Aging SUCCESSFULLY

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Federal $2.5 Million Grant to SLU Aims to Transform Geriatric Care

SLU-Led Program Will Train Primary Care Providers

By Nancy Solomon, Saint Louis University Medical Center Communications Director

Funded by a three-year, $2.5 million grant from the U.S. Department of Health and Human Services, faculty with the Gateway Geriatric Education Center (GEC) are leading an initiative to improve the health of older Missourians by training primary care health providers in geriatrics.

The GEC is working with two other universities, a rural hospital, a hospital system, two public community health centers, a senior center and a health nonprofit to join in an ambitious plan that addresses the significant shortage in underserved urban and rural areas of health care professionals who know how to care for older adults. The project will involve professionals and students in geriatric medicine, geriatric psychiatry, nursing, social work, physical therapy, occupational therapy and interprofessional education.

"Providing the care our older adults deserve is a huge challenge that requires the commitment of many different professionals from many institutions," said John Morley, M.B., B.Ch., Chair, Division of Geriatric Medicine at Saint Louis University and Marla Berg-Weger Ph.D, LCSW, and Executive Director of the Gateway GEC, who is the project's Co-Director.

"As our state has significant shortages of primary care health professionals and rapidly increasing numbers of older adults, we

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what's inside this issue

SLU Geriatricians Recognized as BEST DOCTORS 2015

Seven members of the Geriatrics Division medical faculty have been recognized by St. Louis Magazine as Best Doctors of 2015. This designation is based on the annual "Best Doctors in America" database that analyzes over one million peer evaluations. Geriatricians include:


Dr. Dulce Cruz-Oliver


Dr. John E. Morley


Dr. Julie A. Gammack

VOTED BEST Best Doctors 2015-2016


Dr. Joseph H. Flaherty


Dr. Gerald Mahon


Dr. Frederick Yap


Dr. Milta O. Little

EDITORIAL

Aging SUCCESSFULLY

In 1996, there were 8,424 geriatricians in the United States, whereas today, there are fewer than 7,500. In 2000, there were 4.7 geriatricians for every 10,000 persons in the U.S. who were 75 years and over. This number is expected to shrink to 1.5 per 10,000 by 2050. Clearly, this is a catastrophe of gigantic proportions for the future of our aging population.

WHERE HAVE ALL THE GERIATRICIANS GONE?

There is no question that geriatricians are key to assessing, diagnosing, and treating the more difficult to manage conditions experienced by older adults. Geriatricians also teach medical students, residents and practicing physicians how to care for older patients and strategies for organizing health care systems that are focused on seniors. Those members of the baby boom generation are rightly going to expect higher quality care than has been given in the past to older persons.

The reasons for the dearth of geriatricians are multifactorial. First, geriatricians earn approximately half the salary of other specialist physicians—$184,000/year compared to $498,127 for a radiologist. Secondly, geriatricians are afforded less respect by their colleagues who believe that anyone can provide medical care for older persons. My colleague, Dr. Angela Sanford, reflects on this issue in her poignant "Pep Talk for Geriatricians" (*see p. 15*). Finally, many graduating medical schools do not view geriatric care as being as exciting as other areas of medicine.

John E. Morley, MB, BCh

It is time that all of us who care about the future of aging baby boomers to begin to agitate the system to make the geriatric specialization a more desirable career option for future generations of physicians. In part, this effort will require that we demand better pay for geriatricians, but it will also require a major public education campaign with our general society as well as the physician and health care communities regarding the key role that geriatricians play in the role of the older adults.

John E Morley

Transforming Geriatric Care

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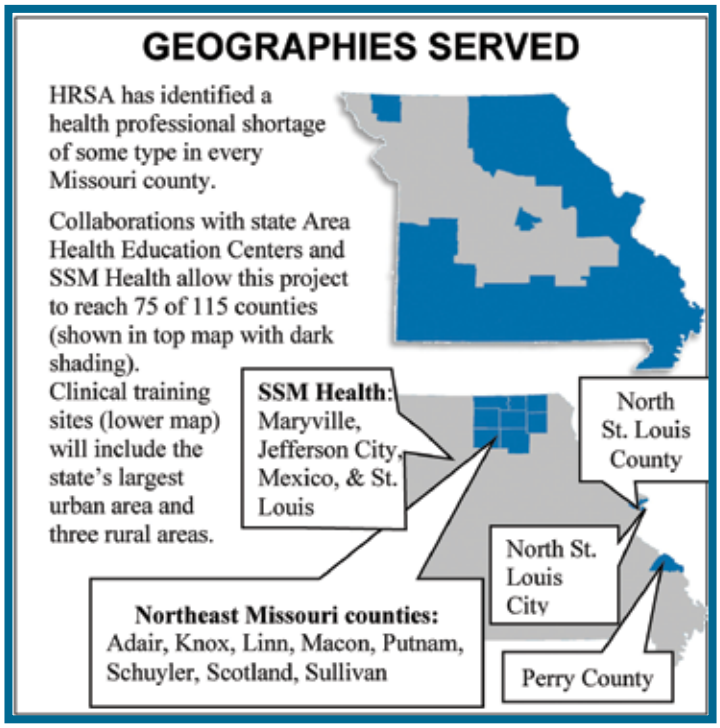
must act now to train primary care professionals how to conduct screenings, assessments and interventions to improve the health of older adults. I'm energized that so many organizations and people are joining SLU in bringing life to a plan that will improve the quality of life for aging Missourians," said Morley, who also is a SLUCare Physician Group geriatrician.



Leading a Team

Collaborative partners include A. T. Still University Osteopathic Medical School/Missouri Area Health Education Centers in Kirksville and Perry County Memorial Hospital. University and community partners are Washington University in St. Louis, SSM Health, Myrtle Hilliard Davis and John C. Murphy Health Centers, Northside Youth and Senior Services and the St. Louis Alzheimer's Association.

The grant to SLU is funded through the Health Resources and Services Administration (HRSA), the main federal agency in the Department of Health and Human Services charged with improving health care for those who are uninsured, isolated, or medically vulnerable.

Slightly more than a quarter of the institutions that submitted applications for federal funding received it. The project is one of 44 Geriatric Workforce Enhancement Programs in the U.S. and one of two in HRSA region VII, which includes Missouri, Iowa, Kansas, and Nebraska.

The initiative targets underserved areas: urban north St. Louis city and county and rural Perry County and an eight county region in northeast Missouri, where the impact of the shortage of health care providers who understand the special needs of geriatric patients is amplified.

Graying of Missouri

Older adults comprise a larger proportion of Missouri's population than in the greater United States. In 2011, 14.2 percent of Missourians were older adults, compared to 13 percent of U.S. residents. By 2030, the percentage of older Missourians is expected to increase to 21 percent, compared to 19 percent in the U.S.

"To keep pace with the growth of the older adult population who often have multiple health problems and complex conditions that require more medical care, the number of primary care providers needs to increase by 34 percent," said Marla Berg-Weger, Ph.D., LCSW, professor of social work at SLU and co-project director. "With 40 percent of the state's population living in rural areas and only 25 percent of physicians practicing in these areas, the need for a well-trained geriatric workforce is at a crisis point."

Further, because the number of geriatric practitioners is insufficient to care for our growing number of older adults, developing geriatric evaluation teams is essential for the health and quality of life of our aging population.

Tackling from Many Angles

The project, which is called the Gateway Geriatric Education Center Workforce Enhancement Program, attacks the problem on multiple fronts by:

- **Educating 1,100 health care students and providers on a team-approach that brings together professionals from multiple health disciplines to best care for older adults**

Health professions students and those who provide care at the senior center, health centers and rural physician practices will be trained to work in interprofessional teams as they conduct physical and cognitive screenings, assessments, and provide interventions. Students and care providers will learn to use screening tools, including many created at Saint Louis University, to detect cognitive impairment, frailty and caregiver well-being. They also will learn to deliver cognitive stimulation therapy, which is a non-pharmaceutical intervention for persons with dementia that stimulates socialization,

Transforming Geriatric Care

(continued from page 4)

conversation and memory; a simple exercise program to restore muscular function; and support and resource information to caregivers of those who have dementia.

