 13 percent of the crashes involving a serious injury in the past three years.

For information on the Older Driver Safety and Community Mobility Campaign in Missouri, visit www.modot.org/safety.

Source: Missouri Department of Transportation

Warning signs to watch for:

- ☐ Feeling uncomfortable, nervous or fearful while driving
- ☐ Dents and scrapes on the car or on fences, mailboxes, garage doors, curbs
- ☐ Difficulty staying in the lane of travel
- ☐ Getting lost
- ☐ Trouble paying attention to signals, road signs and pavement markings
- ☐ Slower response to unexpected situations
- ☐ Medical conditions or medications that may be affecting the ability to handle the car safely
- ☐ Frequent "close calls" (i.e. almost crashing)
- ☐ Trouble judging gaps in traffics at intersections and on highway entrance/exit ramps
- ☐ Easily distracted or having a hard time concentrating while driving
- ☐ Frequent traffic tickets or warnings by traffic or law enforcement officers in the past year or two

Source: AARP

Winter seminars address Alzheimer's, aging research

December, January and February Research Seminars on Aging provided a wide range of topics, presenters and research. In December, **Grace Sun, PhD,** professor of biochemistry, led a panel of seven other researchers in bringing to light current findings in Alzheimer's Disease research conducted on the University of Missouri campus. Attendees learned that major breakthroughs will occur when specific biochemical elements can be introduced into the brain to interrupt the growth of neurotic plaques and fibrilliary tangles that characterize this dreadful disease.

Presenters included **W. Gibson Wood, PhD,** a visiting professor in pharmacology from the University of Minnesota, whose research shows that statins are not only good for the heart, but also for the brain; **Gary Weisman, PhD,** a professor in biochemistry, who explained the role of nucleotide receptors in Alzheimer's Disease; **James Lee, PhD,** assistant professor in biological engineering, who explained the problems associated with mitochrondrial dysfunction; **Renee JiJi, PhD,** assistant professor in chemistry, who revealed how small molecule interference affects amyloid beta aggregation; **Michael Petris, PhD,** an associate professor in biochemistry and nutrition, who showed how copper is connected to the disease; **Mark Hannink, PhD,** professor in biochemistry and associate director of the MU Life Sciences Center, who shared the role of oxidative stress and Keap1/Nrf2; and **J. David Robertson, PhD,** professor in chemistry, who showed how using a nuclear reactor can "light-up" the metals in amyloid plaque.

Interdisciplinary Center on Aging

In January, **Bo G. Eriksson, PhD,** an international guest lecturer, shared his experience of participating as a sociologist on the continuing H-70 longitudinal panel of studies on health and aging in Sweden that began in 1970. He shared the value of collaborative interdisciplinary research and gave examples of the advantages of bringing into play a wide variety of perspectives on a given problem rather than being limited to only one.

In February, plans for three interdisciplinary pilot health intervention studies, made possible by a grant from the RAND/Hartford Interdisciplinary Geriatric Healthcare Center Initiative, were presented by the principal investigators of the respective teams.

Greg Alexander, PhD, RN, assistant professor of nursing, shared how his team is using technology to track the movements and mobility of elders as a means of designing safe and comfortable living environments for older adults.

