

# Aging SUCCESSFULLY



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## Age-Friendly Communities and Health Systems

*John E. Morley, MB, BCh*

In 2004, the World Health Organization (WHO) created the concept of age-friendly health care. The purpose of this movement was to enhance the care of older persons by educating health professionals about the specific differences in health care for older persons and how to adapt health management to the

needs of older persons. The focus was on developing community-based health care systems specifically for older persons and improve the environment and accessibility. They specifically wanted to fight against ageism in the way the older person was treated. They

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## Age-Friendly Communities and Health Systems

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felt these age-friendly principles could be created by enhancing the education and training of health professions.

In 2006, the WHO recognized that improving care for older persons required a broader perspective and they began to promote age-friendly communities globally. The core component of these communities was for older adults to have respect and social inclusion and the opportunity to continue to work if they wished to do this. The other components included quality communication and information on age-related issues, social participation, improvement of the environment and aging-friendly transportation, outdoor recreation spaces and building accessibility and age friendly health services.

More recently, the WHO felt that maintenance of resilience as we age is a major need. To this end, they developed the “Integrated Care for Older People” (ICOPE) program. This program calls for focusing on:

- Improving mobility and decreasing falls
- Maintenance of sight and hearing

- Prevention of cognitive decline
- Promotion of happiness
- Appropriate management of age associated conditions, e.g., urinary incontinence
- Carer support

The John A. Hartford Foundation has introduced Age-Friendly Health Systems in the United States. They have used the slogan 4Ms:

- What **MATTERS** to the individual
- **MOBILITY** and decreasing falls
- Improving **MENTATION**
- Appropriate **MEDICATION** use

The key to their approach is to determine what an older individual with multiple comorbidities would like to be able to undertake and work towards helping her meet these goals. This also includes having an advance directive plan and when necessary access to high quality palliative care. Working with the Institute for Healthcare Improvement they have developed a certification program for health programs that follow these guidelines.



# Age-Friendly Communities and Health Systems

(continued from page 2)

With our Geriatric Workforce Enhancement Program (GWEP) at Saint Louis University, we have developed a highly successful age-friendly education program. Our program has been established in inner city and rural areas. It is based on screening older persons with the Rapid Geriatric Assessment (RGA) which includes screens for frailty (FRAIL), sarcopenia (SARC-F), anorexia of aging (SNAQ), cognitive function (RCS) and advance directives. Most recently, we have added a screen for loneliness *i.e.*, ALONE scale (see pages 12-13). This screening

has been incorporated into the Medicare Annual Wellness Visit. Depending on the results of each of these screenings, we have educated health professionals to look for treatable causes, *e.g.*, for fatigue

## What **MATTERS** to the individual **MOBILITY** and decreasing falls Improving **MENTATION** Appropriate **MEDICATION** use

hypothyroidism. We have also helped the centers develop specialized programs such as Cognitive Stimulation Therapy for moderate dementia, group exercise programs for sarcopenia and the “Circle of Friends” for persons who are lonely and/or socially isolated.

We are now extending these health programs into their communities to create age-friendly communities. In hospitals, we are involved in developing age-friendly hospital systems. This includes exercise in acute care, getting persons out of bed, Delirium Intensive

Care Units, Acute Care for the Elderly systems, orthogeriatric services and the Help program. We have adapted the Rapid Geriatric Assessment together with the 4AT screen for delirium and an opioid screen for older persons to create an age-friendly emergency department.

Working with nursing homes, we have reduced unnecessary hospitalizations, utilized the FRAIL-NH to identify persons who will benefit from palliative care, used an opioid/PAIN scale to determine whether patients are getting appropriate pain relief and the ALONE scale to determine who needs to be in a “Circle of Friends.” About 10% of our nursing home residents are desperately lonely. Persons with moderate dementia can be involved in Cognitive Stimulation Therapy. Most importantly, we have focused on meaningful activities such as “dancing with the STARFS” and BINGO-cise as well as developing a SNOEZELEN room.

Overall, Age-Friendly Health Systems not only improve the clinical care of older persons, but, most importantly, enhance the quality of life of individuals in these programs. To learn more about becoming an Age-Friendly Health System, please contact Marla Berg-Weger at marla.bergweger@slu.edu.

The image shows a sample of the Saint Louis University Rapid Geriatric Assessment form. It includes sections for demographic information, FRAIL questionnaire, SARC-F screen for sarcopenia, SNAQ (Simplified Nutritional Assessment Questionnaire), and Rapid Cognitive Screen (RCS). The form also includes scoring instructions and a section for advance directives.

# EDITORIAL

Aging  
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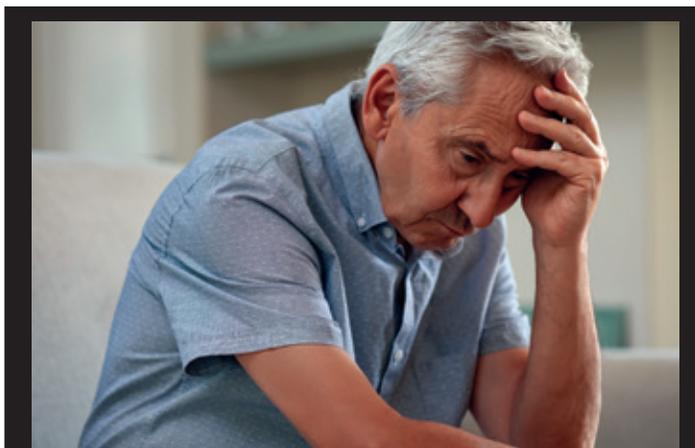
## Loneliness

Loneliness is not a new problem. It is a newly recognized problem. Severe loneliness occurs in 33% of persons younger than 25 years of age to 11% for persons over 65 years of age. Persons who are lonely are more likely to visit a doctor, have emergency department visits, and hospitalizations. Lesser levels of loneliness occur in 25% to 30% of older adults.

Persons who are lonely tend to have a higher number of illnesses and diseases. These include depression, sleep disturbances, cardiovascular disease, hypertension, stroke, emotional problems, substance abuse, dementia, and Type 2 diabetes. Loneliness also results in an increase in mortality and is considered to be at least as dangerous as smoking.

There are four major causes of loneliness in older persons:

- Physical isolation due to mobility impairment, comorbidity, and poverty
- Isolation due to emotional problems (e.g., depression).
- Isolation due to death of a spouse/partner or the



“The most terrible poverty is loneliness and the feeling of being unloved.”

*Mother Theresa*

spouse/partner going into residential care

- Loneliness due to an inability to make or keep friends which may be the result of shyness or poor social skills which can serve to alienate others.

All older patients seeing a health care provider should be asked if they are lonely. This question should be posed to patients in the hospital, out-patient setting, and residential care

facilities. We found that 10% of persons in skilled care facilities are severely lonely. We have developed a rapid scale to assess loneliness, ALONE (see page 12 for a copy of the scale).

All persons who are lonely should be screened for depression. We recommend the PHQ9. If positive (*i.e.*, score <15), they should be referred for clinical services, considered for pharmacological treatment, and/or transcranial magnetic stimulation or electroconvulsive therapy. If the patient reports fatigue, a diagnosis of sleep apnea or restless legs syndrome should be considered.