Training sites for the first year of the grant include Myrtle Hilliard Davis Comprehensive Health Center, Northside Youth and Senior Services, and SLU's Health Resource Center, a free clinic run by SLU medical students in north St. Louis, John C. Murphy Health Center in north St. Louis County, A.T. Still University, Truman State University and Missouri Area Health Education Center in northeast Missouri, and Perry County Memorial Hospital in Perry County. Training sites will be expanded to include SSM Health locations in St. Louis, Mexico, Audrain and Maryville the subsequent two years.

- **Annually designating three faculty members from universities in Missouri annually as Geriatric Leadership Scholars who will receive specialized training and mentoring**

Scholars will receive salary support and travel funds to attend a national geriatric conference; complete a capstone project that focuses on research, patient care or education; and work with students in the clinical training program.

- **Training 5,000 patients, family members and care providers to improve quality of life by becoming healthier**

Project Co-Directors Dr. Morley and Dr. Berg-Weger

The Geriatric Leadership Scholars and St. Louis Alzheimer's Association will partner to create a lecture series on general geriatric issues, dementia, mild cognitive impairment, and caregiver support to be delivered

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SLU GEMS

AVAILABLE ONLINE!

The latest edition of this ever-useful pocket-sized book, chock-full to the brim with screening tools and mnemonics, is available on our website! Visit aging.slu.edu to access this tool.

To order hard copies, email your request to aging@slu.edu.

SERVICES

Services of the Division of Geriatric Medicine include clinics in the following areas:

• Aging and Developmental Disabilities • Bone Metabolism • Falls: Assessment/Prevention • • Geriatric Assessment • • Geriatric Diabetes • • Medication Reduction • • Menopause • • Nutrition • Podiatry • • Rheumatology • • Sexual Dysfunction • • Urinary Incontinence •

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(at Des Peres Hospital)

COGNITIVE STIMULATION THERAPY: Making a Difference for People with Mild to Moderate Dementia

By Julia Henderson-Kalb, MS OTR/L, Marla Berg-Weger, PhD, LCSW, Susan Tebb, PhD, MSW, RYT-500, Max Zubatsky, PhD, LMFT, Janice Lundy, BSW, MA, MHA, Debbie Hayden, RN, BSN, OTR/L, & Daniel Stewart, MSG

When someone demonstrates signs of dementia or Alzheimer's disease, there can be a sense of impending doom for both the individual and his or her loved ones. As a chronic, progressive issue, dementia can lead to decreased cognition, decreased social stimulation, and increased behavioral issues. Individuals diagnosed with dementia and their caregivers might feel helpless. Medications are available to slow the progression of the disease. However, some people are hesitant to try them or are looking for other non-pharmacologic therapies to complement their medication regimen. As healthcare providers for older adults, we need to have a working knowledge of the options available to persons with these diagnoses.

Michele Sakamoto (center), who received her MSW from SLU in 2015, guides patients in chair yoga, a gentle type of yoga that improves strength, flexibility and mental acuity. Photo by Kristina Roselle, MSW.

Cognitive Stimulation Therapy (CST) is an evidence-based, non-pharmacologic individual and group intervention for persons with mild to moderate dementia. Developed in the United Kingdom by a team led by Drs. Aimee Spector and Martin Orrell, CST was created by combining the most effective aspects of several non-pharmacologic interventions and is based in reality orientation. CST is the only non-pharmacologic treatment endorsed by the UK Government National Institute for Health and Care Excellence (NICE), regardless of drug regimen. Although CST is well-known and well-used in the UK, its benefits are just beginning to become apparent here in the US.

At the GEC at Saint Louis University, an interprofessional group of faculty, practitioners, and students have collaborated to create a CST Train-the-Trainer toolkit and training session for healthcare professionals to learn more about CST. Our goal is to provide information and inspire healthcare students and providers to consider the possibility of implementing a CST program in their own programs and facilities.

There are three types of CST: Standard CST, Maintenance CST (MCST), and Individual CST (iCST). The creators of CST have published manuals that guide facilitators through the sessions for all three types of CST. To learn about the origins of CST and obtain information on training and manuals, visit http://www.cstdementia.com/. The manuals also include guiding principles that should be incorporated into each session (Table 1). The GEC Train-the-Trainer toolkit provides information on forming groups, selecting co-facilitators, managing group members' behaviors, adjusting sessions to be culturally appropriate, and other helpful ideas. When used together, providers can develop a CST program.

CST-related research has shown that people who participate in CST often see improved cognition scores, improved self-measured quality of life ratings, decreased levels of depression, and improved language skills. The standard CST sessions are held twice a week for seven weeks and last 45 minutes to an hour. Groups ideally consist of five to eight people with two co-leaders, although the size of the groups can vary based on members' functional status. The groups actively engage members through organized, theme-based group activities. Structure is important to the success of CST, and each group session should flow in the same basic order.

Sessions begin with introductions (of individual members, the group in general, the day and weather, and any

Cognitive Stimulation Therapy

important events that have occurred since the last session). The group then sings the group theme song, which is chosen by group members during the initial session. This activity promotes group cohesion and a sense of structure. An article from a local or national news source is then distributed to members and discussed. Facilitators can invite the group members to provide opinions about the current event and compare the issue/event to a past memory. Following the article discussion, the main group activity is completed as it is outlined in the CST manuals. Topics vary each week and have a lot of room for creativity and adaptation. The group then ends with a time of closure, which includes reviewing that session and discussing plans for the next session.

After the initial seven-week session, maintenance (MCST) groups can be provided. MCST research has demonstrated that, after six months, participants' self-rated quality of life measures were higher than those who did not participate in the groups. When persons with dementia participate in MCST after completing standard CST, their cognition continues to improve slightly while their counterparts who do not continue with maintenance tend to decline. The sessions are usually held once a week for approximately the same length of time as the original sessions with a similar format: introductions, theme song, current event, group activity, closure. What can vary from the standard CST, besides the times per week the groups meet, is the group cohesion. As the standard seven- week sessions end, some members may want to carry on into maintenance groups while some may not. If a program has standard groups starting and ending every seven weeks, maintenance groups will have new members entering at different intervals, which may change the group dynamics. Leaders must monitor group size and determine members who no longer benefit from CST.

Individual CST (iCST) is designed for individuals who may not be comfortable with or are no longer appropriate for a group setting. iCST is meant to be provided by a care partner who has regular contact with the person with dementia, often times a spouse or adult child of the individual or a professional caregiver. While cognitive function and quality of life outcomes have not been shown to be significantly improved with iCST, individuals with dementia report the relationship with their care partners improved with iCST sessions. Caregivers' self-reported quality of life scores improved. Finally, individuals with dementia and their care partners value the mental stimulation that iCST provided. Individual sessions are held three times per week for 20 to 30 minutes at a time. The iCST manual provides for 25 weeks of iCST, or 75 separate sessions. As with the other forms of CST, each session should follow a similar structure. Begin with warming up body movements, music, and a discussion of the weather or current events. This is followed by current events, refreshment, and a main activity, adapted as needed.

All types of cognitive stimulation therapy have positive effects on an individual with dementia. This form of non-pharmacologic treatment can be a cost-effective alternative to maintaining and improving cognition, quality of life, and socialization/language skills while decreasing depression. These improvements not only affect the individual with dementia, but also people who provide care to the individual. Use of the manuals and the GEC Train-the-Trainer toolkit can assist any facility or program in beginning a new CST program. Videos and online training modules are now available on the GEC website at http://aging.slu.edu.