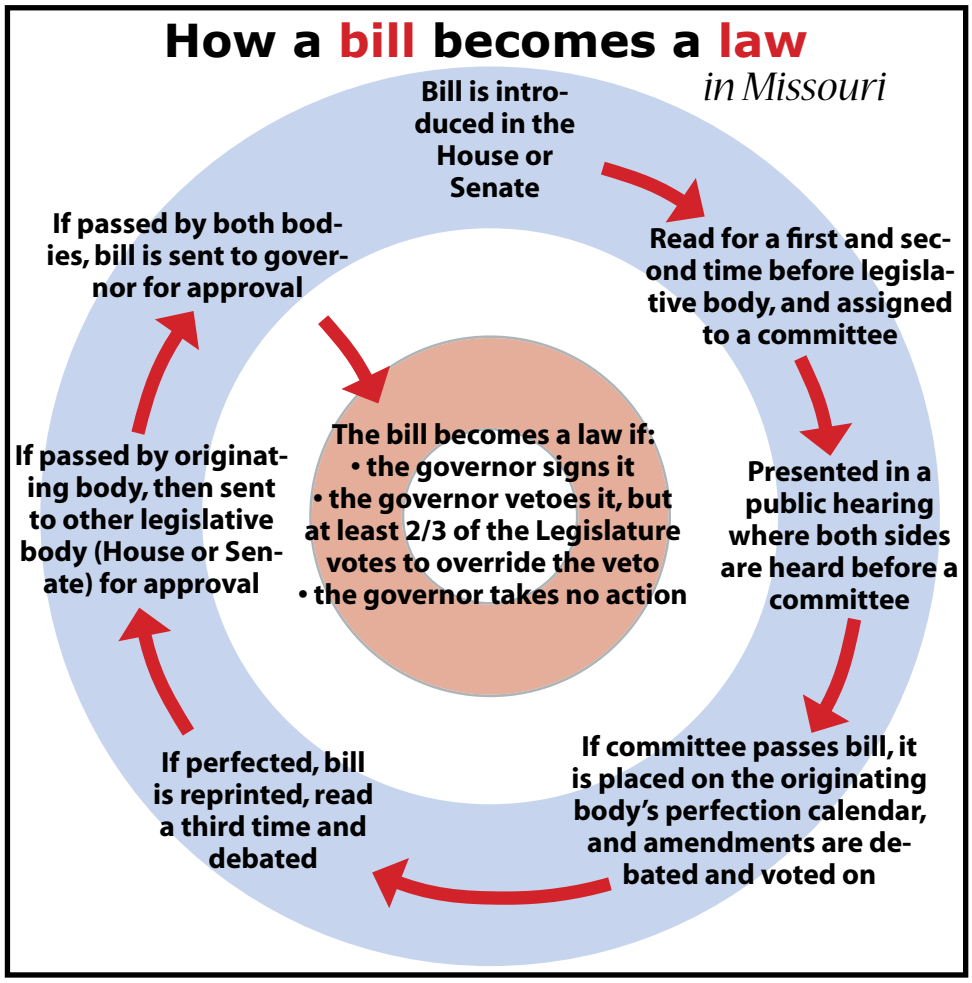
Robin Kruse, PhD, MSPH, research assistant professor in family and community medicine, shared how her team is investigating how and when falls among the elderly occur and how to prevent them. **Denise Swenson,** pre-doctoral student in the School of Social Work, shared how her team is designing an approach to improving end-of-life care in nursing homes. This will include the value of sharing prognostic information with family and residents, care-planning based on this information and environmental changes that will make residents' last days more comfortable.

To receive announcements of Interdisciplinary Center on Aging seminars, e-mail Jane Williams at WilliamsJA@missouri.edu.

MO legislative session addresses needs of elderly

The 2007 Missouri legislative session began Jan. 3 and continues until May 18. Several bills proposed this year deal with elderly issues; listed below are summaries of some of them.

For more information on any of these House or Senate bills, visit the Missouri General Assembly site at www.moga.mo.gov.