For most persons who report feeling lonely, group interventions can be effective in alleviating loneliness and/or social isolation. Developed in Finland, one such group is the evidence-based “Circle



*John E. Morley, MB, BCH (continued on page 18)*



# Moving Past the Fear of Falling

By Debbie Blessing  
GWEP Coordinator  
A.T. Still University



An unintentional fall can be a frightening experience for anyone, but for an older adult it can result in a broken bone, head injury, or just the fear of falling, all of which can lead to reduced physical and social interactions and loss of independence. Each year, millions of adults 55 years and older experience an unintentional fall in the United States, making falls a leading cause of injury for those living independently (Chen et al., 2019, Haddard et al., 2018). In 2015, U.S. healthcare costs for fall-related injuries and deaths of adults 65 years and older totaled more than \$50 billion dollars and with 10,000 people turning 65 years old every day the costs could reach nearly \$67 billion by 2020. In a 2018 report, Stevens &

Lee note that healthcare costs can be averted by implementing evidence-based fall interventions in clinical settings, including medication review, identifying balance, and gait disorders and previous falls, vision impairment, and environmental hazards. The report concludes that U.S. healthcare providers who implement fall interventions have the potential to reduce the number of falls for older adults and significantly contain Medicare and Medicaid costs.

Here is what we know about falls: they are common, predictable, and preventable. It is equally important to note that falls are not an inevitable part of aging. There are a number of risk factors that make one more susceptible to falling. According to

the CDC, one of the best predictors of future falls is a previous fall. In fact, “falling doubles your chances of falling again” (Cost of Falls Among Older Adults, 2019). Other risk factors include lower body weakness, poor balance and gait, vision problems, and the fear of falling. Boyd & Stevens (2004), note that “falls and the fear of falling are interrelated problems; each is a risk factor for the other. Many older adults who fall, whether or not they sustain an injury, develop a fear of falling that may lead to restricted activity, a decline in social interactions, depression, and an increased risk for falling” (p. 524).



(continued on page 6)

# Moving Past the Fear of Falling

(continued from page 5)

In this article, I share the stories of two northeast Missouri women who attended A Matter of Balance: Managing Concerns about Falls (MOB) workshops in their communities and how the program helped them address their fear of falling and improve their physical activity. I will highlight A. T. Still University's training program for health professions students on the importance of screening for fall risks.

"Vera" moved to a small rural community in northeast Missouri less than six months ago with her husband. She is in her mid-80's and has fallen several times in the past. Prior to moving to Missouri, Vera lived near Washington D.C., and participated in a robust exercise program three days a week; something she missed a great deal after moving. Once she and her husband settled into their new apartment, Vera began seeking new opportunities to become more physically and socially engaged. Late in the fall of 2019, the housing community where Vera and her husband live offered the MOB program, and Vera promptly enrolled them both.

Vera has several chronic conditions for which she takes medications; one of those conditions being neuropathy in her feet. According to the Mayo Clinic, peripheral neuropathy can include weakness, numbness, tingling, and pain in the feet and hands

(Peripheral neuropathy - Symptoms and causes, 2019). Due to the neuropathy in her feet, Vera fears falling on a daily basis. She is not always able to feel her feet and often

down to watch her feet; therefore, she is not able to keep her head up and look forward, which affects her balance.

"Lori" never dreamed that she would suffer from chronic and debilitating knee pain in her fifties. She found herself becoming less mobile and more dependent on others. The pain she experienced left her unable to do the things that she enjoyed most, such as taking care of her grandson. Lori was frustrated and embarrassed by her circumstances, which directly affected her quality-of-life. In the spring of 2019, Lori had double knee replacement surgery and proceeded to work with a physical therapist for six months after her surgeries, but as she neared the end of her rehab, she continued to experience muscle weakness, poor balance, and the fear of falling. In Chen *et al.*, (2019), "a high level of fear of falling after surgery can also reduce self-efficacy, or one's perception of their ability" (p. 2). With Lori's diminished confidence, a friend referred her to the MOB class

(continued on page 7)



Matter of Balance group in Northeast Missouri

is not able to recognize changes in terrain. She admits that when walking she is generally looking



Matter of Balance group in Northeast Missouri



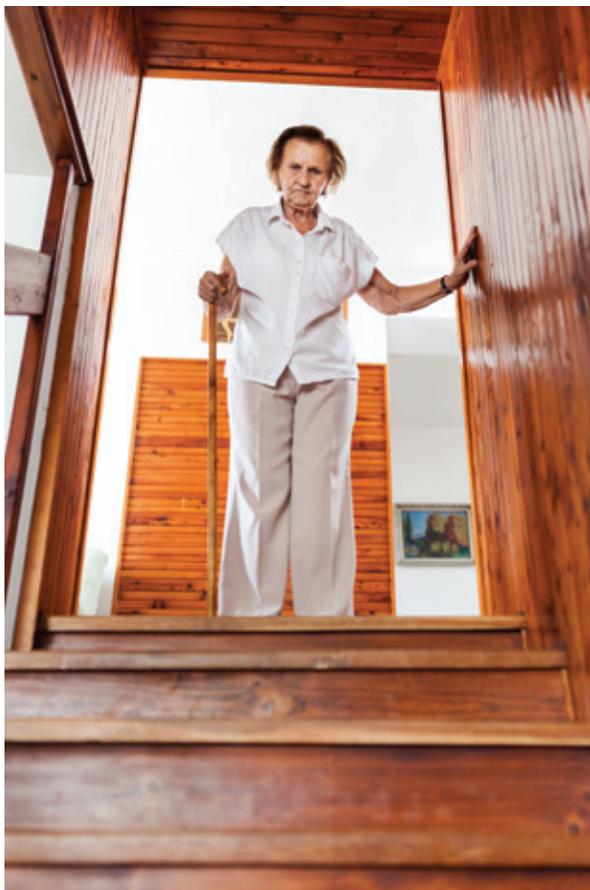
## Moving Past the Fear of Falling

(continued from page 6)

their local community and Lori made the decision to attend the MOB class to see if attending would benefit her.

MOB is an evidence-based program led by health professionals that was developed at the Roybal Center for Enhancement of Late Life Function at Boston University. In 2003, four Southeastern Maine private and public entities were awarded an Administration on Aging grant to develop a lay leader model for MOB (Healy et al., 2008). To date, MOB continues to be delivered by using the lay leader model and is currently offered in 46 states, Puerto Rico, and the Dominican Republic. For more information on MOB, visit: <https://mainehealth.org/healthy-communities/healthy-aging/matter-of-balance>

The program is designed to identify practical ways to reduce fall risks, increase confidence, and improve physical strength and balance. The eight two-hour classes provide group participants the opportunity to examine their thoughts and beliefs about falling. Through group discussion and skill building activities, participants learn to shift their negative thoughts about falls to more positive ones. Group members learn to recognize that fear of falling is a real and shared concern, that physical inactivity can enhance this fear, and that each person has a responsibility to recognize and decide to change their thoughts and behaviors. With each session, new fall risks topics are introduced including postural hypotension (low blood pressure), leg weakness and poor flexibility, assertiveness, and how to develop a plan of action to continue exercising, once the class is completed.



Vera and Lori did not attend the same MOB classes, yet they both walked away from the program with valuable skills and increased confidence. At the last session, Vera shared a story about how she had nearly fallen, a few days before, when walking in the hallway of their apartment complex. She attributed not falling to putting into practice what she learned in the MOB class including being more careful, taking time to think, and examining her environment. She also acknowledged that her balance was much improved.

Lori stated that by participating in the MOB class, she gained practical information and solutions to address her fear of falling. She is now able to care for her grandson which she was not able to do previously. Lori, like Vera, states that she realized she had to slow down and think about what she is doing. She

went on to state that since her surgeries, therapy, and the MOB class, she has a better quality-of-life, a decreased fear of falling, and greater confidence. Lori has added motion to her everyday life and is working on living a healthier lifestyle.

