Your Health:
Dementia Diagnosis

Alleviating Anxiety after a diagnosis

Life Care Managers
Get expert help

Fulfilling Life
Author Abigail Trafford

Fitness Technology
Activity trackers

Affordable Housing Ideas

Medication Alerts
PRIME TIME LIVING

HEALTH PART 1: DEMENTIA  4
Hope for those with dementia and ways to minimize risk factors

MEDICATION  6
How our meds can hurt us

AFFORDABLE HOME OPTIONS  8
Innovative housing to keep your social life active

BOOKS  10
Author Abigail Trafford shares her insights

AGING  12
Aging Life Care Managers care for parents when families can’t

FITNESS  14
Is an activity tracker right for you?

HEALTH PART 2: ANXIETY  18
Alleviating the anxiety around a dementia diagnosis

© 2020 Baltimore Sun Media

If you would like to provide editorial feedback or offer article suggestions, please contact writer Margit Weisgal at mbweisgal@gmail.com
Where are my keys? Determining dementia diagnoses

There is hope for those with dementia and there are ways to minimize risk factors

By Margit B. Weisgal, Contributing Writer

In 2014, Dr. Halima Amjad, M.D., M.P.H., assistant professor medicine at Johns Hopkins University School of Medicine with clinical expertise in geriatric medicine and geriatric psychiatry and whose father suffers from frontotemporal dementia (FTD), penned an award-winning story for the John A. Hartford Foundation’s second annual story contest, Better Caregiving, Better Lives: Real Life Strategies and Solutions. Titled Caring for Dementia: Returning to the Village, it recounts the difficulties she and her family go through on a daily basis and how that phrase, “it takes a village,” took on new meaning in caring for her parent.

“Nothing is more difficult than coping with dementia itself and caring for a husband and father who is a shell of the man we loved.” – Dr. Halima Amjad

Dementia takes different forms and has a variety of causes, but whatever the form or whatever the cause, it is one of the most difficult diseases to live with because it is not just about the patient – who may or may not recognize the changes taking place; there is a huge burden on the family, the caregivers (related or not) and our health system.

“Only families juggling dementia understand the pain of losing a loved one twice, once in mind and later in body,” Amjad wrote. And even though her father’s dementia has a physiological cause, what she and her family experience is replicated by other families with a member suffering from dementia. According to the Alzheimer’s Foundation (www.alz.org), “Frontotemporal dementia (FTD) or frontotemporal degenerations refers to a group of disorders caused by progressive nerve cell loss in the brain’s frontal lobes (the areas behind your forehead) or its temporal lobes (the regions behind your ears).”

Dr. Milap Nowrangi, M.D., M.Be., assistant professor of psychiatry and behavioral sciences at The Johns Hopkins University School of Medicine, explains, “Dementia is a catch-all term, referring to the impairment in cognition and the ability to perform daily activities that stem from changes to the brain. Overall, it is a chronic and progressive disease with many different causes. Various molecules and proteins in the brain cause minute structural changes. These molecular changes kill the neurons and, as they die in areas of memory, patients lose their memory, language abilities and executive functions: activities of the brain lobes that provide you with self-control, impulse control, working memory, mental flexibility and being able to adapt. The four lobes – frontal, parietal, temporal and occipital – are connected to each other as networks; with dementia, they stop working together due to shrinkage or accumulated toxic mechanisms.”

What’s the difference between dementia and Alzheimer’s disease?

“Different types of dementia are associated with particular types of brain cell damage in specific regions of the brain. For example, in Alzheimer’s disease, high levels of certain proteins inside and outside brain cells make it hard for brain cells to stay healthy and to communicate with each other. The brain region called the hippocampus is the center of learning and memory in the brain, and the brain cells in this region are often the first to be damaged. That’s why memory loss is often one of the earliest symptoms of Alzheimer’s,” according to the Alzheimer’s Foundation.

After Alzheimer’s disease, vascular dementia is the second most com-

Dementia, continued on page 16
Unforeseen dangers
How our meds can hurt us

By Margit B. Weisgal, Contributing Writer

Something we take for granted, something all of us do every day, something we assume will improve our health and our lives, has the potential of causing us a great deal of harm or, possibly, kill us. It’s the vast array of medications (pills, inhalers, drops, patches, topicals, injections, suppositories, etc.) we take daily.

A report published by the Lown Institute in January 2020, exposed the risks. “Every day, 750 older people living in the United States (age 65 and older) are hospitalized due to serious side effects from one or more medications. Over the last decade, older people sought medical treatment more than 35 million times for adverse drug events (ADEs) and were hospitalized more than 2 million times due to ADEs.”

An epidemic in the making, the predilection of doctors to prescribe drugs is causing something called medication overload or, in scientific literature, called polypharmacy; this is when you take more medications than you require on a regular basis. Drugs are prescribed but rarely reevaluated as to an ongoing need, so they’re not stopped or deprescribed – when the cause no longer exists. Plus, there are the meds we take p.r.n. (pro re nata, Latin for ‘when needed’). This leads to a higher probability for dangerous interactions.

A 2019 article in U.S. Pharmacist.com says overmedicating the older population must be addressed, citing the following statistics: “Approximately 44% of men and 57% of women older than 65 years take five or more nonprescription and/or prescription medications per week, and 12% of persons in this age group take 10 or more nonprescription and/or prescription medications per week.”

How does this happen? More easily than you can imagine. You go to your primary doctor and, over time, she prescribes a pill for your high cholesterol and your high blood pressure. You take each one daily. You also take an 81-milligram aspirin because you have a family history of heart disease. A friend recommended you take a supplement to prevent memory loss, so you add that to your daily regimen. You also take additional over-the-counter (OTC) supplements, such as calcium, vitamin D, magnesium and fish oil. So far, you’re doing OK.

Then you visit a specialist, and he prescribes another drug to take occasionally. The first time you take it, you end up in the hospital with an adverse drug event because there is a conflict between this medication and your others.

What ADEs – adverse drug events – could happen to you? Delirium, dementia, internal bleeding and falls are common, or you could have a stroke, a heart attack or die. Your risk increases 7-10% with each additional medication you add.