Table 1. Guiding Principles of Cognitive Stimulation Therapy

1. **Mental Stimulation: Get people's minds active and engaged**
2. **Encourage new ideas, thoughts, and associations**
3. **Use orientation sensitively and implicitly**
4. **Focus on opinions rather than facts**
5. **Use reminiscence as an aid to the here-and-now**
6. **Provide triggers to aid recall: Using all five senses is encouraged**
7. **Continuity and Consistency is necessary between sessions***
8. **Focus on implicit (rather than explicit) learning***
9. **Stimulate language: Encourage group members in language use**
10. **Stimulate executive functioning: Encourage "mental organization"**
11. **Person Centerdness: Treat people as individuals**
12. **Respect: Allow differences and avoid exposing people's difficulties***
13. **Involvement: encourage individual contributions***
14. **Inclusion of all opinions***
15. **Choice: Group members help shape the group**
16. **Fun!**
17. **Maximize potential using the "Just Right" challenge**
18. **Build/strengthen relationships between group members and leaders**

*Standard CST and MCST principle only

Resources

D'Amico F, *et al*. Maintenance cognitive stimulation therapy: An economic evaluation within a randomized controlled trial. *J American Medical Directors Association*. 2014: 16(1), p. 63-70.

Orrell M, *et al*. A pilot study examining the effectiveness of maintenance CST (MCST) for people with dementia. *International Journal of Geriatric Psychiatry*, 2005: 20, p. 446-451.

Woods B, *et al*. Improved quality of life and cognitive stimulation therapy in dementia. *Aging & Mental Health*. 2006: 10(3), p. 219-226.

Interprofessional Education

By Milta O. Little, D.O., and Helen Lach, Ph.D., RN, CNL, FGSA, FAAN

Interprofessional health education has come to the forefront of geriatric medicine and Saint Louis University is emerging as a leader in interprofessional geriatric education. In order to adequately create an environment of engaging interprofessional education, five main issues are being addressed. The first is positive professional role identification of oneself and others. Second, identify and address hierarchical roles (both positive and negative). Third, provide adequate incentives for interprofessional collaboration and acknowledgment of team members' strengths and successes. Fourth, measure team function and outcomes in order to improve teamwork and collaboration. Last, emphasize the role of reflection and team facilitation. Reflection and de-brief should take place frequently and should be part of one's daily work life.

Pictured above: Students and faculty who participated in geriatric case competition

As part of the Geriatric Workforce Enhancement Program at Saint Louis University, several interprofessional geriatrics education opportunities have been developed to address those five issues. Coordinators Dr. Helen Lach and Dr. Milta Little have been working to integrate the Rapid Geriatric Assessment (RGA) into the curriculum in health science classrooms across the Saint Louis University campus, including social work, occupational therapy, physical therapy, nursing, medicine, medical family therapy, and communication sciences and disorders. Students trained to perform the RGA have been able to participate in community screenings across the St. Louis region.

Competition winners (l to r): Danielle Thomas (Department of Family & Community Medicine, Medical Family Therapy Program), Colin Gallagher (School of Medicine), Tara Dauer (School of Nursing), and Kylee Sachtleben (Department of Communication Sciences and Disorders).

Interprofessional Education

Students from across the health professions also participated in the first annual "Geriatric Case Competition" in February 2016. Nine teams – each with students from multiple disciplines were charged with becoming an interprofessional team and developing a plan of care for a geriatric patient based on a standardized case. Students met over one month and had access to a faculty mentor. Each team made a formal presentation of their plan, and they were rated on the quality of their plan and interprofessional collaboration. Winners were announced at a reception to congratulate all the students on their exceptional work.

The competition was modeled after a similar program at A. T. Still University, a partner in the Geriatric Workforce Enhancement Program grant from the Health Resources Services Administration (HRSA). Student professions included medicine, nursing, physical therapy, communication sciences and disorders, medical family therapy, social work, and public health.

Students enjoyed the challenge and opportunity to work with peers from other professions. One student enjoyed "the opportunity to really dig into a case from so many perspectives." Another found the competition "a safe environment to learn about other professionals and learn how to work on a team." Another student stated: "I really enjoyed the case competition. I thought it was a great opportunity to be exposed to other professions."

Organizers Dr. Milta Little and Dr. Helen Lach were impressed with the quality of the student's work. "These students had a range of experiences and knowledge and were creative and resourceful in addressing this patient's problems" reports Lach. Little further noted "this is what we want our students to do – take this geriatric experience and think about how they can use it in their future roles to become change agents and improve care for older adults." They anticipate the competition will be an annual event, and is being held in the Fall 2016 semester on Thursday, October 27, 2016. For more information on the case competition, email aging@slu.edu.

To build on the training and work with students across the University, an Interprofessional Geriatric Interest Group has been started with a kickoff event March 29th for Careers in Aging Week. Students had the opportunity to hear a lecture by Dr. Little on Successful Aging and engage in "speed mentoring" with geriatric professionals.

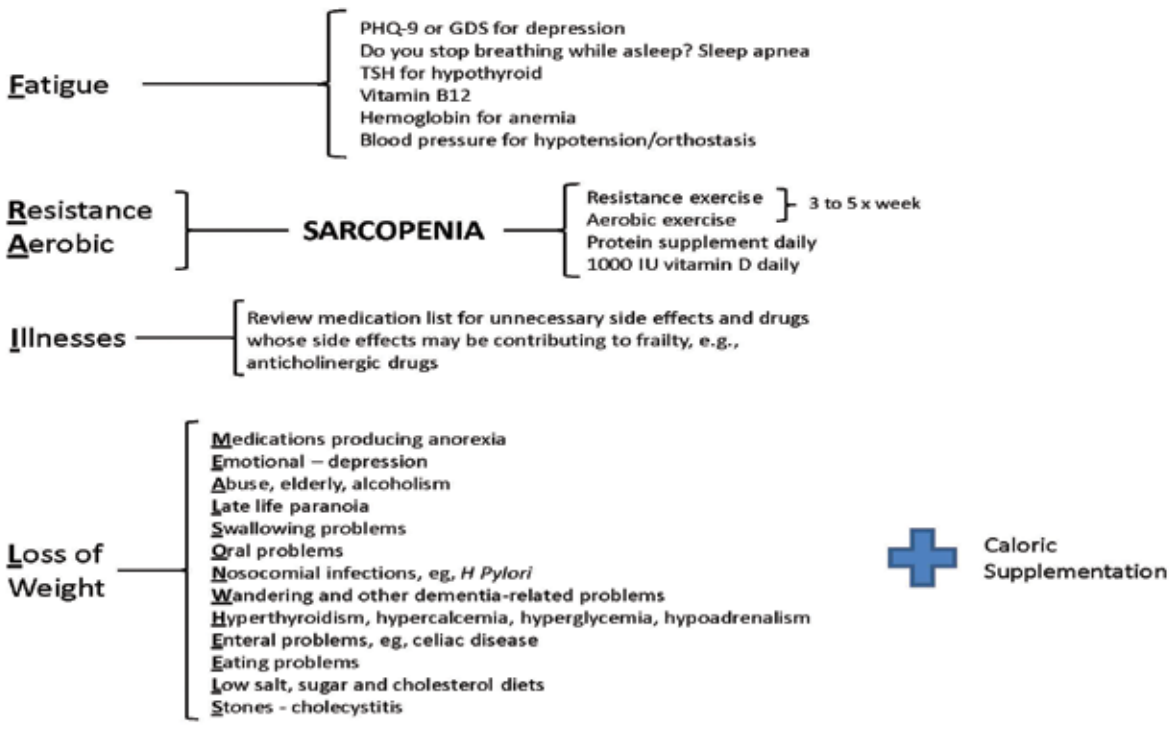
The *Rapid* Geriatric Assessment

At Saint Louis University, we have developed the Rapid Geriatric Assessment (RGA).[1] The purpose of the RGA is to allow primary care physicians to do simple case-finding for the presence of geriatric syndromes in older persons. The RGA screens for frailty, sarcopenia (muscle weakness), anorexia, and cognitive dysfunction. The RGA is presented in its entirety in the centerfold of this newsletter.