The A.T. Still University Area Health Education Centers (ATSU AHEC) Program office in Kirksville, Missouri offers a number of evidence-based community programs designed to improve the health and well-being of older adults and reduce fall risk factors. MOB is only one of the programs offered in an eight-county region in northeast Missouri. As a follow-up to the MOB program, the Northeast Regional Arthritis Center, housed in the ATSU AHEC Program office, offers exercise/walking programs and PACE (People with Arthritis Can Exercise) classes.

In addition to the community-based efforts being made at ATSU to address the public health burden of unintentional falls, all first-year medical students are trained prior to their summer clinical immersion experience to assess a patient's fall risk by administering the Saint Louis University's Rapid Geriatric Assessment (RGA), which screens for frailty and loss of muscle mass (sarcopenia) (Morley et al., 2017). Through the Interprofessional Health Partners (IPHP) program, ATSU students are educated about the importance of screening patients. ATSU first- and second-year medical and dental students are paired with health professions students from Truman State University (TSU), placed on teams of two or three, and assigned a volunteer patient to work with

(continued on page 18)

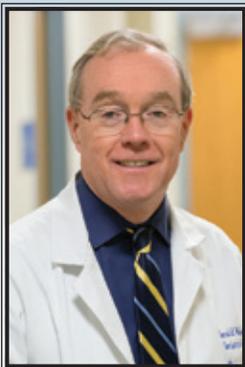
# SLU Geriatricians Recognized Best Doctors 2019

Congratulations to the Saint Louis University Division of Geriatric Medicine physicians who were recognized as Best Doctors of 2019. The Best Doctors list includes more than 1,000 physicians, chosen by their peers. SLU Geriatricians honored include:

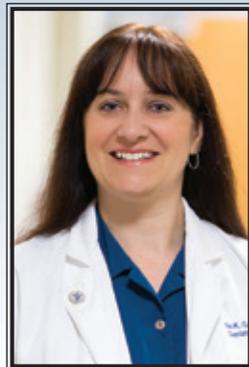
 Best Doctors®



Dr. John E. Morley



Dr. Gerald Mahon



Dr. Julie A. Gammack



Dr. Angela Sanford



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would like to congratulate

**CARA WALLACE**

PhD, LMSW, APHSW-C

for her honor as a recipient of the **Excellence in Psychosocial Research award** at the 2020 Social Work Hospice and Palliative Care Network's (SWHPN) Annual Assembly. It is wonderful to see others recognize the excellence that we at SLU so appreciate in you!



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*SLU Geriatrics is always on the move. Keep up with us!*

Find us on  [facebook.com/GatewayGEC](https://facebook.com/GatewayGEC)

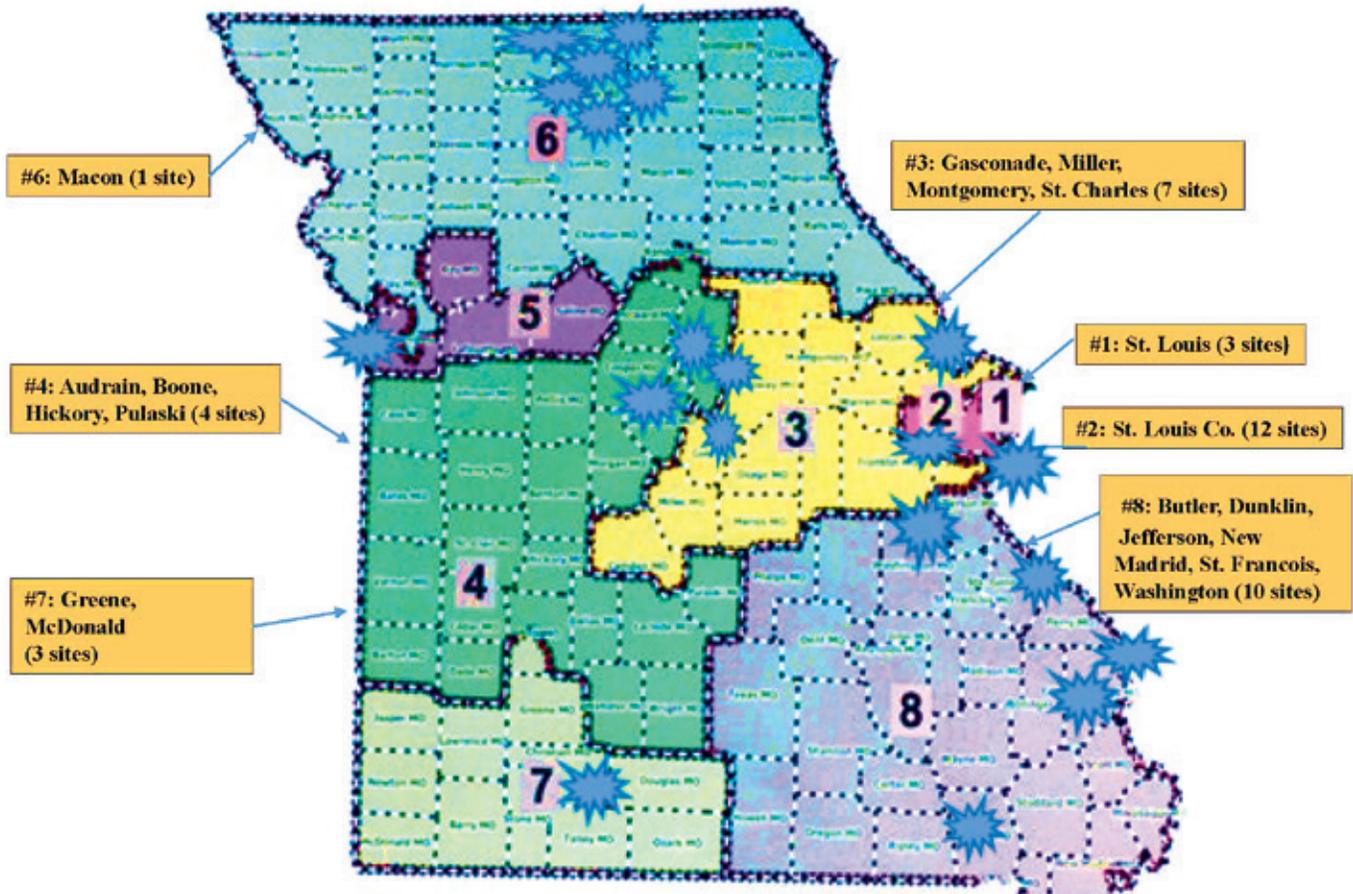


@GatewayGEC  
@meddocslu



<http://www.youtube.com/c/GatewayGeriatricEducationCenterstl>





# Gateway GEC Receives Funding to Continue Geriatric Workforce Enhancement Program

The Gateway Geriatric Education Center (GEC) has been awarded a second Geriatric Workforce Enhancement Program (GWEP) grant. Funded by the Department of Health and Human Services, Administration, the new funding is in the amount of \$3.75 million for a five-year period, from July 1, 2019 through June 30, 2024. This continued funding builds upon the GEC's 30-year legacy of educating, studying and caring for older adults to further advance geriatric care across Missouri.

During these five years, GWEP faculty and staff will continue to expand several of the previous

initiatives and partnerships as well as develop new programs and collaborations. The overall objectives of the current programming include:

- Expanding the number of health systems in Missouri that are age-friendly
- Collaborating with communities to develop age- and dementia-friendly initiatives
- Launching a program to address social isolation and loneliness among older adults
- Training practitioners to detect cognitive impairment and refer those in need to appropriate services
- Promoting caregiver well-being

through education and service

- Educating the general public about geriatric issues

“The growth of Missouri’s geriatric population is outpacing the number of doctors trained to care for them,” said John Morley, M.B., B.Ch., Saint Louis University’s co-investigator, with Marla Berg-Weger, PhD., LCSW, on the project. “With this GWEP grant, we will expand geriatric education to train more health care practitioners from multiple fields to detect and treat diseases and other problems in those who are older, using telemedicine and other

*(continues on page 10)*

# Geriatric Workforce Enhancement Program

(continued from page 9)

strategies to reach those who live in rural and underserved areas.”