SENIOR SERVICES

HB 98: Authorizes each Area Agency on Aging to establish a volunteer program for the transportation of the elderly to scheduled health-related appointments (Sponsor: Rep. Michael Parson)

HB 454: Authorizes Family Support Division to assist certain elderly individuals who qualify for federal Food Stamp Program in obtaining supplemental food stamps (Sponsor: Rep. Rod Jetton)

HB 959: Requires the Missouri Public Service Commission to implement an energy assurance program pilot project to provide heat-related utility services to low-income individuals (Sponsor: Rep. Jeanette Mott Oxford)

HB 1025: Requires the allocation of funds from a county's senior citizens' services tax fund to be used on operational and capital needs expenditures of senior centers (Sponsor: Rep. David Sater)

SB 11: Creates a hot weather rule for maintenance of utility service (Sponsor: Sen. Maida Coleman)

SB 14: Authorizes volunteer transportation services for the elderly (Sponsor: Sen. Delbert Scott)

CRIMES AGAINST SENIORS

HB 170: Imposes a minimum term of imprisonment for offenders who have pleaded guilty or been found guilty of a crime of violence against children or the elderly (Sponsor: Rep. Nathan Cooper)

HB 542: Prohibits unsolicited commercial mail to individuals older than 65 who register with the Office of the Attorney General (Sponsor: Rep. Trent Skaggs)

HB 769: Provides protections for vulnerable adults and children and transfers the Division of Aging from the Department of Social Services to the Department of Health and Senior Services (Sponsor: Rep. Mark Bruns)

SB 177: Provides for mandatory minimum punishment for securities fraud crimes against the elderly or disabled (Sponsor: Sen. Tim Green)

SB 675: Modifies the offense of misappropriations of funds of elderly nursing home residents (Sponsor: Sen. Jack Goodman)

HEALTH

HB 1107: Expands eligibility for Missouri Rx Plan to persons 65 and older who are retired with incomes of up to $25,000 for individuals and $50,000 for married couples (Sponsor: Rep. Joseph Fallert Jr.)

SB 418: Increases the monthly personal needs payment under the Supplemental Nursing Care Program (Sponsor: Sen. Norma Champion)

SB 530: Modifies provisions relating to the Alzheimer's Demonstration Project (Sponsor: Sen. Michael Gibbons)

TAXES

HB 133: Allows a full $6,000 pension deduction from state income tax for taxpayers when they reach the age of 65 regardless of income (Sponsor: Rep. Danielle Moore)

HB 359: Exempts residential property owned by individuals 62 years of age or older from certain increases in assessed valuation (Sponsor: Rep. Michael Frame)

HB 611: Authorizes an income tax deduction for Social Security and retirement benefits for the elderly (Sponsor: Rep. Edward Wildberger)

SB 59: Exempts 25 percent of the social security benefits included in senior citizen taxpayers' federal adjusted gross income (Sponsor: Sen. Yvonne Wilson)

Tax credit for caregivers

The Missouri Shared Care Tax Credit helps families offset the costs of caring for an elderly person age 60 or older. The credit may be up to $500 for the tax year. The older person must live in the same residence as the caregiver for an aggregate of more than six months per tax year.

For information on eligibility, call the Missouri Department of Health and Senior Services Information Line at 800-235-5503.

CHRONICLE-*ing the news*

1 Newspapers across the country honored humor columnist Art Buchwald and his efforts to make "hospice" a household word after he died Jan. 17 of kidney failure. Read about his efforts in this *St. Louis Post-Dispatch* story: **www.stltoday.com/stltoday/lifestyle/columnists.nsf/janebrody/story/68FB3311B54683108625726F007ABA83?OpenDocument** In another *Post-Dispatch* story, a columnist shares the life lessons Buchwald taught: **www.meaning.ca/archives/archive/art_art_dying_R_Pearson.htm**

2 A *New York Times* article published in December discussed the trend in brain health programs springing up across the country. "From 'brain gyms' on the Internet to 'brain-healthy' foods and activities at assisted living centers, the programs are aimed at baby boomers anxious about entering their golden years and at their parents trying to stave off memory loss or dementia," the article reported. Even Nintendo has joined the market with "Brain Age," a video game designed to give aging brains a workout.