Michelle Fritsch, Pharm.D., of Retirement Wellness Strategies is dual board-certified, meaning she is an expert in care for people over 60. “I have found medications are part of health decline at least 80% of the time,” she says. “A typical scenario occurs because many of the drugs we take have side effects, so, if we don’t like how they make us feel, we stop taking them as prescribed, but we don’t tell our primary care physician (PCP) what we’re doing. When we have a follow-up appointment with our PCP, tests show the med is not working so the dosage is increased. Meanwhile, you’re still not taking the medication as you should so the medical condition is not being treated and, if hospitalized, now you’re even more at risk because you’ll be put on that medication based on your doctor’s report,” Fritsch says.

“If you add two or three other doctors,” Fritsch continues, “it compounds the issue. We have specialists because the body is extremely complex. Today, physicians need a lot of knowledge...”
about their fields, what can go wrong, what tests need to be done and how to address these various issues. Specialists don’t see what the primary doctor sees. However, because the specialist knows the specialty area better, when a specialist says, ‘do this,’ your primary doctor doesn’t always make a change to avoid an interaction.”

Even if our primary doctor thinks she knows about everything we take, there are still gaps. Louisa C., 87 years old, lied about her health concerns and what she was diagnosed with kidney disease, she did a lot of research. When she saw a new primary care physician, that doctor prescribed a medication she knew wasn’t appropriate for those with renal problems. She contacted her specialist to find out what would be a good alternative. By doing so, she prevented future problems.

Ilene Harris, Pharm.D., Ph.D., vice president and chief research officer at IMPAQ International, is a nationally recognized researcher with deep understanding of chronic disease management, pharmacoepidemiology, drug policy, and medication use and quality. She is currently working with the Centers for Medicare & Medicaid Services (CMS) to support a new model for providing medication therapy management (MTM) services to Part D Medicare beneficiaries.

“It’s frustrating,” says Harris, “that people are not more aware of the potential problems that can arise from their medications, what side effects they can cause, and why they should take what they are given as prescribed. People assume their doctor knows all about them and what meds they’re taking, but unfortunately doctors have a finite amount of time to spend with each patient and don’t always have ready access to all of their patients’ health information. We are lucky that most pharmacies have a warning system in place for drug interactions, but that doesn’t include vitamins or OTC supplements people add on their own. So, you have to be your own advocate. You need to know what your medication should do, and how often and how long a period of time to take it. If you can’t monitor this yourself, ask a family member do it.”

Other factors come into play that contribute to polypharmacy. The Lown Institute report lists three primary causes: 1. We live in a culture where we believe there’s a pill to cure every ill. Add “direct-to-consumer advertising,” the limited time doctors have to spend with patients, and the assumption that there’s a drug that keeps us from getting old, and suddenly we’re taking far too many pills. 2. Doctors with clinical practices have limited education on how to prescribe medications for patients with multiple chronic conditions or, more important, how to safely stop the drug. 3. Our fragmented health system means we receive prescriptions from multiple providers, often in different settings, such as urgent care, clinics, hospitals or office practices, so no one person is tracking all the pills someone is taking.

There’s another facet that has to be taken into account vis-à-vis our medication. With age, our bodies react differently to medications than they did when we were younger; consequently, there is a greater potential for side effects. Some drugs can make certain conditions worse, and some can be replaced with safer ones or even non-medical treatments. Because of this, the American Geriatrics Society publishes the AGS Beers Criteria of Potentially Inappropriate Medication, continued on page 15.
A place to call home

Affordable housing options to keep your social life active

By Margit B. Weisgal, Contributing Writer

Fans of The Waltons, a television show that aired from 1972 through 1981, may remember the Baldwin sisters, two somewhat elderly ladies who derived their income from their still, referred to obliquely as “the recipe.” Paula Dolgin imagined that she would retire to a Victorian abode with dormer windows like the one where the Baldwins lived, situated in the mountains of North Carolina, rocking chairs placed along a porch wrapping around the front of the house and a vista that never got boring. The multi-roomed home would be populated with her single friends who could happily coexist, share chores and expenses, while still having enough space and alone-time to retain their autonomy.

A dream? Not really. Places like this already exist with friends joining forces to develop living spaces that fulfill their needs. With the surge in the baby boomer population, creative living solutions are sprouting from myriad sources. Yes, if you want, there are still lots of familiar senior living spaces, depending on your health, such as active senior housing, retirement communities, continuous care facilities and nursing homes. Many have extensive amenities – restaurant-style dining rooms, state-of-the-art fitness centers and classes, swimming pools, artists’ studios, and more – so, as you age, you have choices based on personal requirements.

But … there’s much, much more. Today’s seniors are seeking innovative options, new ways to remain independent and, hopefully, age in place, yet still be safe. Here are just a few ideas to think about as you consider your future.

**Homesharing**

In The Golden Girls, a television show that ran from 1985 to 1992, four senior singles share a living space. It’s a great idea, similar to Dolgin’s plan. Obviously, you can start with others the same age, either one or several, but here’s a clever twist.

Instead of another senior, you can live with someone who is 40 or 50 years younger. It’s a great idea, but how do you find younger people you could trust and who would be interested? There are programs around the country that make matches between oldsters and youngsters.

In Baltimore City and County, St. Ambrose Housing Aid Center Inc. (www.stambros.org/pages/homesharing.html) connects potential roommates and ensures all parties are trustworthy. “A successful match offers homesharers the opportunity for companionship, reduced housing cost and the continuation of an independent lifestyle. The community benefits from our program. Homesharing makes use of existing housing supply and helps preserve the fabric of neighborhoods,” according to the organization.

For options similar to what St. Ambrose offers, the National Shared Housing Resource Center (NSHRC: www.nationalsharedhousing.org) “is a network of independent non-profit homesharing programs across the United States. Our goals are to raise awareness of the benefits of homesharing, encourage best practices and cross learning among programs, and to foster the development of new homesharing programs,” the organization states on its website.