The grant will impact older adults in every congressional district in the state (see map on page 9). In addition to continuing to focus on programming in the underserved areas of St. Louis and southeast and northeast Missouri, new partnerships have been developed in the Kansas City and mid-Missouri regions. Continuing collaborative partners include A.T. Still University of Health Sciences, SSM Health, Perry County Memorial Hospital, the Alzheimer’s Association, Missouri Area Health Education Center, Care STL Health, Northside Youth and Senior Service Center, Inc. New partners include University of Missouri School of Nursing’s Missouri Quality Improvement Project, Saint Louis University Emergency Department, Kansas City Care Health Center, Mid-America Regional, Kansas City. Each area has older adults who live in poverty and are members of underrepresented groups.

Our state continues to have healthcare profession shortages and increasing numbers of older adults. As Missouri lags behind most other states in embracing the age-friendly movement, which supports older adults so they can enjoy good health and fully participate in community activities, current focus will be on building on earlier GWEP initiatives (2015-2019) in which 9,466 individuals were trained in geriatric assessment who completed 11,458 Rapid Geriatric Assessments. Current activities include strengthening primary care professionals’ competence in geriatric screening, assessment, and intervention by creating two

new age-friendly healthy systems, establishing telehealth delivery for education and services, and developing strategies for dementia-friendly communities. Informed by Healthy People 2020 goals, five-year project objectives include:

1. Strengthening age-friendly health systems and expansion of the model to SSM SLU Emergency Department and

- Screening and treating mental problems, such as dementia
  - Making it easier for older adults to get around
2. Lessening social isolation through evidence-based Circle of Friend intervention delivered via in-person and telehealth formats to older adults.

One of the key pillars of the grant is developing and expanding



the 40 skilled care facilities participating in the University of Missouri Quality Improvement Project.

The GWEP Team will tackle the health side of the equation, replicating successful age-friendly care models that teach students and professionals to screen for geriatric problems such as cognitive impairment, opioid addiction, frailty and treat patients and their caregivers.

The grant supports fostering a health care system that responds to the needs of older adults that considers:

- What matters to patients
- Avoiding harmful medications

a successful Circle of Friends® program to combat social isolation and loneliness among older adults. Between 30 and 50 percent of older adults say they are sometimes lonely and 10 percent say they always are lonely. Loneliness can trigger a host of physical and mental health and social health problems. A model developed by scholars at the University of Helsinki, Finland<sup>1</sup>, will be replicated for the first time in the U.S. Dr. Morley’s editorial on page 4 provides more details.

“Lonely people tend to become socially isolated, depressed, and feel too sad to do anything. Because they are inactive, they become frail,

(continues on page 11)



# Geriatric Workforce Enhancement Program

(continued from page 9)

which both worsens their current health problems and creates new ones,” Morley said. The program will have a telehealth component that reaches older adults who live in rural areas or are home-bound.

Berg-Weger shares that “we are excited to have the opportunity to share this evidence-based intervention to improve the quality of life for older adults. Training has already begun in the St. Louis area and will continue to expand throughout the state.”

3. Providing training and conducting screening/assessment for cognitive dysfunction and Cognitive Stimulation Therapy (CST) and creating strategies for dementia-friendly communities.

The need for dementia care is growing in Missouri. Currently, 110,000 Missourians are estimated to have dementia, and the number is expected to increase 18% -- growing to 130,000—by 2025. Saint Louis University has been designated as North America’s official training site for Cognitive Stimulation Therapy, a non-pharmacologic treatment for dementia that stimulates memory through engaging guided group activities. Evidence has found that CST, which was founded in the United Kingdom and has been studied for nearly two decades, is as effective as drugs at treating dementia. In person and through a new telehealth platform, SLU will continue to train caregivers, students and health care professionals in facilitating how to lead CST sessions.

4. Providing screening, education, and interventions for informal (family, friends) and formal (healthcare



**110,000 Missourians are estimated to have dementia, and the number is expected to increase to 130,000 by 2025.**

professionals) caregiver well-being.

Through community health fairs, assessment clinics, and integrating assessment into electronic health record systems, GWEP faculty, staff, and students will expand their capacity to screenings for such geriatric syndromes as frailty, sarcopenia, anorexia, and cognitive impairment. New measures to assess opioid abuse risk and loneliness have been developed (see articles on pages 12 and 13).

5. Continuing delivery of interprofessional geriatric, caregiver, and opioid education in

all Congressional districts through in-person, on-line, and social media formats.

Saint Louis University has a proven track record for teaching other professionals the best practices in caring for older Missourians, and through the grant will continue to improve the quality of life for the state’s older residents.

“During the past four years, we educated nearly 7,000 health professionals and community members, screened nearly 12,000 older patients for geriatric problems and reached 17,676 through social media, educating the general public

about health problems faced by older adults,” Morley said. “We are both humbled and gratified that the federal government has entrusted us to continue the important work that supports older Missourians in living their best lives.”





# Rapid Clinical Assessment

Faculty at Saint Louis University have developed these assessments intended for use in clinical settings and can be administered in person, via telephone, and caregiver well-being.

## OPIOID RISK TOOL (ORT)

While attention being devoted to the opioid crisis is primarily focused on younger adults, there is concern regarding the opioid use and abuse among older adults. Pain is experienced in up to 78% of community-dwelling older adults and an even higher percentage in those residing in long term care. Nine percent of older persons in the U.S. use chronic opiates. In Missouri, the death rate from opioids is 15.9 per 100,000 of the population. These figures suggest a potential for overuse of opioids in older persons. Providing education to raise awareness, tools to assess, and interventions is key. The ORT was developed to serve professionals with a tool to quickly assess use, self-perception, and potentially related causes. Efforts are underway to validate the ORT.

**Opioid Risk Tool (ORT) Assessment for Older Persons**

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Check each item that applies

Have you abused:

Alcohol	_____
Illegal drugs	_____
Prescription drugs	_____

Do persons in your family abuse:

Alcohol	_____
Illegal drugs	_____
Prescription drugs	_____

Did anyone sexually abuse you? \_\_\_\_\_

Are you sad or being treated for depression? \_\_\_\_\_

Are you lonely? \_\_\_\_\_

Are you currently using pain medications? \_\_\_\_\_

As prescribed	_____
Tylenol	_____
NSAIDS	_____
Tramadol	_____
Opiates	_____

Do you have pain 3 or more days/week? \_\_\_\_\_

Do you have back pain? \_\_\_\_\_

Rate your level of pain:

**Wong-Baker FACES™ Pain Rating Scale**

					
<b>0</b>	<b>2</b>	<b>4</b>	<b>6</b>	<b>8</b>	<b>10</b>
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

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## ALONE SCALE

With recent estimates of loneliness ranging from 10% to 20% of the population, the negative effects of long-term loneliness and social isolation on health and intervention. Older adults experiencing loneliness are more likely to be affected in quality-of-life<sup>2</sup>, cognition<sup>3,4,5</sup>, physical health<sup>6</sup>, and increased use of services<sup>4,10-11</sup>, mortality<sup>12</sup> and social isolation is seldom included in geriatric assessment. A brief strategy for raising awareness and about social isolation suggests in his editorial on Page 4, there are several ways that social isolation can be addressed. In order to address loneliness and social isolation, they must first be identified. Topics that will make older adults (and providers) more likely to acknowledge their concerns when they are in professional encounters.