Read more here: **http://query.nytimes.com/gst/fullpage.html?sec=health&res=9E0DEED71E31F934A15751C1A9609C8B63**

3 The Associated Press recently wrote about Cranky.com, a new online search engine designed for baby boomers: **www.msnbc.msn.com/id/16564164/**

4 In a January opinion column, *USA Today* addressed the challenges older workers face in finding employment. It cited a McKinsey & Co. report that found 40 percent of people who described themselves as retired had stopped working earlier than they had planned. Of that group, 47 percent stopped working for health reasons, and 44 percent did so because of job loss or downsizing.

The column also cited a Center for Retirement Research study on age discrimination in which researchers found that a younger worker was more than 40 percent more likely to be called for an interview than someone 50 or older: **http://blogs.usatoday.com/oped/2007/01/too_young_to_re.html**

5 A March *New York Times* article focused on the rise of home health aides in the so-called "gray market" — often untrained, unscreened and unsupervised, but more affordable. By hiring these aides, families avoid the fees of home-care agencies, and the aides make more money, though sometimes without benefits, worker's compensation or Social Security. **http://query.nytimes.com/gst/fullpage.html?sec=health&res=9807E3D61F3EF932A35750C0A9619C8B63**

6 AARP recently reported the 2004 median income distribution among U.S. men and women ages 65 and older. Men made $21,120, while women made $12,000. **http://assets.aarp.org/rgcenter/econ/dd148_income.pdf**

$33.6 BILLION ●●●● Annual cost to U.S. businesses of workers who care for elderly relatives — in absenteeism, replacement costs and lost productivity.
Source: National Alliance for Caregiving and the MetLife Foundation

$20,234 ●●● Average amount of debt for seniors 75 and older as of 2004 — an increase of 160 percent since 1992. During that time period the median amount of mortgage debt rose 63 percent to $60,000 for those 55 and older.
Source: Employee Benefit Research Institute

80% ●●●● ...of 302 large private employers surveyed said they likely would increase retiree health premiums in 2007.
Source: The Kaiser Family Foundation and Hewitt Associates

300 MILLION ●●●●●● Predicted number of people 60 and older in China by 2026 — equivalent to the current U.S. population. That number is expected to grow to 400 million by 2037.
Source: China National Committee on Aging

-1% ●●●● The country's personal savings rate in 2006 — the worst showing since the Great Depression 73 years ago. A negative rate means people are spending all of the money they have left after paying taxes and then dipping into savings or increasing borrowing.
Source: U.S. Commerce Dept

MU Principles of Geriatric Care

Our program is based on 10 principles of geriatric care that we weave into the fabric of our curricular initiatives and the training of faculty and community-based physicians.

These are not new concepts to any of you – but they help us maintain and communicate our vision to learners and colleagues at all levels.

Multidisciplinary

Family Caregivers

Evidence-Based

The Right Drugs

Cost-Effective

Quality of Life and Function

Relationships

Advocacy

Ethics

End-of-Life Care

Upcoming Conferences

April 2007

"They Are Here and They Are Grey: Issues Impacting the Future of Gerontological Nursing," 10th Annual Nursing Research and Leadership Conference
April 12. Rochester, NY. www.gvna.us

The Simon Foundation For Continence: Innovating For Continence — The Engineering Challenge
April 19-20. Lincolnshire, IL. www.simonfoundation.org

National Hospice And Palliative Care Organization's 22nd Management And Leadership Conference On Hospice And Palliative Care
April 19-21. Washington, DC. www.nhpco.org/MLC2007

May 2007

2007 Annual Scientific Meeting of the American Geriatrics Society (AGS)
May 2 to 6. Seattle, WA. www.americangeriatrics.org

Hospice Minnesota's 2007 End-Of-Life Conference
May 16-17. St. Cloud, MN. www.hospicemn.org

Caregiving Near Life's End: The National Train-the-Trainer Program
May 22-24. Clearwater, FL. www.thehospice.org

June 2007

Policy by the People: Nursing Care in Life, Death and Disaster," 2007 ANA Quadrennial Policy Conference
June 20-22. Atlanta, GA. www.nursingworld.org/meetings/

July 2007

National Consensus Conference on Geriatrics Education
July 11-13. St. Louis, MO. More information will be available at www.aamc.com in early April.