The New York Foundation for Senior Citizens (www.nyfsc.org/home-sharing) has a free Home Sharing Program its managed for over 30 years. It links “adult “hosts” with extra private spaces in their homes or apartments with appropriate adult “guests” to share their space. One of the matchmates must be age 60 or older.” Its professional staff screens and checks references for all applicants and then uses a program to ensure compatibility.

Odd Couples Housing in St. Louis, MO (www.oddcoupleshousing.com), “is a unique service that brings together healthy, active adults with compatible and responsible younger adults to share housing. Living and learning together, the two generations find mutual support, share expenses and household responsibilities, and discover a range of social and educational benefits.”

Toronto HomeShare (www.torontohomeshare.com) pairs adults over 55 with university and college students who need affordable housing. The reduced rent is subsidized by the student contributing seven hours spent providing companionship or light work around the residence. Nesterly (www.nesterly.io) has this service
in the Boston area.
Or you can also share your home with someone your own age. Senior Homeshares (www.seniorhomeshares.com) is a nationwide online housemate service specifically for older adults.

Another one is Silvernest (www.silvernest.com), "creating the next generation of roommates. A more modern kind. A well-matched kind. A kind that's just your style. The result? Extra income and an expanded community, with support every step of the way. After all, this is your house,” it states on the website.

Cooperative housing
In the United Kingdom, there is Older Women’s Cohousing (www.owch.org.uk), “a group of women over 50 who have created our own community in a new, purpose-built block of flats in North London. As an alternative to living alone, we have friendly, helpful neighbours,” according to the organization.

Who are they? Trailblazers. The first in England to put something like this together. “We are a group of 26 women, almost all of whom previously lived alone. We come from a variety of backgrounds and cultures and our ages range from early 50s to late 80s. Although we are all very different and have our own particular interests, family connections, work — some of us are still working — or health difficulties or disabilities, what we all share is a determination to stay as self-dependent and active as we can as we get older.”

Best of all, they want to help other groups like theirs. This concept started in Holland, and they then adapted it to work for them. On their website, they offer information on how they got started (it was the first in the UK and took 20 years) and what you can do if this is something that you find appealing. They are in charge of their lives, self-manage the property, and have good companionship while doing so. Check out their videos for more information.

The benefits of co-housing are huge. No isolation – which leads to decline, lots of companionship, shared activities with people you enjoy being around. And, yet, they still have their own spaces. Those can be apartments, mobile homes or townhomes, set up as a Homeowners Association (HOA) to which they pay a fee that covers all the common areas. Since the property management is shared by the owners, they all have a part in decision-making.

Tiny houses, etc.
For many, there’s a desire to downsize, to live in a smaller space, one that’s more eco-friendly, easier to care for and costs a lot less than just about any other residence. The popularity of tiny houses (under 400 square feet) has grown a lot for just these reasons. Variations on this concept include modular (or mobile) homes, prefabricated units that can be moved to different locations or be a permanent home, and houseboats that, again, can be permanently moored or used for travel.

All these abodes are beautifully designed, efficiently using every bit of space available, and can fit any budget. For tiny houses, construction plans are readily available so you can choose exactly what amenities you want. Some can also be on wheels. For modular homes, the options are endless: single or double wide, motor coach (used for travel as opposed to staying in one place), and a huge variety of interior layouts.

Though more popular in the Sun Belt states, tiny house communities and mobile home parks exist everywhere. Some have facilities to rival any resort and an active social calendar for residents. The only caveat is to check local zoning ordinances before buying your own space or placing a mobile home on a lot. Check also for access to water, sewage, and electricity or gas.

Wherever you choose to live, in whatever circumstances, if there is an option to try something out first before you commit, do it. For instance, Airbnb has tiny house rentals. Some of these may sound great on paper, but the reality can be far different than your expectations. And, no matter what, you can always move to another location. Just be open to all the possibilities afforded you and you can’t go wrong.

Your peace of mind is always top of ours
Acts is one of the most trusted, most experienced names in retirement communities. Our worry-free Acts Life Care® plan protects your nest egg with predictable monthly fees. Add nearly 50 years of financial stability and a long-tenured staff known for loving-kindness, and you’ll see why we earn a 98% satisfaction rating with current residents. Contact us today.

 Acts

RETIREMENT-LIFE COMMUNITIES

Where loving-kindness lives

BUCKINGHAM’S CHOICE - 3200 BAKER CIR, ADAMSTOWN, MD
FAIRHAVEN - 7200 THIRD AVE, SYKESVILLE, MD

FOR PRICING AND MORE INFORMATION VISIT ABOUTACTS.COM/BALTSUN
A series of events forced author Abigail Trafford to reevaluate her life. The first occurred when she was 50, after a colleague subtly implied she was a bit too old for a new job opportunity. It stopped her dead. That person used the phrase, “At your age.” It stung. What does that mean, “At my age?”

That first ‘jolt,’ as she called them, became the genesis of her second book, My Time: Making the Most of the Bonus Decades AFTER FIFTY, celebrating people who took their jolts, their “aha moments” or their tragedies, and created new, better, more fulfilling lives for themselves.

If you read the obituaries, you’ll notice that people are living longer – and not just a little longer; they’re living into their 90s. Suddenly, we have all these extra years, healthy years, years where our brains and bodies still function – most of the time – and long past what used to be the average retirement age of 65.

“I knew inside that my life was far from over at 50,” Trafford reminisces, “but we make assumptions regarding age because that’s what we’re repeatedly told – in advertising, movies, TV programs, books. It was time to reassess these stereotypes. What may have been true in the past is no longer true or accurate, not for me, nor for others I know. The new reality was we had a freedom to do pretty much whatever we chose.

“I called these turning-point moments jolts because that’s how I felt when they happened” Trafford relates, “akin to lightning bolts that shocked me out of complacency: a comment, a statement, sudden insights that changed how I viewed myself and my life. Sometimes these jolts are major such as the death of a loved one, or the end of a job; some are wondrous a new love, the coming of grandchildren. There was a cumulative effect, each jolt pushing me to take time to figure out who I was, where I was going, and, most importantly, what did I want to do next. It was my time, my choice. The rules that I grew up with were no longer relevant.”