1. Musich S, Wang SS, Hawkins K, Yeh CS. The impact of

**ALONE Scale**

To assess an individual's perception of being lonely, use the following rating scale: **Yes** **Sometimes**

<b>A</b>	Are you emotionally <b>Attractive</b> to others as a friend?	Yes
<b>L</b>	Are you <b>Lonely</b> ?	Yes
<b>O</b>	Are you <b>Outgoing/friendly</b> ?	Yes
<b>N</b>	Do you feel you have <b>No</b> friends?	Yes
<b>E</b>	Are you <b>Emotionally upset</b> (sad)?	Yes

older, sicker adults. *Gerontol Geriatr Med* 2015; 1 doi: 10.1177/2333721415582119.

2. Jakobsson U & Hallberg IR. Loneliness, fear, and quality of life among elderly in Sweden: A gender perspective. *Aging Clin Exp Res* 2005. 17:494-501
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7. Bisschop MI, Kriegsman DM, van Tilburg TG, Penninx BW, van Eijk JT, Deeg DJ. The influence of differing social ties on decline in physical functioning among older people with and without chronic diseases: the Longitudinal Aging Study Amsterdam. *Aging Clin Exp Res* 2003; 15:164 - 173.

For more information or electronic versions of these assessment tools, email [aging@slu.edu](mailto:aging@slu.edu)

# Assessment Tools

Assessment tools for use with older adults and caregivers. These brief tools are completed in two minutes or less. These tools assess opioid use, loneliness and social

from 17% - 57%<sup>1</sup> in the U.S. and the significant social isolation, tools are needed for assessment of loneliness and social isolation can be negatively related to health and disability<sup>6, 7, 8</sup>, stress and depression<sup>9</sup>, mortality<sup>4, 12-13</sup>, and institutionalization.<sup>7</sup> As loneliness is a key issue in geriatric assessment, the ALONE Scale provides a tool to assess the issues with older adults. As Dr. Morley and his colleagues have provided evidence-based interventions to loneliness and social isolation, change the course and deleterious effects of loneliness can be recognized. Despite concerns about raising the burden (readers) uncomfortable, most older adults will complete the tool, both in questionnaires and in in-person

of loneliness on quality of life and patient satisfaction among

Simply, ask each of the items below using the

No	Sometimes	No
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Ekwall AK, Sivberg B, & Hallberg IR. Loneliness as a predictor of quality of life among older caregivers. *J Adv Nurs* 2005; 49:23-32.
- Geller J, Janson P, McGovern E, Valdin A. Loneliness as a predictor of hospital emergency department use. *J Fam Pract* 1999; 48:801-804.
- Elaway A, Wood S, Macintyre S. Someone to talk to? The role of loneliness as a factor in the frequency of GP consultations. *Br J Gen Pract* 1999;49:363-367.
- Russell DW, Cutrona CE, de la Mora A, Wallace RB. Loneliness and nursing home admission among rural older adults. *Psychol Aging* 1997; 12:574-589.
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## RAPID CAREGIVER WELL-BEING SCALE (R-CWBS)

The R-CWBS is a rapid assessment tool adapted from two earlier versions (CWBS and Shortened CWBS<sup>1,2,3</sup>). All versions of the scale are rooted in the premise that caregivers' basic needs and activities of living must be met in order to sustain the caregiver's well-being. Grounded in the strengths-based perspective, this tool can be completed in collaboration with family caregivers individually or in a group setting to identify the strengths and areas for change occurring in their current caregiving experience. Caregivers' responses and insights can become conversation-starters to further explore caregiver needs.

**Rapid Caregiver Well-Being Scale (R-CWBS)**

**Basic Needs:**

- Physical—receiving appropriate health care?
- Emotional—feeling fulfilled
- Self-security—feeling secure about financial future

**I. ACTIVITIES**

Below are listed a number of activities that each of us do or someone does for us. Thinking over the past three months, indicate to what extent you think each activity has been met by circling the appropriate number on the scale provided below. You do not have to be the one doing the activity. You are being asked to rate the extent to which each activity has been taken care of in a timely way.

	1. Rarely	2. Occasionally	3. Sometimes	4. Frequently	5. Usually
1. Taking care of personal daily activities (meals, hygiene, laundry)	1	2	3	4	5
2. Taking time to have fun with friends and/or family	1	2	3	4	5
3. Treating or rewarding yourself	1	2	3	4	5

**II. NEEDS**

Below are listed a number of needs we all have. For each need listed, think about your life over the past three months. During this period of time, indicate to what extent you think each need has been met by circling the appropriate number on the scale provided below.

	1. Rarely	2. Occasionally	3. Sometimes	4. Frequently	5. Usually
1. Receiving appropriate health care	1	2	3	4	5
2. Feeling good about yourself	1	2	3	4	5
3. Feeling secure about your financial future	1	2	3	4	5

Use only with permission by authors Susan Tebb, Marla Berg-Weger and Doris M. Rubio, Saint Louis University (314)977-2730. 1999 Susan Tebb, Marla Berg-Weger and Doris M. Rubio (original scale, 1993), revised 2012 & 2015.

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*This new feature will highlight the work of a GWEP partner organization.*



## GWEP PARTNER HIGHLIGHTS: Mid-America Regional Council

*James Stowe, PhD., Director of Aging and Adult Services, Mid-America Regional Council, Kansas City, Missouri*

As an Area Agency on Aging for the Kansas City region, prioritization of service delivery is an important component of the Mid-America Regional Council (MARC) Department of Aging and Adult Services' work to help older adults and individuals with disabilities thrive in the community for as long as possible. When referrals from the general public, health care professionals, or social service professionals arrive at MARC, funding or provider staff may or may not be available to provide services. Therefore, detailed characterization of function and risk level is a major part of how decisions are made in allocating resources.

To ensure that staff can make these decisions in an objective, standardized way, MARC developed a brief screening battery that is now implemented with every client. The battery was informed by expert faculty at universities along the I-70 corridor. The Rapid Geriatric Assessment is at the heart of the battery and helps to identify key areas of risk. If clients exceed the necessary risk score using the screen, an in-home assessor is dispatched to gather additional information on eligibility and priority, including the written portion of the Rapid Cognitive Screen, the clock-drawing task.

This information helps in the care planning process as well as identification of additional resources and referrals that may assist the client. The process of building capacity in client assessment has assisted MARC in efforts to pursue integrated care initiatives that pair medically and socially complex hospital and primary care patients, as well as health plan members,



**Implementation would mean tens of thousands of older people across Missouri would be screened for common geriatric syndromes**

to social health interventions. Several important social health contracts are launching in 2020 that will test the effectiveness of interventions such as home-delivered meals, community care management, and transportation assistance on utilization and cost outcomes for healthcare clients.

As with many social service organizations, automation and data insights are of increasing importance to MARC. MARC is collaborating with the Missouri Association of Area Agencies on Aging to modernize an information platform used by all Missouri AAAs, AgingIS,

including the incorporation of client assessments into platform-based workflows. These workflows will include automated triggers for suggestion of services, referrals, and escalation of clients to certain internal teams. Unsurprisingly, the Rapid Geriatric Assessment is a candidate battery to include in this system update. Implementation would mean tens of thousands of older people across Missouri would be screened for common geriatric syndromes that could be better assisted through intervention and referral.

The burgeoning aging population is already testing systems and service providers. Accurate screening and client characterization provide opportunities for AAAs and other service providers be more effective in offering services that consumers need and want to maintain independence. These actions serve to bolster and maintain the important community asset of older people and individuals with disabilities. They also save tremendous public and private expense on health care and institutionalization.