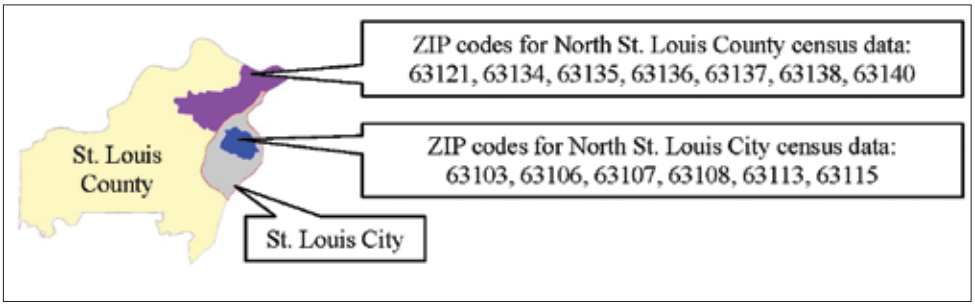
If the associated algorithm is followed within these screening measures, the majority of persons with depression, sleep apnea, weight loss, polypharmacy, inappropriate drug use, and endocrine disorders (*e.g.*, hypothyroidism and vitamin B_{12} deficiency) can be identified. Figure 1 provides additional information on the algorithm.

The simple screens that are used have been well validated psychometrically. Both the frailty (FRAIL) screen[2,3,4,5] and the sarcopenia measure (SARC-F) have been validated on four continents[6,7] while the nutrition assessment (SNAQ) has been studied and validated on three continents[8,9,10]. The Rapid Cognitive Screen (RCS) is derived from the Saint Louis University Mental Status (SLUMS) examination and is available in 30 languages[11,12] which are available at http://aging.slu.edu.

Figure 1. Algorithm for Management of Frailty



In addition to assessing the four areas noted here, the RGA includes an item to determine if the older adult has completed an advance directive to guide future and end-of-life care. Advance directives are a key to appropriate health care in persons of all ages, and need to be obtained while the person still has the capacity to be involved in their own decisions.



Here at Saint Louis University, as part of the current Geriatric Workforce Enhancement Program (GWEP), we have developed a computer-assisted management system for primary care health professionals to use in making appropriate diagnostic and treatment decisions. In addition to making the RGA available in paper and electronic formats, we have developed health literacy appropriate patient handouts which stress lifestyle changes such as exercise and high protein diet for frailty and sarcopenia. Patient materials are also provided on issues related to exercise, mental stimulation, and a Mediterranean diet with extra virgin olive oil (polyphenols) for mild cognitive impairment. GWEP faculty, staff, and students provide this assessment protocol to physicians of those persons who screened positive on the SNAQ, the MEALS-on-WHEELS mnemonic for treatable causes of weight loss. These informational materials are available in their entirety in this newsletter.

Utilizing our Geriatrics Workforce Enhancement Program (GWEP) grant, faculty are integrating the RGA into the clinical services provided by Saint Louis University, Perry County Memorial Hospital, Northside Youth and Senior Services and two community health centers—Myrtle Hilliard Davis Health Care Center in North St. Louis and the St. Louis County Health Centers in North St. Louis County. The map that accompanies this article provides an overview of the geographic areas being served in the St. Louis area. Utilizing GWEP faculty, staff, and health professions students, we are also providing screening in the St. Louis community.

We are very excited at our success utilizing the RGA to allow primary care health professionals to improve outcomes for older persons in Missouri. The RGA can be used as part of the Medicare Annual Wellness Visit (G0439) along with a depression screen (SLU "AM SAD" Tool), immunizations, listing of medical conditions, female history, listing of medications and allergies, vital signs and weight.

For more information about the RGA please visit the GEC website and view the video depicting Dr. Milta Little administering the RGA to an older patient. For questions or information on screening opportunities please send an email to aging@slu.edu.

References

1 Morley JE, *et al*. Rapid Geriatric Assessment. *J Am Med Dir Assoc* 2015 Oct 1;16(10):808-12.
2 Malmstrom TK, *et al*. A comparison of four frailty models. *J Am Geriatr Soc* 2014 Apr;62(4):721-6.
3 Woo J, *et al*. Comparison of frailty indicators based on clinical phenotype and the multiple deficit approach in predicting mortality and physical limitation. *J Am Geriatr Soc* 2012 Aug;60(8):1478-86.
4 Woo J, *et al*. Frailty Screening in the Community Using the FRAIL Scale. *J Am Med Dir Assoc* 2015 May 1:16(5):412-9.
5 Theou O, *et al*. Identifying common characteristics of frailty across seven scales. *J Am Geriatr Soc* 2014 May 62(5):901-6.
6 Woo J, *et al*. Validating the SARC-F: a suitable community screening tool for sarcopenia? *J Am Med Dir Assoc* 2014 Sep;15(9):630-4.
7 Cao L, *et al*. A pilot study of the SARC-F scale on screening sarcopenia and physical disability in the Chinese older people. *J Nutr Health Aging* 2014 Mar;18(3):277-83.
8 Wilson MM, *et al*. Appetite assessment: simple appetite questionnaire predicts weight loss in community-dwelling adults and nursing home residents. *Am J Clin Nutr* 2005;82(5):1074-81.
9 Rolland Y, *et al*. Screening older people at risk of malnutrition or malnourished using the Simplified Nutritional Appetite Questionnaire (SNAQ): a comparison with the Mini-Nutritional Assessment (MNA) tool. *J Am Med Dir Assoc* 2012 Jan;13(1)31-4.
10 Reliability and validity of the Japanese version of the simplified nutritional appetite questionnaire in community-dwelling older adults. *Geriatr Gerontol Int* 2015 Dec;15(12):1264-9.
11 Malmstrom TK, *et al*. The Rapid Cognitive Screen (RCS): A Point-of-Care Screening for Dementia and Mild Cognitive Impairment. *J Nutr Health Aging* 2015 Aug;19(7):741-4.
12 Cummings-Vaughn LA, *et al*. Veterans Affairs Saint Louis University Mental Status examination compared with the Montreal Cognitive Assessment and the Short Test of Mental Status. *J Am Geriatr Soc* 2014 Jul;62(7):1341-6.

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Rapid Geriatr

ID#:_____ Sex: _____
Ethnicity (circle): African/Am Asia

The Simple "**FRAIL**" Questionnaire - Screening Tool

Fatigue: Are you fatigued?
Resistance: Cannot walk up one flight of stairs?
Aerobic: Cannot walk one block?
Illnesses: Do you have more than 5 illnesses?
Loss of weight: Have you lost more than 5% of your weight in the last 6 months?

Scoring: 3 or greater = frailty; 1 or 2 = prefrail

From Morley JE, Vellas B, Abellan van Kan G, *et al. J Am Med Dir Assoc* 2013;14:392-397.