For a majority of her career, Trafford was editor of the Health section of the Washington Post. “We wrote about the common health stories – medications, changes in treatments, new discoveries – but one narrative stood out from all the others. It was about health span and life span. Yes, we lived longer, but it was more than that. We lived healthier longer.”

Given her observations, these new realities – experienced and witnessed – removed prior expectations embedded in us as children. Yes, we had friends die, or we experienced a personal tragedy, or we divorced or retired. These events only acted as spurs to look inward. Then we moved on, said “I get it,” and chose how we would live after them. As Trafford wrote, “Study after study shows that you’re much more resilient in the face of crisis compared to young adults.” One phrase jarred her more than others: “Too old to live. Too young to die.” That’s other people’s expectations, that should be slotted into a category that simply wasn’t accurate.

And so, we charged into our “bonus years,” those years from 50 to 80 and beyond, finally choosing to be our own best selves, to fulfill our dreams. “We’ve completed the agenda of adulthood,” Trafford wrote. Because we were more comfortable in our own skins, at last, we could say, “This is what I always wanted to do, this is the person I always wanted to be, and now I can.”

“I started reaching out to people, interviewing them on how their journeys had taken them into their bonus years,” Trafford says, “and I was inspired by their resilience. Those who survived tragedies were able to love again. Others wanted to combat the constant barrage of hateful messages and contribute to making their personal worlds a better place and giving back.

“What I found was a new lifecycle, a personal renaissance between middle age and old age. For many this new stage begins with a transition phase, one I’ve dubbed ‘second adolescence,’” says Trafford. “In our teens and 20s, our first adolescence, we have no qualms, no fears, and willingly try new experiences. This is echoed in these bonus years. Biologically, a 75-year-old is a 65-year-old, so we view mortality differently. It’s also why asking, ‘What’s next?’ is so important. It’s about how our life will look in this stage.”

With this book, Trafford has created a psychological road map for us and the generations that follow, to navigate this part of our lives, to show that we have the option to recreate ourselves many times
over. “Dreaming,” she warns, “is essential and takes time.” There is no right answer. The question, though, is “what makes you happiest?” “What matters most?”

Some people really branch out, seeing this as a growth period. We are representative of the longevity revolution. We can have creative lives. To find answers, take a break. Do something totally different that allows your mind to roam, to consider all options out there.

But, sadly there’s a double paradox. While we have the opportunity to reinvent ourselves, at the same time there are real insurmountable obstacles, usually built on ageism, like when we’re told, “You’re too old.” So, it’s an existential question that society and individuals need to ask. “I have another 20 or 30 years. How am I going to live it?”

Trafford recommends figuring out who will be on your team, who will you love and who will surround you? Partners? Friends? Grandchildren? Yes, we’re slowing down a bit, but it’s more about quality than quantity. When you’re younger, you meet and connect with lots of people. Now, it is about choosing with whom you want to spend time. We know how to be a friend, how to relate to people, so we value this inner circle and these friendships more.

She had a few final thoughts to toss into the hopper for consideration. “Be kinder to yourself. Every stage in life has its problems, its complications, and depression can be a real issue. So, do something. Get feedback. Fight the ageism you encounter. Find your personal cheerleaders to be sounding boards.”

What’s her next step? “I’m writing a memoir, mainly for my family,” Trafford says, “and I wrote two plays, musicals that were produced in Boston. Time with my grandchildren is a delight. Most of all, I mirror the positive energy I saw in those I met while writing the book.”

Do you have bonus years ahead of you? Probably. There are no statistics, no studies that provide concrete proof. But look around. Most of my contemporaries haven’t retired or, if they did, they’ve created a new, multi-faceted life for themselves. Two friends, one 68 and the other 75, both started new businesses over a decade ago and they have no intention of quitting yet. Another has a home-schooled grandchild and he’s the PE teacher. A woman in her mid-80s works at a farmer’s market on weekends.

Trafford, in the epilogue of My Time writes, “Sometimes, you don’t realize you’re in a rut until you get out of it.” Ask her “What’s next?” Her response, “I can hardly wait.”

Abigail Trafford: The chronicler of our lives

Abigail Trafford writes books for every consequential period in our lives, helping us get through those times when we need to know we’re not alone, that what we’re going through is often a shared experience. Her first book, Crazy Time: Surviving Divorce and Building a New Life, was published when American divorce rates skyrocketed.

My Time: Making the Most of the Bonus Decades AFTER FIFTY appeared as the first cohort of baby boomers had an epiphany: they were nothing like their parents, heading into retirement. Instead, they felt as if they were just coming into the prime of their lives, still vibrant, energetic and capable of great accomplishments – despite the ageism they started to face.

Her most recent tome, As Time Goes By, describes “romantic adventures in an age of longevity.” As one reviewer wrote, her “powerful, well-told tales of love in the second half of life shine a light on what matters most – not only in later life, but all along the way.” Love and affection come in many forms as do the ways we connect with partners, families and friends. “The dynamic variety of relationships in this stage is stunning.” Trafford writes, inviting us to join her in a journey to understand the myriad of ways we integrate with these varied people. She gives us a different roadmap that says anything we choose is now normal, is now permitted, as long as it works for us.
Stanley Cook lives in New Jersey; his parents, now in their late 80s, in Ohio. For a while, they managed their lives by hiring a part-time driver who could take them on their errands and help with small tasks. Soon, that wasn’t sufficient. Many more doctors’ appointments — but what did the doctor say? Greater difficulty getting around — but what if one of them had a fall? Flying back and forth wasn’t really feasible or practical. Since Cook left his hometown years ago, he didn’t know what services or support were available or to whom he could go for help.

He, like many of us, learned about role reversal as he became responsible for the people who raised him. His solution: a Geriatric or Aging Life Care Manager.

“Although our profession has been around for over 35 years, we’re still the best kept secret when it comes to managing the aging process,” says C. Taney Hamill, CEO of the Aging Life Care Association (ALCA: www.aginglifecare.org). “Our members understand care management and understand what a family is going through, all the different parts that are involved, and how to bring it into focus.”