*Dr. Berg-Weger*

**MARLA BERG-WEGER, PHD., LCSW**, Professor, School of Social Work, and Executive Director, Gateway Geriatric Education Center was elected President-Elect for the National Association of Geriatric Education. Berg-Weger additionally received these awards in 2019: 1) From the Harvey A. Friedman Center for Aging at Washington University—

Harvey A. and Dorismae Hacker Friedman Award for Excellence in Service to Older Adults; 2) Council on Social Work Education Council on the Role and Status of Women in Social Work Education Mentorship Recognition; and 3) Association for Gerontology Education in Social Work Leadership Award.

GWEP Team member and Coordinator of the Caregiver Well-Being Initiative, **MAX ZUBATSKY, PHD, LMFT**, Department of Family & Community Medicine, Medical Therapy Program, received tenure and promotion to Associate Professor. In addition, Max was appointed at Chair of the Medical Therapy Program.



*Dr. Zubatsky*

**JOHN E. MORLEY, MB, BCH**, received the International Association on Nutrition and Aging Lifetime Achievement Award in recognition of his contribution to aging and nutrition research. The award was given at the annual meeting held in Toulouse France on March 8, 2020.



*Dr. Morley*



*Dr. Wallace*

GWEP Team member and Coordinator of the university-wide Interprofessional Graduate Certificate Gerontology, **CARA WALLACE, PHD, LMSW, APHSW-C**, was awarded the Social Work Hospice & Palliative Care Network's 2020 Award of Excellence in Psychosocial Research. This award

recognizes outstanding contribution to the field of palliative social work in research. The recipient demonstrates an ongoing consistent record of research and publication that adds/contributes significantly to the body of knowledge in psychosocial palliative care, hospice, grief, loss, and bereavement.

**These physicians are completing fellowships in the Division of Geriatric Medicine for specialized training:**

**LINDSAY HINKLE-JOHNSTON, D.O.**, is completing a Hospice and Palliative Medicine Fellowship through June 2020. Dr. Hinkle-Johnston graduated from Kansas City University of Medicine and Biosciences in Kansas City, Missouri, in May, 2012. She completed her residency at Abington Memorial Hospital Department of Internal Medicine in June, 2015. After working as a hospitalist for several years, she decided Hospice and Palliative Medicine was her true calling and will join the staff at St. John's Mercy Medical Center in St. Louis beginning July 1, 2020.



*Dr. Hinkle-Johnston*

**LINA M. TOLEDO-FRANCO, M.D.**, is completing a one-year Fellowship in Hospice and Palliative Medicine at Saint Louis University. Dr. Toledo-Franco graduated from Pontificia Universidad Javeriana - Bogotá, Colombia in June 2003. She completed her residency and Geriatric Fellowship at Yale University School of Medicine (St Raphael Hospital) in June 2010. She returned home to Bogota, Columbia, before deciding she wanted to specialize in Hospice and Palliative Medicine and will complete her fellowship in June, 2020. After graduation, she continues to pursue a position in Hospice and Palliative Medicine in the United States.



*Dr. Toledo-Franco*

# COVID-19 UPDATE

## OLDER PERSONS and the COVID-19 PANDEMIC

A corona virus (COVID-19) that first occurred in Wuhan, China, has rapidly spread through the United States. This virus group causes the common cold, but it has also been related to epidemic lung diseases such as severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS). The COVID-19 virus is especially severe in older individuals with multiple diseases, with about 15% of affected individuals over age 80 dying. For this reason, we suggest that all older persons are tested with the FRAIL screen. If results from the FRAIL scale are positive, the older adult will require hospitalization. A copy of the FRAIL scale is included here.

These findings are typical of COVID-19. Eventually, the lungs fail to function and the patient needs to be artificially ventilated. The person can also go into shock, and experience heart disease, liver dysfunction, and kidney failure.

COVID-19 is spread by droplet infection and through the air. Viruses can live on surfaces such as plastic for up to 72 hours. Persons should use alcohol to sanitize these surfaces. We should remember that pumping gas and ATM machines can be a source; so wipe them before using.

If you develop a fever, new cough, or upper respiratory infections, you need to be tested for the virus. This

- Socially distance
- Wash hands for as long as it takes to sing “Happy Birthday” (20 seconds)
- Use alcohol wipes on surfaces
- Isolate as much as possible
- Develop a plan in the event symptoms appear, and have an advance directive
- Remember young persons often have no symptoms and they are the persons most likely to infect others
- Stay connected to family, friends, and others through the phone, videoconferencing, and social media

Some drugs such as chloroquine and Remdesivir are showing some promise to treat people with severe disease. If you are taking ACE inhibitors, *e.g.*, lisinopril, or ibuprofen or other NSAIDs, ask your doctor if you should take them. Tylenol® is the better option for fever and pain.

For many older persons, the stress of this time and loneliness due to social isolation will be a major aggravating and impactful factor. It is essential that family and neighbors support older persons making certain they have food but also are communicated with regularly by telephone, FaceTime, or Skype. It is important not to get stressed over this pandemic, as we have the tools to get over it.

This is a DIFFICULT TIME for all of us, but it will get better, and we all need to keep a positive attitude at this time.

### 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

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

COVID-19 virus typically begins as a cough and a runny nose. Many patients have a fever, but in some older persons, it may start without a fever. It also can present with diarrhea. It then can cause severe breathlessness as it produces a pneumonia. This pneumonia has patches (ground glass opacities) in the lungs on X-Ray or CT scan.

is done with a nasal swab which is then sent for a PCR assay to identify viral mRNA. A quicker immunoassay has been developed where you can get the answer within 15 minutes.

The first vaccine tests have just begun but it is expected a vaccine will be found to prevent the disease. In the meanwhile, older persons must:



# Caregivers: The Silent Patients in our Healthcare System

By Max Zubatsky, PhD, LMFT, and Randy Gallamore, MA

Chrissy knows that the caregiving journey for her mom is going to be a long road, even though she's been preparing for this role for years. Her mother, Dorothy, was diagnosed last year, at age 66, with Alzheimer's Disease. Dorothy has been mostly a private



person, not wanting to discuss health or medical issues with family or friends. Yet, deep down Dorothy knows that she will need Chrissy to help manage the regular shopping, cooking, cleaning, and other weekly tasks. Chrissy is an only child and a mother of two, with a part-time job in the family business. Chrissy is the “sandwich caregiver,” assuming the caretaking responsibilities of two different generations of family members. But Chrissy knows that taking care of her mom will not only be challenging in their relationship, but taxing on the responsibilities she wants to attend to in her own home. Dorothy has been increasingly isolated in recent months and often gets a temper with Chrissy when

things are not organized, cooked or stored the right way. Chrissy is at the point of exhaustion and wondering when she will be able to get her previous life back, or what the future holds with increased caregiving responsibilities.

This caregiving story is not an uncommon one today. While many family members may take on the role of caregiving out of choice, the burdens and challenges with this role can be evident. Over \$400 billion dollars is lost in the country on an annual basis for caregivers sacrificing work, family time and other life duties to

attend to a loved one. Almost a quarter of the United States has provided “substantial” care for a family member or friend within the last month, while experiencing frequent economic hardships and challenges setting boundaries with their own families. Over half of medical caregivers report that they have noticed some decline around an aspect of their health, whether physical or mentally. Primary caregivers (informal or unpaid) have been associated with increased risks of anxiety, depression, use of psychoactive medications, hypertension and cardiovascular problems over time.

The demographics of caregiving have also shifted significantly in the past decade. Family caregivers are not only varied in their age, but their physical proximity to a chronically ill or home-bound family member. There is an increased trend in shared caregiving, where multiple family members take on the responsibilities of monitoring one's activities of daily living and other daily regimens.