See calendar on page 3 for conferences on elder abuse.

Interdisciplinary Center on Aging Grants and Awards: Fall/Winter 2006

Grants

Marilyn Rantz, PhD, RN

Rantz

Principal Investigator for "Building Interdisciplinary Geriatric Health Care Research Centers"; RAND Health; Oct. 1, 2006, to Sept. 30, 2008; $200,000.

Principal Investigator for "Quality Improvement"; Primaris Healthcare Business Solutions; Aug. 1, 2006, to July 31, 2007; $125,196.

Awards

The Annual Award for Baccalaureate Education in Geriatric Nursing was presented to the MU Sinclair School of Nursing Gerontological Nursing Care course for "Clinical Settings in Geriatric Nursing," submitted by Myra Aud and Roxanne McDaniel. This award was presented by the American Association of Colleges of Nursing and the John A. Hartford Foundation Institute for Geriatric Nursing at the fall semiannual meeting of the American Colleges of Nursing on Oct. 29, 2006.

The architectural mystique of our gerontopia

Ruth Brent Tofle, PhD

My contributions as a designer are both modest and magic. Untangling the architectural mystique as we seek our own gerontopia is this challenge. Whether therapeutic or prosthetic, environments make the most difference to the vulnerable — elderly, children and the disenfranchised. Compensating for sensory and motor disabilities to promote optimal function and privacy for activities of daily living, we are concerned with removing physical barriers. We consider carpet pile height, figure/ground object contrast, door widths, floor clearances, foot-candles and more. Design, however, cannot be extracted to prescriptive modern efficiencies of dos and don'ts. Standardized static checklists have limited value because they ignore the multifaceted needs of the dweller.

While a designer's *raison d'etre* is to solve people-problems of environments seeking order over chaos, function and safety with comfort, we must also strive to achieve a beguiling synthesis and harmony. As humans struggling between aspirations and physical realities, we find beauty in what gives us strength. A favorite armchair and television transports us to audiences of laughter; a webcam crosses vast distances keeping our loneliness at bay; a low window overlooking flowers connects us with nature. When homes provide shelter, bestow autonomy, protect from peril, hold our treasures near, exhilarate with new perspectives and enchant us…we are oriented with goodness.

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More than rearranging furniture, designers strive to provide a comfortable bed to caress an aching body, warmth from the chill of fear, close proximity to a bathroom to relieve and cleanse, treasured heirloom embroidered pillowcases to remind us of grandmother, silence to hear a beloved's whispers and restful sleep to awaken renewed at sunrise. Beyond specifying paint colors, designers want to create a sacred place for prayers of blessings and breaking of bread, illumination to contemplate tiny-print medicine bottles while hoping for relief and a civilized setting to taste, smell and see the vivid delights of nourishment.

No universal manifesto or occult formula creates this magical beauty. Cottage or castle, beauty can be achieved with extravagance or with graceful restraint and humble materials. We can recognize, however, its dichotomy of bad architecture. Alain de Botton writes in *The Architecture of Happiness* that bad architecture is in the end as much a failure of psychology as of design. It is the same tendency to marry the wrong person, choose inappropriate jobs and book unsuccessful holidays. This is the tendency to not understand ourselves and what gives us satisfaction (2006: 248).

The mystique of satisfying architecture prevails when it genuinely interacts with us. It translates our culture, values our heritage, enables control, affords safety, empowers will, compensates for disabilities, stimulates intellect, piques sensations, establishes serenity, speaks stability and proclaims identity. Rather than a "one size fits all" tube sock, our own gerontopia considers unique weaknesses and robust desires. Successful elderly housing relies on modest abilities in listening to visions of happiness. The mystique of architecture is ours to create.

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