Case managers, certified by the American Case Management Association (www.acmaweb.org), are usually employed by hospitals or health care delivery systems, so their mandates revolve around the services a hospital provides. For aging individuals, though, their needs extend beyond medical requirements. That’s where an Aging Life Care Manager steps in.

“Aging Life Care Managers are highly educated and credentialed professionals who take on the role of a health and human services specialist,” says Hamill. “They are experts in eight different areas, so they can guide family members or individuals through the maze of care and personal needs as they get older. They also invest in education and training so they’re current with new information and research.”

“We help people navigate longevity,” explains Ellen Platt, M.Ed., C.R.C., C.C.M., of the Option Group (www.theoptiongroup.net) and an ALCA member. “Yes, there’s usually a health issue, but it is so much more. Each client has a different story, different requirements, different issues, so every care plan we create has to fit that individual’s needs.”

Platt has a Master of Education degree and is credentialed as a Certified Rehabilitation Counselor and a Certified Case Manager. She and her staff constantly attend continuing education classes to maintain their certifications and to ensure their knowledge is always current.

“We always start with an initial assessment that includes a cognitive screening as a baseline,” says Platt. “It will include an inventory of the person’s life and situation. For instance, are all the legal documents, including an advanced directive, in place? We find out if there’s a point person with whom we can be in contact. Next, needs are ranked by importance and an understanding of what the person wants.”

Included in this assessment is a clinical picture: diagnoses, medications and basic activities of daily living (ADLs) — fundamental tasks a person performs to maintain autonomy throughout the day, such as bathing, personal hygiene, dressing, eating and mobility. Instrumental ADLs include executive functions, like the ability to pay bills, shop, meal preparation, home maintenance and managing medications. As these abilities change, so do the client’s needs.

“We look at gaps,” Platt says, “such as the infrastructure around the person. The care plan should be the least restrictive but, at the same time, the safest. With so many resources now for staying in one’s home and aging in place, we are
like the hub of a wheel, bringing in only the specific help required. Of course, this changes over time and we’re there to act as a go-between, only adding what is necessary. Health care is local. Our job is to know all the players, all the services that are available – both private, state or federal, all the options as people age.”

Long distance families are only one type of client Platt works with. “Sometimes there is a short-term need, and we have to act immediately. It can then morph into a long-term care plan that’s sustainable and affordable. Other times, when we step in, it’s to relieve caregivers who are burned out.”

And, sometimes, it’s an individual. Michelle Douglas is 65 and an “elder orphan;” she’s been single all her life and doesn’t have any remaining relatives. “I want someone in my back pocket whom I could trust. If I become ill or can’t take care of myself, I wanted someone to be my advocate, to represent me if I couldn’t. I also wanted to know my options going forward.”

For Douglas, Platt created a blueprint.

“She wanted me to go with her to doctor’s visits, trap the information and be an objective participant. We schedule regular reviews so that I was constantly updated on her status. It would probably be many years before she needed me for more, but, when the time came, we’d both be ready.”

Hamill explains the eight knowledge areas in which her members are qualified to assist. “Health and Disability is the first, and that ranges from physical problems to mental health and dementia issues. Aging Life Care Managers can deal with various health care delivery systems, going with clients to doctors’ appointments and reporting to the family. When the time comes, we can help figure out what services are essential, even including home health or hospice. They’ll engage and monitor them.

“Next is Financial, reviewing or overseeing bills. Because our members stay current with federal and state entitlements, they can connect clients to those and any local programs of which they may not be aware. Housing covers living arrangements, relative to either aging in place or helping to find appropriate venues. When it comes to Families, having someone who is stays unbiased while looking at the whole picture is extremely worthwhile. As mentioned, previously, access to Local Resources is a strength as are recommendations to Legal professionals who understand issues related to aging. Last are Advocacy, standing in for family, and Crisis Intervention for when an emergency occurs, or there’s need for ongoing care.”

Being an Aging Life Care Manager can be labor intensive as many are on-call 24 hours a day. There’s also an emotional toll. “Yes, you have to be professional at all times, similar to being a fiduciary – always acting in the best interests of the client – and we don’t take that lightly,” says Platt, “but at the same time, it’s intimate. Ultimately, your clients die, so we try to take care of ourselves whenever possible. Plus, because we have a team with different areas of expertise, we can take breaks.” Nonetheless, her role is be aware of future needs. “We’re always scanning the horizon for upcoming issues or to prevent bad things from happening. We also know what is normal and what isn’t. And if there’s a medical event, any emergency, we are there.”

When looking to hire an Aging Life Care Manager, you have a couple options. It can be a one-time visit where they create a blueprint for you and your family to follow and provide you with options or recommendations for resources. For instance, if you’re visiting a senior living residence, they can provide a list of questions, so you get all the information you need to make an informed decision. Some are now offering tele-care management.

Alternatively, they can work under a long-term contract with hourly rates, meeting regularly to make sure everything is on track. In many ways, this person becomes a member of your family, your local, personal representative when you can’t take on this job. With age, it helps to have an extra pair of eyes and ears when

Aging, continued on page 17
Is an activity tracker right for you?

Technology to help keep your fitness regimen on track

By Margit B. Weisgal, Contributing Writer

Activity trackers seem to be everywhere with more coming on the market every day. There are different types, such as bracelets and watches you wear on your wrist (the most common), plus rings, clip-ons and even a version that is in helmets.

“Physical fitness is not only one of the most important keys to a healthy body, it is the basis of dynamic and creative intellectual activity.”
– John F. Kennedy

And the options go on forever depending on what information you want to elicit your purpose for using one. Most people track steps but, depending on how fancy a tracker you choose, you can see your heart rate, how much sleep you get and the sleep state, calories you burn and your location. If you’re a swimmer, biker or runner, sports-specific information is also available.

With prices ranging from $25 for a device that provides very basic information (like a pedometer) to hundreds of dollars for more complex gadgets that measure all kinds of data, first figure out what you want a tracker for and how committed you are to using one.