Professional caregiving has also seen a dramatic rise, where both employees at organizations and in-home services have provided increased care for older adults. With more than 80% of Americans choosing to live in their home post-retirement stage, the expansion of a professional caregiving workforce will be

*(continued on page 19)*



# Fear of Falling

(continued from page 7)

throughout a semester. Students administer a variety of screening tools during their home visits. They not only implement the RGA, but also administer the Timed Up and Go (TUG) to assess fall risk. To date, TSU students from the Health Education, Exercise Science, and Nursing programs have completed MOB lay coach training.

For more information on ATSU AHEC programs, contact Hong Chartrand, DrPH, AHEC Program Director at [hongchartrand@atsu.edu](mailto:hongchartrand@atsu.edu) or Debbie Blessing, GWEP Coordinator, at [dblessing@atsu.edu](mailto:dblessing@atsu.edu) or by phone at 660-626-2887.

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# Loneliness

(continued from page 4)

of Friends.” The Circle of Friends approach is excellent as it involves meeting together weekly for twelve sessions and engaging with others who report feeling lonely. Each session includes these components: creativity, health/exercise,



Member of Circle of Friends group at Les Chateaux Senior Development, St. Louis with the quilt they made.

reflection and discussion. Research has demonstrated that loneliness and health care visits are reduced. Two years following participation in the intervention, 95% of participants reported not feeling lonely.

Other approaches can involve individual therapy with a focus on strategies to make friends, improving self-esteem and social anxiety, and exploring how to gain meaning from relationships. All lonely persons should be encouraged to be involved with family members, volunteer opportunities, engaging with religious and

spiritual events of their choice, getting exercise that is of interest and safe for them, and finding social involvement at coffee shops, senior centers, and other meeting places. Developing a hobby or adopting a pet

are both excellent talking points to make new friends.

Overcoming loneliness can be a major challenge. It is for this reason that our Saint Louis University GWEP has worked with the founders of Circle of Friends to develop training which has been delivered to multiple organizations throughout the St. Louis area. When providing care for a person experiencing loneliness or social isolation, one must remember that “lonely is not being alone, it’s the feeling that no one cares.”

For more information on Circle of Friends and training, contact Marla Berg-Weger at [marla.bergweger@slu.edu](mailto:marla.bergweger@slu.edu).



# Caregivers: The Silent Patients

(continued from page 17)



Saint Louis University Memory Clinic partners (left to right): Max Zubatsky, Pracheta Bhagat, Jessica Leuthauser, Anna Brende, Randy Gallamore, and Matthew Amick

needed to attend to the in-home needs of adults, especially those with memory loss and mobility challenges.

Our healthcare system does very little to incentivize caregivers for the work that they provide for their loved ones. Research has indicated that caregivers have high levels of frustrations with their healthcare team around areas such as communication around the initial diagnosis, lack of follow-up resources, explanations of medications, and formulating a more thorough treatment plan. Physicians and specialists alike should continue to be mindful of the emotional burden that caregiving places on family members. Even taking two minutes out of every encounter to assess the caregiver's well-being or motivations to continue to put in this work are invaluable. Providers should also be aware of the ongoing groups and meaningful engagements taking place in our community.

At Saint Louis University, The Memory Clinic was developed to offer community resources to individuals with memory loss and their family members. Providers take a family-

**Our healthcare system does very little to incentivize caregivers for the work that they provide for their loved ones.**

centered approach to address the physical, emotional, and familial challenges of not just dementia, but how seniors can learn to thrive through the aging process.

Master's and doctoral students facilitate several meaningful groups and activities as part of their gerontological training in Medical Family Therapy, Social Work and other programs at SLU. To date, the Memory Clinic has served more than 100 families through reminiscence group therapy, process groups, assessments, psychotherapy, and other services.

The following services at the Memory Clinic help address the caregiver's health and well-being:

## Caregiver-Assisted Cognitive Stimulation Therapy

Cognitive Stimulation Therapy (CST) is an evidenced-based intervention that was developed in the U.K. by Dr. Aimee Spector and colleagues. The group's aim is to improve memory and orientation in individuals with mild to moderate types of dementia. Activities may include face and scene recognition, working with money, childhood reminiscence or identifying different foods. Our protocol includes the work of caregivers to help continue these activities in the home of the group participants. A coinciding caregiver process group runs during the CST group, where caregivers in a separate room can not only process feelings of their role but become informed of the activities taking place in CST.



## Circle of Friends Group

Developed in Finland, Circle of Friends is a group rehabilitation (continued on page 20)

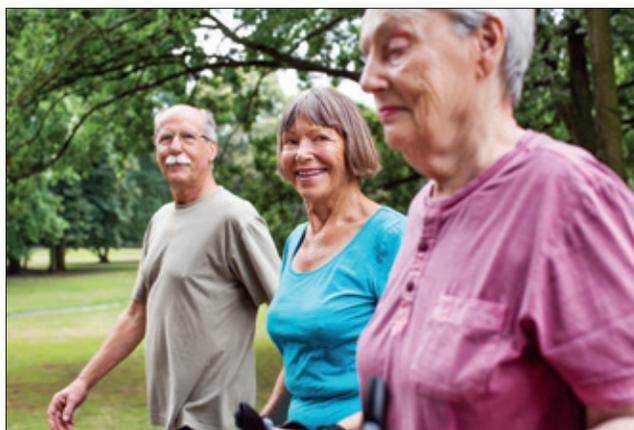
# Caregivers: The Silent Patients

(continued from page 19)

model for older people who experience loneliness and social isolation on a regular basis. The group meets 12 times over a 3-month period, with the goal of the group sustaining itself over time in the community. The three main areas of activities that are implemented are physical exercise, arts and creative writing. Our upcoming group also includes individuals who are caregivers for loved ones with differing chronic health problems. The socialization aspect of the group not only helps reduce isolation but can normalize the issues and challenges that family members and carepartners often experience in that role.

## Caregiver Speakers Series

Caregivers are often challenged in finding the right information in the community and seeking the appropriate professionals for healthcare advice. We developed a monthly speaker's series as a way for family and professional caregivers to gain new knowledge on a variety of topics that would benefit the caregiving process. Areas such as communication with families, legal areas of aging, caregiver well-being, proper



nutrition and staying physically active have helped caregivers learn more from experienced professionals. The series meets on the first Monday of the month in Morrissey Hall on the SLU campus.

## The Family Consult

At the Memory Clinic, we offer free family geriatric assessments for individuals and caregivers to get a better sense of what resources or referrals could be needed for their current situation. One option for family members who need more formalized decisions about their plan of care or caregiving coordination is the Family Consult. This consult is usually one hour long and facilitated by an experienced therapist in the Medical Family Therapy Program. The goal is to help the family plan upcoming steps in a loved one's care and gather perspectives from family members about a health situation that necessitates coordination from loved ones.

For additional information, please visit our website at: <https://www.slu.edu/medicine/family-medicine/center-counseling-family-therapy/memory-clinic.php> or check out "Saint Louis University Memory Care Clinic" on Facebook.





# The Ride of Her Lifetime

This heartwarming article is reprinted from *Aging Successfully*, Summer 2005, Vol. XV, No. 2.

Twenty years ago, I drove a cab for a living. When I arrived at 2:30 a.m., the building was dark except for a single light in a ground floor window. Under these circumstances, many drivers would just honk once or twice, wait a minute, then drive away. But, I had seen too many impoverished people who depended on taxis as their only means of transportation. Unless a situation smelled of danger, I always went to the door.