SNAQ - **S**implified **N**utritional **A**ssessment **Q**uestionnaire

My appetite is
a. very poor
b. poor
c. average
d. good
e. very good

Food tastes
a. very bad
b. bad
c. average
d. good
e. very good

Normally I eat
a. Less than one meal a day
b. One meal a day
c. Two meals a day
d. Three meals a day
e. More than three meals a day

When I eat
a. I feel full after eating only a few mouthfuls
b. I feel full after eating about a third of a meal
c. I feel full after eating over half a meal
d. I feel full after eating most of the meal
e. I hardly ever feel full

Scoring: a=1, b=2, c=3, d=4, e=5
A score of ≤14 indicates significant risk of at least 5% weight loss within 6 months.

From Wilson, *et al. Am J Clin Nutr* 2005;82:1074-81.

SLU "**AM SAD**" Tool (Validated Geriatric Depression Tool)**

AM SAD	Question	Frequency (Points)			Points Scored
A (Appetite)	Within the past 2 weeks, how many times have you experienced **unexplained change in appetite**?	Never (0)	One day (1)	More than one day (2)	
M (Mood)	Within the past 2 weeks, how many times have you experienced **unexplained lowered mood on a day to day basis**?	Never (0)	One day (1)	More than one day (2)	
S (Sleep)	Within the past 2 weeks, how many times have you experienced **unexplained disturbed sleep**?	Never (0)	One day (1)	More than one day (2)	
A (Activity & energy)	Within the past 2 weeks, how many times have you experienced **less energy or not being interested in performing your usual daily activities**?	Never (0)	One day (1)	More than one day (2)	
D (Death or worthlessness)	Within the past 2 weeks, how many times have you experienced **feelings of worthlessness or guilt or that your life is not worth living**?	Never (0)	One day (1)	More than one day (2)	

Total Points _____/10

Total points	Scoring
0-2	No depression
3-5	Mild depression
6-10	Moderate/Severe depression

**Chakkamparambil B, *et al.* Development of a Brief Validated Geriatric Depression Screening Tool: The SLU "AM SAD." *Am J Geriatr Psychiatry* 2014 Oct 16

is University
ric Assessment

ted into the Electronic Health Record without permission and at no cost.

__ Age: _____ Primary Care Provider Y / N
n Caucasian Hispanic Non-Hispanic

SARC-F Screen for Sarcopenia (Loss of Muscle)

COMPONENT	QUESTION
Strength	How much difficulty do you have in lifting and carrying 10 pounds? **Scoring: None = 0 Some = 1A lot or unable = 2**
Assistance in Walking	How much difficulty do you have walking across a room? **Scoring: None = 0 Some = 1 A lot , use aids or unable = 2**
Rise from a Chair	How much difficulty do you have transferring from a chair or bed? **Scoring: None = 0 Some = 1A lot or unable without help = 2**
Climb stairs	How much difficulty do you have climbing a flight of ten stairs? **Scoring: None = 0 Some = 1A lot or unable = 2**
Falls	How many times have you fallen in the last year? **Scoring: None = 0 1-3 Falls = 1 4 or more falls = 2**

Total score of 4 or more indicates Sarcopenia.

From Malmstrom TK, Morley JE. *J Frailty and Aging* 2013;2:55-6.

Rapid Cognitive Screen (RCS)

1. **Please remember these five objects. I will ask you what they are later.**
   [Read each object to patient using approx. 1 second intervals.]
   Apple Pen Tie House Car
2. [Give patient pencil and the blank sheet with clock face.]
   This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock. Score 2 points if hour markers ok; 2 points if time correct

What were the five objects I asked you to remember? Score 1 point/each

I'm going to tell you a story. Please listen carefully because afterwards, I'm going to ask you about it. Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.
What state did she live in? Score 1 point if correct

SCORING: 8-10 = Normal; 6-7 = Mild Cognitive Impairment; 0-5 = Dementia

From Malmstrom TK, Voss VB, Cruz-Oliver DM, *et al. J Nutr Health Aging* 2015;19:741-744.

DO YOU HAVE AN ADVANCED DIRECTIVE? YES/NO


Dr. John E. Morley

John Morley, M.B., B.Ch., traveled to Geneva, Switzerland to participate in the World Health Organization Headquarters Experts Meeting, "WHO Knowledge Network on Frailty and Sarcopenia," focused on developing information about future aging around the world.

Cruz-Oliver Developing Palliative Care Resources


Dr. Cruz-Oliver

Dr. Dulce Cruz-Oliver has been selected as one of the ten members of the 2015 Cambria Foundation Sojourns Scholar Leadership Program. Dr. Cruz is focusing her project on developing the first Hospice and Palliative Medicine fellowship program in Missouri and creating the first outpatient clinic for palliative care services in the St. Louis region. Dr. Cruz-Oliver's passion for this work is clear in her statement about this opportunity: "Several factors motivated me to become a doctor. Most importantly, I like to talk to people, especially elderly people with advanced illness. I was inspired by my grandmother who always received sick people in her house where she cared for them with prayers and home remedies, and by my grandfather, who due to prolonged illness, lived in my home where I helped take care of him. Most recently, I have seen a close friend go through cancer and chemotherapy treatment. She encountered many difficulties and challenges, some resulting from the fragmented palliative care services in St. Louis, which caused her and all of us around her to suffer. This program will advance improving care for patients in St. Louis who are being treated for a serious illness" (http://www.cambiahealthfoundation.org/).


Dr. Gammack

Julie Gammack, M.D., who has been serving as Assistant Dean for Graduate Medical Education, has accepted the role of Associate Dean for Graduate Medical Education and Designated Institutional Official. Congratulations to Dr. Gammack!


Dr. Little

Milta O. Little, D.O., is the new director of the Geriatric Medicine Fellowship Program. Dr. Little also presented a poster at the Harvard Macy Scholar Showcase at the Association of American Medical Colleges (AAMC) Annual Meeting in Chicago, IL. Her presentation, "Critical Reflection Transitions of Care" focused on the the medical student education curriculum. Dr. Little was interviewed for Missouri Viewpoints and the link can be found at http://vimeo.com/111945931 with advice for the whole family on how to have those sometimes difficult conversations on arranging care when help is needed for day to day life.

The GEC welcomes the following new faculty to the Division of Geriatric Medicine:


Dr. Kaehr

Ellen Kaehr, MD, has joined the Division of Geriatric Medicine as an Assistant Professor. Dr. Kaehr is a graduate of the Medical College of Wisconsin, completed her residency in Internal Medicine at Indiana University School of Medicine, and is an alumnus of the Saint Louis University School of Medicine Fellowship in Geriatrics. She is certified by the American Board of Internal Medicine in Geriatics.


Patricia Abele

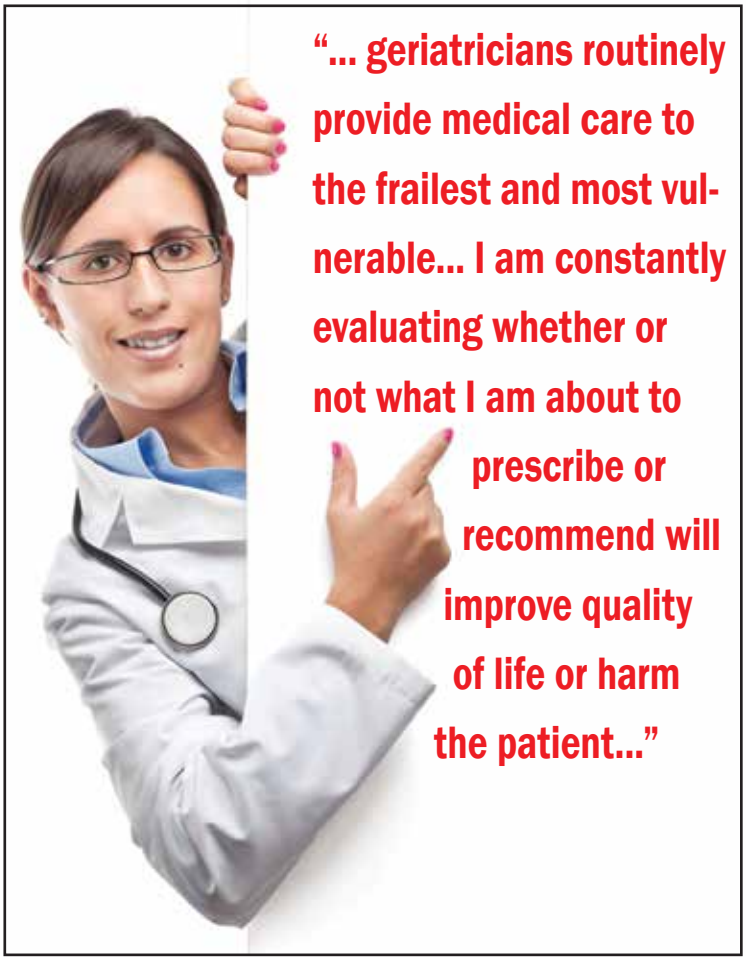
Patricia Abele, MS, RN, FNP-BC, received undergraduate and graduate nursing degrees and post-Masters training in Family Nurse Practice at the University of Missouri. Prior to joining the geriatrics faculty at Saint Louis University, Patty's experiences include long term care, cardiology, and heart transplant services. As a member of the geriatrics faculty, Patty is working in the residential care facilities and with the GWEP project.