Before making a purchase, though, alternatives to trackers are also available. A quick glance at the app store of your choice, either iOS or Android, and you’ll see dozens of tracking programs you can load to your smartphone, ones that count your steps or monitor your sleep, so you don’t necessarily have to spend any money.

But then there are questions you should answer before you buy or download. How will you use it? What activities do you plan to track? What health information do you plan to track? And when you track that data, will it improve your health? Could the use of a device really motivate you to improve your physical health?

A study of 800 participants and how they use fitness trackers was published in The Lancet Diabetes & Endocrinology. The investigators randomly assigned them into four groups, looking at their motivation and on-going use.

- A: no tracker or incentives
- B: a Fitbit tracker and no incentives
- C: a Fitbit plus charity incentives
- D: a tracker and cash incentives

After six months, researchers found the cash incentive was most effective for producing results but, once the incentives were discontinued, the use by those who received trackers slacked off. Not only that, they identified “no evidence of improvements in health outcomes, either with or without incentives, calling into question the value of these devices for health promotion.”

Then there was an analysis of previously conducted studies published last year in The American Journal of Medicine. It concluded that there was “little benefit of the devices on chronic disease health outcomes.” Yes, activity trackers play a role in “motivating and accelerating physical activity,” but that is all they do. If that is what you’re looking for, then go for it. But, long term, there were no consistent health benefits such as incentivizing you to do enough to lower your blood pressure or reduce your cholesterol levels.

One more study cited by the Mayo Clinic (www.mayoclinic.org) looked at weight loss and found that the control group – those without a fitness tracker – lost more weight than those using them, suggesting that those who reached their goals rewarded themselves a bit too often when they reached their goals.

So, how can you use a device effec-
How Dangerous Can It Get?

Michelle Fritsch, Pharm.D., of Retirement Wellness Strategies (www.retirewellness.com) recounted a case study that highlighted the dangers you can face. These types of scenarios are often not caught and fixed, leading to rapid decline and death. It is also why you should always carry a complete list of the medications you are using: ones prescribed by your doctors that you take daily and those you take occasionally (as needed), plus all the supplements and vitamins.

Arthur V., a 71-year-old man who lived alone, suddenly experienced a loss of memory during a phone conversation and was rushed to the hospital. Over the course of several weeks it was determined he did not have a stroke. His records indicated a seizure disorder, but the cause of the confusion was not found. He was sent to, then failed, rehabilitation because his thinking continued to be clouded. He was then transferred to an assisted living facility where he usually stayed in his room, in his bed, and did not engage with other residents or activities.

“Sadly,” relates Fritsch, “there was no communication between the primary, the neurologist and the hospital, so no one person had the complete picture. I was asked to participate in finding the source of this big change in his thinking. Upon talking with his primary care doctor, we learned one of his primary medication doses had been increased to treat some nerve pain. At the same time, his neurologist had started a new medication for another condition. Of note, three of Arthur’s medications could be used to treat a seizure disorder, but in his case, all had different purposes.”

In conjunction with the primary care doctor, Fritsch created a plan to very gradually taper him off the nerve pain along with the medications the neurologist prescribed. These medications (and many others) must be tapered slowly and one at a time, so it should always occur under the guidance of a doctor. Another snag was that the primary care doctor’s order was not accepted by the assisted living facility, which required the order to come from the internal prescriber. After two weeks of daily phone calls and e-mails, one of the prescribers in that office consented to write the taper orders. With each dose decrease, Arthur became more alert. He regained all his cognitive/thinking abilities. But, because he had been bed-ridden and hadn’t walked in a few months, physical therapy was required to get him back to his former physical abilities. After nine months, he finally returned home, completely independent again.

Medications for the Elderly, updated in 2019. It states, “With more than 90% of older people using at least one prescription and more than 66% using three or more in any given month, the AGS Beers Criteria plays a vital role in helping health professionals, older adults and caregivers work together to ensure medications are appropriate.” Physicians and other health care providers may not be aware of the list or what medications are included. But these are not absolutes. The medications and alternatives are there for guidance; your doctor’s expertise and knowledge and your specific situation should always be taken into account.

Another person you should consult with is your pharmacist. Ask if you can make an appointment to review your medications. When you do, include all the OTC supplements and vitamins you also use. But, because the FDA does not oversee supplements with the same level of scrutiny as drugs, there are very few studies as to whether or not they work or are safe for older adults to use. Another caveat is that, again, because there is limited oversight, you don’t always know what ingredients are included and if the correct dosage is on the label.

When you start a new drug regimen, ask the pharmacist about potential side effects that may happen when you take it and review the insert. Harris recommends you know the answers to the following questions:
1. Why am I taking this medication?
2. For how long should I take it?
3. When should I stop it?
4. What should I look out for?

Harris says, “Some people stay on medications for too long or even after the condition has cleared up. When you’re prescribed a medication, you should understand how you’ll feel if it’s working, and for how long your doctor expects you to take the medication: Weeks? Months? The rest of your life? If it causes problems, don’t wait to react. Contact your doctor and pharmacist right away. Anything you add into your medication mix can potentially cause a problem. Ask if there are any specific foods, medications or supplements you should avoid. And, whenever you are prescribed a new medication, ask whether any of your currently prescribed medications can be discontinued.”

You should do your own investigation into medications and supplements but choose your sources wisely. MedLine Plus (https://medlineplus.gov/) is a service of the National Library of Medicine (NLM), the world’s largest medical library, which is part of the National Institutes of Health (NIH). Search under “Drugs & Supplements” for detailed information including warnings, such as special precautions, dietary instructions, side effects, and what to do in case of emergency.

The Lown Institute report concluded that strong measures need to be implemented immediately. “Without swift action Medication, continued on page 19
Dementia from page 4

mon form and is caused by bleeding and blocked blood vessels in the brain. But, just because someone experiences memory loss, it doesn’t always indicate you’re getting dementia. Thyroid problems, vitamin and nutritional deficiencies, sleep disorders, and other conditions can also be the cause.