This passenger might be someone who needs my assistance, I reasoned to myself. So I walked to the door and knocked. "Just a minute", answered a frail, elderly voice. I could hear something being dragged across the floor. After a long pause, the door opened. A small woman in her 80s stood before me. She was wearing a print dress and a pillbox hat with a veil pinned on it, like somebody out of a 1940s movie. By her side was a small nylon suitcase. The apartment looked as if no one

had lived in it for years. All the furniture was covered with sheets.

There were no clocks on the walls, no knickknacks or utensils on the counters. In the corner was a cardboard box filled with photos and glassware. "Would you carry my bag out to the car?" she said. I took the suitcase to the cab, then returned to assist the woman. She took my arm and we walked slowly toward the curb. She kept thanking me for my kindness. "It's nothing", I told her. "I just try to treat my passengers the way I would want my mother treated". "Oh, you're such a good boy", she said.

When we got in the cab, she gave me an address, then asked, "Could you drive through downtown?" "It's not the shortest way," I answered quickly. "Oh, I don't mind," she said. "I'm in no hurry. I'm on my way to a hospice." I

looked in the rear-view mirror. Her eyes were glistening. "I don't have any family left," she continued. "The doctor says I don't have very long."

I quietly reached over and shut



off the meter. "What route would you like me to take?" I asked. For the next two hours, we drove through the city. She showed me the building where she had once worked as an elevator operator. We drove through the neighborhood where she and her husband had lived

(continued on page 22)



# The Ride of Her Lifetime

(continued from page 21)

when they were newlyweds. She had me pull up in front of a furniture warehouse that had once been a ballroom where she had gone dancing as a girl. Sometimes she'd ask me to slow in front of a particular building or corner and would sit staring into the darkness, saying nothing.

As the first hint of sun was creasing the horizon, she suddenly said, "I'm tired. Let's go now." We drove in silence to the address she had given me. It was a low building, like a small convalescent home, with a driveway that passed under a portico.

Two orderlies came out to the cab as soon as we pulled up. They were solicitous and intent, watching her every move. They must have been expecting her. I opened the trunk and took the small suitcase to the door. The woman was already seated in a wheelchair.

"How much do I owe you?" she asked, reaching into her purse. "Nothing," I said. "You have to make

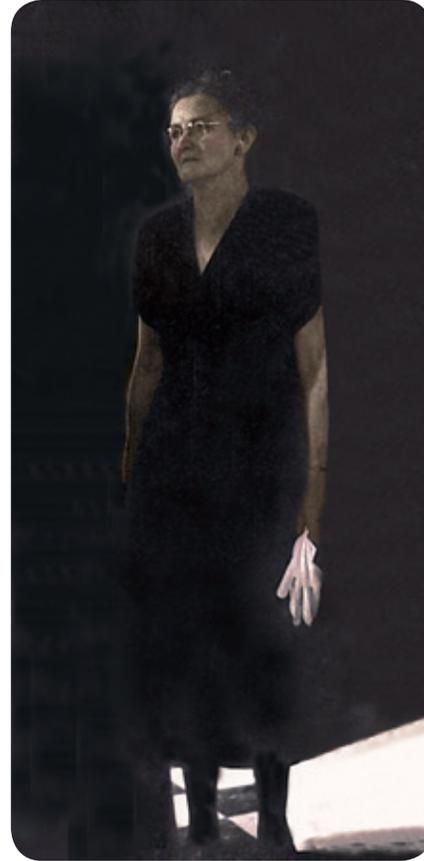
a living," she answered. "There are other passengers," I responded.

Almost without thinking, I bent and gave her a hug. She held onto me tightly. "You gave an old woman a little moment of joy," she said. "Thank you."

I squeezed her hand, then walked into the dim morning light. Behind me, a door shut. It was the sound of the closing of a life. I didn't pick up any more passengers that shift. I drove aimlessly lost in thought.

For the rest of that day, I could hardly talk. What if that woman had gotten

an angry driver, or one who was impatient to end his shift? What if I had refused to take the run, or had honked once, then driven away? On a quick review, I don't think that I have done anything more important in my life. We're conditioned to think that our lives revolve around great moments. But great moments often catch us unaware—beautifully wrapped in what others may consider a small one.



*This article was written by Kent Nerburn and was published in his 1999 book Make Me an Instrument of Your Peace. What a sobering reminder to be kind.*

## Interprofessional Graduate Certificate in Gerontology Now Offered at Saint Louis University

With an emphasis on developing competencies in interprofessional care of older adults, highlights of the certificate include:

- 15 credit-hours which include interprofessional and experiential/practicum opportunities
- Designed for post-baccalaureate students, current graduate students, and professionals currently working with older adults, including: dietitians and nutritionists, health care workers, occupational therapists, physical therapists, speech-language pathologists, nurses, nurse practitioners, social workers, and more.
- Opportunity to take courses across the university with a focus on:
  - Foundational competencies (frameworks for understanding human aging; biological, social, and psychological aspects of aging; humanities and aging; research and critical thinking)
  - Interactional competencies (attitudes and perspectives, ethics and professional standards, communication with and on behalf of older persons, interdisciplinary and community collaboration)
  - Contextual competencies (well-being, health and mental health; social health; and policy)



For more information, contact Cara L. Wallace, PhD, LMSW, Gerontology Certificate Coordinator at [Cara.wallace@slu.edu](mailto:Cara.wallace@slu.edu) or call 314-977-2746.

**NOW AVAILABLE ONLINE!**



## 31<sup>st</sup> Annual Saint Louis University Summer Geriatric Institute: The Elixir for Health: Age-Friendly Systems

June 1-2, 2020

Cognitive Stimulation Therapy (CST) Facilitator Certification Training

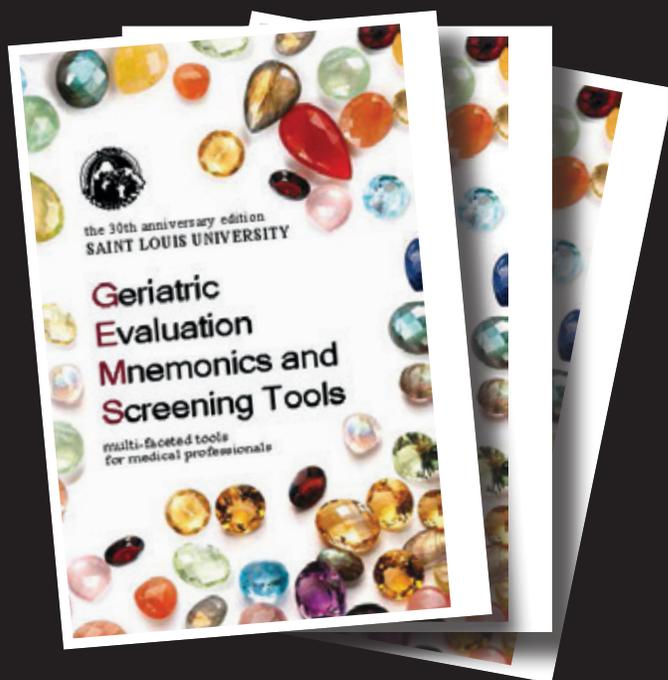
June 3, 2020

Saint Louis University, St. Louis, Missouri

To ensure the safety and health of our presenters and attendees, **The Summer Geriatric Institute and Cognitive Stimulation Therapy Training** is being postponed until Fall, 2020. Please visit our website at [aging.slu.edu](http://aging.slu.edu) for updated registration information.

We hope to see you there!

# SLU GEMS



The ever-popular SLU GEMS booklet was just updated and expanded to include the latest screening tools and mnemonics. Order your copy now! Email [aging@slu.edu](mailto:aging@slu.edu).

## SERVICES

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

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Saint Louis University School of Medicine  
Gateway Geriatric Education Center of Missouri (Gateway GEC)

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