On October 31, 2015, the Division of Geriatric Medicine held the 5th Annual Geriatric Boot Camp. This is a free half-day workshop for residents throughout the community interested in geriatric medicine and possibly a geriatric medicine fellowship. For information on the upcoming Boot Camp scheduled for October 15, 2016, please call 314-977-8462 or e-mail Sue Brooks at brookssa@slu.edu.

A PEP TALK FOR GERIATRICIANS

By Angela Sanford, MD

One day, shortly after becoming a geriatric attending physician and when my white coat was still bright white and without pen stains on the front pocket, I was in the doctors' lounge of a private community hospital when a surgeon approached me. He introduced himself as "Dr. Important Surgeon" and asked me when I would be completing residency (strike one against "Dr. Important Surgeon"). The geriatric fellow who was working with me angrily responded, "This is my attending! She is done with her training!" Completely perplexed, he asked why I liked geriatrics and I went into my usual spiel about the medical care of older patients being a challenge and how much I enjoy working with the older patient population and their families, particularly in the nursing home setting. He responded shamelessly with, "I thought only doctors who couldn't get jobs worked in the nursing home!" and then proceeded to hand me his card and say that he would be happy for any referrals that I sent his way (strike two against "Dr. Important Surgeon"). Being the passive-aggressive individual that I am and not knowing how to express my anger in an appropriate way, I walked over to the trashcan and ripped up "Dr. Important Surgeon's" card directly in eyesight.



I have never forgotten that day and luckily, have never run into "Dr. Important Surgeon" again. I assume he is still walking the halls of the operating room ignorantly believing that nursing home physicians are the "reject doctors," last in their medical school class, who were unable to match into any other specialty. Have you ever heard anyone say to an interventional cardiologist, "Wow, I am shocked you would ever choose that field! I guess you weren't good enough to do anything else?" No, of course not, because that would be absurd!

Had I recovered quicker from my shock on that pivotal day, I would have informed this physician of the importance of my specialty. Namely, that geriatricians routinely provide medical care to the frailest and most vulnerable patient population. It takes a very special skill set to manage numerous complex medical comorbidities, all while weighing the risks and benefits of each intervention. I am constantly evaluating whether or not what I am about to prescribe or recommend will improve quality of life or harm the patient, and more often than not, there is a fine line between the two. To add complexity, our patients do not fit into our most popular treatment algorithms because they are not the healthy 50-year-olds enrolled in the studies that were used to formulate the algorithms. I would undoubtedly cause harm if I treated every older patient's blood pressure to 120/80 mmHg and started him/her on a statin because of a remote history of a myocardial infarction 30 years ago.

Another pet peeve that I have encountered on numerous occasions is the sentiment that a fellowship in geriatrics is not particularly useful because other specialties (*i.e.*, internal medicine or family practice) treat older adults. Yes, that may well be, as the supply of geriatricians cannot meet the demand, but I

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guarantee that there are specific issues and conditions that geriatricians are better at diagnosing and managing. Take falls, for instance. What other specialty treats falls as well as we do? Geriatricians understand that falls are multifactorial and have the skills to comprehensively evaluate gait, balance, lower extremity strength, polypharmacy, orthostasis, possibility of cardiac arrhythmia, and the numerous other factors that contribute to fall risk. Patients who are falling have been referred to me when "no doctor could fix mom's falls," and have been able to markedly decrease falls and fall risk by checking a simple orthostatic blood pressure or stopping nighttime Benadryl®. Granted, it is not always that easy, but when it is, I might as well wear my batman cape instead of my white coat because I feel like a superhero doctor.

Similarly, consider dementia. Yes, probably any specialty could perform a screening test and diagnose dementia, but I think geriatricians develop a sixth sense to detect cognitive issues and the ability to work up potential contributing factors and causes in a comprehensive manner. Just last week, a patient was referred to me for "Alzheimer's disease." I did a simple screening for depression and out of fifteen questions, she answered positively on thirteen of them. She was severely depressed and I am sure that this depression is contributing to her "Alzheimer's disease." We put a plan in place to begin treatment for depression with an antidepressant and cognitive behavioral therapy and I look forward to administering another cognitive screening test in the future. This patient had seen numerous doctors and had not been diagnosed with depression by any of them. Again, roll out the superhero cape because geriatricians are superheroes!

As geriatricians, we need to unite and spread the word about how important we are. We are too meek and humble and allow others to underestimate our abilities to truly improve patient care in our older population. Yes, most physicians can care for older adults, but we do it better! Our Geriatrics Division at Saint Louis University had the fortune to film a 30-minute special with our local television news station earlier this year that featured three members of our department*. We provided the basics of geriatric care and the reasons we are "super-specialized specialists." Since that airing, we have had hundreds of calls from older adults and their families seeking comprehensive geriatric assessment.

Based on these results, it is imperative that we lobby for the mainstream geriatric health societies to advertise and advocate on our behalf. The general population, as well as other physicians, have little understanding of the advantage we can provide. As patients and physicians begin to see our inherent value, more medical students and residents will become interested in the field.

In addition to increasing recruitment efforts is, of course, increasing reimbursement from Medicare and other health care insurers, but that deserves a commentary article of its own and would require changing an entire culture.

In summary, geriatricians need a pep talk. We need to rally and exclaim in droves that we are the best at caring for older adults. While most of us truly believe this in our hearts, we let others' misperceptions cloud our own self-worth. We are part of one of the most fulfilling specialties and it is time for us to tell others how important we are!

*To view the KMOV special, "The Science of Healing," visit www.aging.slu.edu.

Who's Hearing *Their* Voices?

Attending to the Needs of Dementia Caregivers

By Max Zubatsky, PhD, LMFT and Sue Tebb, PhD, MSW, RYT-500

Entering her 70s, Joyce never thought that life would be this demanding after retirement. Working as a paralegal for much of her life, she was ready to enjoy this new phase without the daily grind of work to stress her. Her upcoming trips with friends to South America and Europe were all planned. Joyce was also excited to get back to crafting and photography classes. She could finally spend more time seeing her young granddaughters who live only two hours away. Unfortunately, her plans were dramatically changed. Over the next six months, Joyce's husband, Joe, started weekly to misplace multiple items in the home and lost track of the location of his parked car. Joyce was also concerned with Joe's new problems in which he had difficulty verbalizing thoughts or writing complete sentences. Joe was a long-time accountant and took pride in ordering his life based on numbers and calculations of tasks. After a series of memory tests administered by their physician, Joyce and Joe were told that he had early-stage Alzheimer's disease. Joyce was given few resources from Joe's care team and was directed to monitor his new dementia medications.