Amjad recently completed a study that found “a substantial majority of older adults with probable dementia in the United States have never been professionally diagnosed or are unaware they have been. Timely diagnosis is important for maintaining or improving health and planning care,” she says, “so it’s important to identify which populations are less likely to be diagnosed or less likely to be aware of their diagnosis. Without a diagnosis, treatment and support are delayed which could help alleviate the effects.”

It’s not always dementia
Not every lapse of memory should concern you. Memory gaps happen throughout our lives, like losing your keys, forgetting why you walked into a room or grapping for a word that eludes you in a conversation. There’s a real fear many of us experience as we age, that every time something like this happens, we should worry and rush out to be assessed.

Seniors with depression can exhibit signs of dementia. Sometimes called pseudo-dementia, depression with cognitive impairment can be a harbinger of dementia. “It depends on the patient,” says Amjad. “Sometimes we treat the depression and the symptoms clear up; other times we send them for a full neuropsychological assessment.”

In addition, some medical conditions can mimic dementia or cause memory problems, which is why a comprehensive examination is so important. Once these are addressed, the incidences of dementia may decrease. The Alzheimer’s Association lists these:

• Side effects of certain medicines
• Emotional problems, such as stress, anxiety or depression
• Certain vitamin deficiencies
• Drinking too much alcohol
• Blood clots, tumors or infections in the brain
• Delirium

• Head injury, such as a concussion from a fall or accident
• Thyroid, kidney or liver problems

Medication overload should always be assessed. According to the Centers for Disease Control and Prevention, one in five adults aged 40-79 “used at least five prescription drugs (22.4% in the United States and 18.8% in Canada). Polypharmacy, often defined as the simultaneous use of five or more prescription drugs, is more common in an aging population where multiple coexisting chronic conditions often occur.” Thus, there is a greater possibility of multiple side effects and conflicting drug interactions.

Early detection
Should you – or someone you know – exhibit any of the following symptoms, see a doctor. Early detection of dementia allows for earlier intervention. Conversely, if there is a separate cause for the symptoms, it can be addressed more quickly. Some symptoms to look out for include:

• problems with short-term memory
• keeping track of a purse or wallet
• paying bills
• planning and preparing meals
• remembering appointments
• traveling out of the neighborhood

Dementia and Alzheimer’s diagnoses are usually determined by several factors: a comprehensive medical history, a physical examination, laboratory tests and recognition of early symptoms in a person’s normal routine. Since there are lots of types of dementia, many overlap so it’s difficult to get a precise diagnosis. Referral to a neurologist or other specialist may be the next step.

“At our Memory Clinic, we have a procedure for individual evaluations. Sleep disorders are screened for, as is hydration, nutritional status, vitamin deficiencies, depression and anxiety. Our first goal is to see what it is not. Is there a secondary condition causing the problems? Alzheimer’s is a diagnosis of exclusion,” Nowrangi explains.

Amjad adds, “We look at ‘has there been a change?’ If it’s memory or behavioral, does the person understand and retain information. If it’s functional, what activities are a problem? We take other factors into consideration. For instance, how difficult is the activity? Eating is easy; arranging your medications is more difficult and takes more brain muscle to accomplish. We also determine if there’s been a change in personality. Change is the key to detecting dementia.”

“On the plus side,” Nowrangi he continues, “we can now detect Alzheimer’s using sophisticated neuroimaging. With Alzheimer’s, there is an accumulation of two proteins that occur naturally in the brain: amyloid and tau. In a normal brain, garbage cells get rid of proteins the brain doesn’t need, but with this disease, these two proteins accumulate and disrupt the normal function of the brain’s networks. With a PET scan (Positron-emission tomography), we can see the build-up of the amyloid proteins and, later, the tau toxic proteins. We’re also well on our way to developing a blood test to detect Alzheimer’s, probably within the next year or two.”

Despite knowing that amyloid and tau proteins accumulations disrupt normal brain network functioning, 30 years of research and 150 trials later scientists still don’t have a solution for Alzheimer’s. They’re now looking at alternative theories. “Since medications, so far, haven’t progressed, we don’t have something that targets the underlying mechanism of Alzheimer’s disease. It’s like looking at an elephant,” says Nowrangi. “One person only sees the trunk, another the leg. We have to change our perspective.”

One area that’s showing progress is understanding the interaction between lifestyle and disease. The FINGER study in Finland tested the effect of intervention in delaying cognitive impairment and disability in at-risk participants 60-77 years of age. They reported that a two-year combination therapy simultaneously targeting physical exercise, a healthy diet, cognitive stimulation, and self-monitoring of heart health risk factors had a protective effect on cognitive function.”

This study is being replicated now in other countries including the U.S.

“In many countries,” explains Nowrangi, “people benefit from multigenerational living so those who are aging are not left to flounder on their own. In the U.S., depending on their support system, seniors can skate by without a formal diagnosis. Today, there are approximately 5.7 million Americans living with Alzheimer’s and more with other forms of dementia, but that is expected to grow to 17 million over the next few years. It’s an epidemic in the making.”

With our aging population, the amount of money needed to care for those with dementia is taxing available funds. The Alzheimer’s Association says, “…In 2019, Medicare and Medicaid will spend an estimated $195 billion caring for those with Alzheimer’s and other dementias – 67% of total costs.” As the number of
those with dementia grows, so will the costs.

Potential prevention

“Age is the biggest risk factor,” says Amjad. “By the time people are 90 years old, 30-40% will have some dementia, but it is not part of the normal aging process.”

“There’s usually some cognitive change that’s appropriate for advancing age. That’s normal. We’re learning that lifestyle is the most important prevention to dementia: diet, exercise, eating a Mediterranean diet – akin to the lifestyle recommended for preventing heart disease,” says Nowrangi. “What varies in the two types of lifestyle is the importance of brain plasticity: mental resilience and accrued mental and intellectual capital we build up over our lifetimes. This will create a small barrier to age-related decline.”

Amjad concurs. “Risk factors for dementia such as age and genetics cannot be changed. If you’re really concerned, talk to your doctor. With normal aging there’s some deterioration in memory. Ask if what you’re experiencing is normal or could it be more. Those with a family history tend to be more aware of lapses and become concerned more quickly. Most of all, don’t panic. If your symptoms are mild and you’re doing regular activities, don’t imagine the worst possible scenario. You can live well with dementia and, depending on your age and other medical conditions, may never see the severe stage. And you can control your environmental and lifestyle factors that will keep you healthier.”