Throughout the first few years of Joe's disease, Joyce received very little support from family and friends, most of whom lived out of town. She was never asked by the medical team about Joe's condition or her own overall health and wellness. As time went on, Joe's muscle strength started to decline. Joyce sacrificed thousands of hours taking Joe to appointments, making meals, dressing and bathing him,

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and transferring him from the chair to the bed and back. She came to the stark realization that "this is going to be the road for the rest of my life."

Joyce's story is all too familiar. Family members and close friends often follow similar struggles and challenges in the early years of their caregiving role. After a diagnosis of dementia is received, primary caregivers are often left alone wondering, "Where do I even go from here?" Instead of transitioning into a "non-work" role during one's empty nest years, later life caregiving places individuals in a new full-time job for which they received no training or preparation. When caregivers are faced with these daunting tasks of attending to their loved one's daily living needs, the motivation to attend to their own needs and find meaning in their lives is often diminished or even lost. Had the care team included Joyce as a member of the team and helped support her through this initial phase, providing her with the necessary resources and tools, the pain of this journey may have been slightly alleviated. Now, the question becomes: who will take care of Joyce if her emotional and physical health starts to decline as well?

Family caregiving for persons with a dementia diagnosis has become more commonplace in the United States. An estimated eighty-five percent of unpaid caregivers who provide services to a diagnosed individual are family members.[1] These caregivers often want to be the primary mode of assistance because 1) they (and others) desire to keep the family member in the home, 2) the proximity they have to the person, and 3) the perceived obligation they have to help the parent, partner or spouse.[2] As those suffering from the disease are living longer, increased strains regarding finances, medication management, assistance with activities of daily living, and medical appointments often overwhelm first time caregivers. These constant sacrifices for a loved one can frequently and quickly take a toll. Long term dementia caregivers have increased risk of facing emotional, medical or financial hardships along the way.[3]

Health care professionals have found the care management for those with dementia harder than most chronic health conditions[4] with several unpredictable demands and challenges regarding symptoms and disease management for both the patient and family.[5,6] Primary care providers have particularly difficult challenges with this diagnosis, considering that dementia is just one of hundreds of diagnoses they make in routine care of patients. Diagnoses often go undocumented in the patient's chart or misdiagnosed based on a limited amount of assessment from the patient.[7] Little is known about the way in which physicians deliver effective care to dementia patients and work with families around the patient's cognitive symptoms and medication management.[8] Many providers even sidestep the conversation of dementia with families, fearing negative reactions or a lack of trust in their diagnosis of the patient.[2] With these important conversations lacking during medical appointments, caregivers are left unsure as to the road of their loved one's health moving forward.

Healthcare providers should consider the following questions when working with dementia caregivers following a family member's diagnosis:

How much does the caregiver know about the diagnosis and term dementia?

Many times, caregivers are lost and unprepared when attempting to identify signs and symptoms in a loved one following a physician's diagnosis.

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What level of stress is the caregiver going through? Caregivers vary considerably in the levels of stress they can endure during the initial phase of the disease. Low tolerance of stress for caregivers can often lead to poorer health outcomes for both themselves and their loved ones over time.

What is the reaction of the caregiver following the delivery of a diagnosis? While some caregivers may have predetermined a diagnosis of dementia in their mind, others can be taken back even intimidated by the words "dementia," "Alzheimer's" or Parkinson's disease."

Does the caregiver have outside support through family, friends, and other resources? An overlooked aspect of caregivers' strain is the lack of outside support from immediate or extended family. Those who assume all of the formal caregiving responsibilities are prone to enduring significant strain and sacrifices in the quality of their own lives.

Is the caregiver going through her or his own life issues (work, mental health, physical health, or family circumstances)? Dementia caregiving is, in itself, a full-time job that requires a significant amount of sacrifice for loved ones. Detecting any barriers or challenges in the caregiver's life can be valuable for physicians and other professionals when directing individuals to referrals and resources.

Currently, there are two focus group studies in the Saint Louis University Department of Medical Family Therapy and the School of Social Work that are aimed at exploring the experiences and well-being of dementia caregivers. In one study, the format of these groups is centered on what medical, mental health, and community resources caregivers have utilized and their perceptions of the journey caring for a loved one with dementia. Participants are being asked to report personal challenges and frustrations with their medical team (physicians, geriatricians, nurses, and other professionals) regarding the overall dementia care for the patient and caregiver. The second study is examining the use of available and supportive caregiving resources by health care providers and caregivers, specifically under-utilization and existing barriers to use. For more information on these projects, contact Dr. Zubatsky at zubatskyjm@slu.edu.

> "Dementia caregiving is, in itself, a full-time job that requires a significant amount of sacrifice for loved ones."

The Gateway Geriatric Education Center (GEC) has several projects that are striving to address the needs of dementia caregivers at all stages of the disease. "Caregivers Like Me" helps Latino caregivers find strategies through the support of health care workers to keep their loved ones in their homes longer. Developed by Dr. Dulce Cruz-Oliver, the curriculum is available in English and Spanish on the GEC website http://aging.slu.edu.

An innovative approach to improve memory and cognitive ability for individuals with dementia, called "Cognitive Stimulation Therapy," has been implemented in several medical clinics, residential care facilities and community centers in the area. Professionals are now seeking ways to include caregivers in these groups, further impacting the cognitive capacity and physical mobility of individuals with dementia. Lectures, seminars, and geriatric activities are provided by GEC faculty on a local and national level to highlight strategies for coping, prevention of burnout, and assistance of loved one's needs. More information for both dementia caregivers and healthcare professionals can be found at the GEC website at: http://aging.slu.edu.

If providers are going to curb the stress and burnout being experienced by dementia caregivers, intervention at the initial diagnosis is critical. Caregivers are often the best reporters of "early warning signs" for their loved one's condition and must be listened to more closely at appointments and made

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Geriatric Workforce Enhancement Program Announces 2016 Geriatric Leadership Scholars

The Geriatric Workforce Enhancement Program (GWEP) provides the opportunity for three faculty each year to be selected from colleges and universities across Missouri to participate in the Geriatric Leadership Scholars Program. This GWEP initiative is aimed at developing competent gerontology faculty who have the skills to teach and assess students is key to improving future care for older adults and to develop healthcare faculty with expertise in geriatrics and gerontology, the Geriatric Leadership Scholars Program provides support for these health care faculty to enhance their geriatric knowledge and skills. Scholars participate in and lead GWEP education events. Each of the Scholars are paired with a Gateway GEC Faculty Mentor who works with the Scholar throughout the year to address teaching, research, and program development issues.

The 2016 Geriatric Leadership Scholars include:

James Zubatsky, Ph.D., LMFT, is an Assistant Professor in the Saint Louis University School of Medicine, Department of Family and Community Medicine Medical Family Therapy Program. Dr. Zubatsky's research and clinical interests include: family caregiving, geriatrics, community health issues and disparities, collaboration in primary care, couples therapy, chronic illness in families, and hoarding disorders. During his time in the Leadership Scholars Program, he is working with GWEP faculty in the Caregiver Support and Cognitive Stimulation Therapy Initiatives.

Cara Wallace, Ph.D., MSW, is an Assistant Professor in the Saint Louis University School of Social Work. Dr. Wallace's research, teaching, and clinical work focuses on hospice and end-of-life care, family communication, barriers to care, and healthcare decision-making. During her Scholar experience, she is working with Drs. Dulce Cruz-Oliver and John Morley to conduct research and training in these areas.

Olaide Sangoseni, PT, DPT, MSc, PhD, is an Assistant Professor of Physical Therapy at Maryville University in St. Louis. Dr. Sangoseni has research and clinical activities in the areas of: evidence-based physical therapy practice, health disparities and active aging issues, health promotion and wellness, physical therapy practice advocacy, and manual therapy approaches to management of musculoskeletal conditions.

Applications are accepted each year of the GWEP project. If you are interested in learning more about the program, contact Marla Berg-Weger, Gateway GEC, bergwm@slu.edu or 314/977-2151.

Visiting International Scholars

The Division of Geriatric Medicine hosts three visiting international scholars

Dr. Li Cao is spending a year with the Saint Louis University Geriatrics Division working with faculty and staff. A graduate of the Sichuan University Medical School, Dr. Cao is an attending physician at the Center of Gerontology and Geriatrics, Est China Hospital, Sichuan University in China. While serving as a visiting scholar at Saint Louis University, Dr. Cao is working on developing her knowledge of geriatric educational program is engaged in research on the treatment of depression.

Dr. Li Cao arrived in the Geriatrics Division June 2015 and will stay through May 2016. Her hospital, which has over 4,000 inpatient beds and has over 2 million outpatient visits per year, was ranked #1 by

Dr. "Alex" Shum (l) and Dr. Li Cao (r)

the Chinese Academy of Medical Sciences, Institute of Medical Information in the annual Chinese hospital technology influence.

Dr. Li Cao is studying several aspects of health care and systems of care for older adults in the U.S., which she plans to develop when she returns to her hospital. Her areas of study include Acute Care of the Elderly (ACE) Units, Delirium Rooms, Ortho-Geriatrics Hip Fracture Services, Palliative Care, Hospice Care, Skilled Nursing and Rehab Care, Outpatient Geriatric Assessment, and Home Care.

While in St. Louis, Dr. Li Cao is involved in the following research projects: Association of Depression and Mortality in African American Health study (with Dr. Morley and Dr. Malmstrom), Association of Cytokine Levels and Depression in African American Health study (with Dr. Morley and Dr. Malmstrom), Rapid Geriatric Assessment in Older Patients with Cancer (with Dr. Morley and Dr. Tu), An Exploratory Study to Evaluate Family Members a A Source of Important Clinical Information for Older Patients with Geriatric Syndroms (with Dr. Flaherty and Pinwen Chen), Clinical Outcomes of Older Adults Admitted to Hospital (with Dr. Flaherty and Dr. Shum), Metformin and Reduced Risk of Dementia (with Dr. Malmstrom and Dr. Scherrer), and the Cochrane systematic review "Pioglitazone for Adults With High Risk of Developing Type 2 Diabetes " (with Dr. McKee and other Chinese authors).

• • •

Dr. Chun "Alex" Keung Shum was with the Saint Louis University Division of Geriatrics from October – December, 2015. He is a geriatrician from the Department of Medicine and Geriatrics, Tuen Mun Hospital in Hong Kong. He also studied several aspects of health care and systems of care for U.S. elders, including Acute Care of the Elderly (ACE) Units, Delirium Rooms, Ortho-Geriatrics Hip Fracture Service, Palliative Care, Hospice Care, Skilled Nursing and Rehab Care, Outpatient Geriatric Assessment, and Home Care. His research included a quality improvement project on immobility of hospitalized patients and started a research project on the effectiveness of older patients on the ACE Unit.

• • •

The Council for International Exchange of Scholars awarded **Sandra Maria-Lima Ribeiro, Ph.D.,** a Fulbright Scholarship. Dr. Ribeiro, an Associate Professor at the University of Sao Paulo, Brazil, served as a visiting scholar in the Division of Geriatric Medicine in late 2014 where she organized the "Update on Nutrition in the Nursing Home" conference. Her focus of study is "Sarco-osteopenia and Sarcopenic Obesity in African-Americans, Prevalence and Relationship With Biological and Socio-economic Variables. **John Morley, M.B., B.Ch.,** served as her Faculty Associate at Saint Louis University. ■

Transforming Geriatric Care

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in one-on-one consultations, group sessions and online.

- **Teaching 220 health care professionals how to deliver a non-drug treatment for Alzheimer's disease and related disorders called Cognitive Stimulation Therapy**

Developed in the UK, cognitive stimulation therapy is a low-cost, non-pharmaceutical intervention for those who have dementia that has been proven to be effective. The themed seven-week support group engages and stimulates those who have dementia. It will be taught at all training sites that are part of the project and to nursing, social work, occupational therapy, medical, communication disorders and exercise science students.

Building on Success

The new project builds on the strengths of SLU's Gateway Geriatric Education Center, which had been funded by HRSA for over 22 years to develop cutting edge education for current and future geriatric professionals. The Gateway GEC has trained tens of thousands of public groups, students and professionals across the region and country.

"We know this community very well, and the grant allows us to deepen and extend our previous impact with a new, broader focus," says Berg-Weger. "Through our work in the primary care clinical setting, we will be able to reach a larger number of students, professionals, direct care workers, older adults and their support networks."

Morley said faculty, collaborating and community partners and other universities enthusiastically accepted the invitation to participate in the new initiative.

"They're excited to work with us to deliver quality care for older persons and develop human relationships for care and healing," Morley said. "Our new project presents an opportunity to make transformative change in geriatric care and education." ■

Their Voices?

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part of the active health care team. Keeping caregivers emotionally and physically healthy is of utmost importance; providers need to continue to assess and screen for any risk factors with both the patient and the care provider during these visits. Training in health professions will greatly benefit medical care professionals early in patient and family care around neurodegenerative diseases. Considering dementia as a systemic disease, our healthcare system can focus on those closely connected to the lives of patients. The well-being and quality of life of dementia patients is only as good as the ones providing care for them. Otherwise, the next generation in our country will be forced to assume the role of "caretakers of the caregivers."

References

1. Gitlin LN, Schulz R. Family caregiving of older adults. In: Prohaska RT, Anderson LA, Binstock RH, eds. Public health for an aging society. Baltimore, Md.: *The Johns Hopkins University Press*;2012:181–204.
2. Alzheimer's Association (2015). 2015 Alzheimer's Disease Facts and Figures. Retrieved on February 18, 2016 from: www.alz.org/facts
3. Papastavrou E, Kalokerinou A, Papacostas SS, Tsangari H, & Sourtzi P. Caring for a relative with dementia: family caregiver burden. *J of Adv Nursing* 2007;58(5):446-457.
4. Harris DP, *et al*. Primary care providers' views of challenges and rewards of dementia care relative to other conditions. *J Am Geriatr Soc* 2009;57:2209-2216.
5. Fortinsky RH, Zlateva I, Delaney C, *et al*. Primary care physicians' dementia care practices: evidence of geographic variation. *Gerontologist* 2010;50:179-191.
6. Pimlott NJ, Persaud M, Drummond N, *et al*: Family physicians and dementia in Canada: Part 1. Clinical practice guidelines: awareness, attitudes, and opinions. *Can Fam Physician* 2009;55:506-507.
7. Boise L, Neal MB, Kaye J. Dementia assessment in primary care: results from a study in three managed care systems. *J Gerontol Series A: Biological Sciences and Medical Sciences*. 2004;59(6):M621-M626.
8. Fortinsky RH, *et al*. Primary care physicians' dementia care practices: evidence of geographic variation. *Gerontologist* 2010; 50(2): 179-191. ■

Upcoming Continuing Education Programs

27th Annual Saint Louis University Summer Geriatric Institute

Geriatrics in Practice

June 6-7, 2016
St. Louis, Missouri USA

For more information, call 314-977-8462.

For registration information, visit aging.slu.edu

Barcelona

Aging Successfully

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Moving?

So you won't miss an issue, please send your new email address or mailing address to aging@slu.edu.