Five research studies reported at Alzheimer’s Association International Conference (AAIC) 2019 suggest:
- Adopting four or five healthy lifestyle factors reduced risk of Alzheimer’s dementia by 60% compared to adopting none or only one factor.
- Adherence to a healthy lifestyle may counteract genetic risk for Alzheimer’s disease.
- Having a higher cognitive reserve, built through formal education and cognitive stimulation, may benefit the aging brain by reducing risk of dementia among people exposed to high levels of air pollution.
- Confirmation that early adult to mid-life smoking may be associated with cognitive impairment at mid-life, as early as one’s 40s.
- Alcohol use disorder significantly increased risk of dementia in older women.

A post from the Alzheimer’s Foundation blog sums up the studies’ findings: “The future of dementia prevention could be in treating the whole person with a combination of drugs and modifiable lifestyle changes – as we do now in cardiovascular disease.”

Tips for dealing with forgetfulness

The National Institute on Aging provides some techniques you can use to deal with memory lapses. Here are its recommendations:
- Learn a new skill.
- Stay involved in activities that can help both the mind and body.
- Volunteer in your community, at a school or at your place of worship.
- Spend time with friends and family.
- Use memory tools such as big calendars, to-do lists and notes to yourself.
- Put your wallet or purse, keys and glasses in the same place each day.
- Get lots of rest.
- Exercise and eat well.
- Don’t drink a lot of alcohol.
- Get help if you feel depressed for weeks at a time.

Most of us know someone with dementia or Alzheimer’s and have seen or heard, first-hand, the challenges created by this cognitive impairment. It doesn’t mean, nor should you worry about, it happening to you. Accept that you’ll misplace or lose your keys or your glasses. Accept that you’ll go back a few pages in that book you’re reading. Accept that you’ll occasionally forget why you entered a room. Accept that you can’t remember what you were going to search for when you open a browser.

Choose, instead, to adopt a lifestyle that will give you the best chance possible to remain mentally healthy throughout your life. Stretch your mind (a lot), interact with multiple generations, be active. And, if the time comes, know there are good people out there who will help you find your way.

•

Questions to Ask When Looking for an Aging Life Care Professional

Aging Life Care Professionals who primarily work with older adults bring more to their practice than an expertise in geriatrics. They bring knowledge of aging issues that allows them and their staff to overcome the myths relating to aging and to focus on the problems at hand. At the same time, they will bring an experience of working with resources in your community. They are most aware of real-life problems, health and otherwise, that emerge as persons age and the tools that are available to address those issues. They are also connected with a community of social workers, nurses, psychologists, elder law attorneys, advocates, and other elder care professionals who may be of assistance to you.

It is important for the wise consumer to ask questions. Some of these include:
- What are the primary services provided by your agency/business?
- How many Aging Life Care Professionals are in your agency/business?
- Is there a fee for the initial consultation and, if so, how much?
- Are you licensed in your profession?
- How long have you been providing aging life care or care management services?
- Are you available for emergencies?
- Does your company also provide home care services?
- How do you communicate information?
- What are your fees? (These should be provided to the consumer/responsible party in writing prior to services starting.)
- Can you provide me with references?

The answers to your questions will assist you in determining whether that particular Aging Life Care Professional and agency/business has the qualifications important to you for a successful relationship. If you have a specific issue that requires immediate attention, be sure to inform the Aging Life Care Professional of this during the initial conversation.

Source: Aging Life Care Association

ALCA (www.aginglifecare.org) has a search function for you to locate professionals in your area. “ALCA members have specialized degrees and experience in human services, such as social work, psychology, gerontology or nursing, and are expected to adhere to ALCA’s Standards of Practice and Code of Ethics.” The association still recommends you do your due diligence in selecting someone and has a page of questions for you to ask when you interview someone.

Families will always be on the front line as their relatives age, but knowing there are competent, qualified people out there who can guide you and support you is priceless. •
Good news? Bad news?
Alleviating the anxiety around a dementia diagnosis

By Margit B. Weisgal, Contributing Writer

For some reason, you – or a family member – thinks you need to be evaluated for dementia. Before assuming the worst, know that there are myriad causes that mimic dementia, so don’t immediately think there is something wrong with you. That is the whole point of getting an assessment: to figure out what is really going on.

“The purpose of a cognitive evaluation,” says Dr. Cynthia D. Fields, a geriatric psychiatrist at MedStar Good Samaritan’s Neuropsychiatry Institute and The Center for Successful Aging, “is to figure out what is really happening, why someone is having memory problems. Especially during a first visit, patients arrive filled with anxiety, fearful of having their memory tested and what I will tell them. They anticipate something awful, along the lines of ‘you have dementia’ or ‘you have Alzheimer’s disease.’ It doesn’t work that way.”

Fields usually begins with an interview. Her time is spent, one on one, only with the patient, putting her or him at ease because they’re frequently afraid. They are usually there because a family member noticed changes. Patients are afraid of what she will say, expecting bad news right away.

“There are indirect methods of assessing memory through judicious questioning,” Fields explains, “so I ask them to tell me about themselves. Have they noticed any changes? Has someone else commented about a problem? Has it affected their day-to-day life? What do they think is going on? I’ll then ask about their medical conditions, what pills they take, how much alcohol they drink, etc. A loss of memory means a loss of control. If small issues can be fixed, they feel in control again, a positive beginning.”

After the first visit, Fields brings in the family to get their impressions. If they instigated the evaluation, she wants to learn what they noticed and when, a timeline of the changes. They may have noticed a worsening of short-term memory, changes in problem-solving, or problems with finding words. They often bring up functional disparities – cooking, shopping, medication management, handling finances and even driving.

“An accurate diagnosis takes time, over several visits, and it’s somewhat a process of elimination,” explains Fields, “so you cannot jump to conclusions. One big imitator of dementia is depression, as well as medication side effects, so those need to be ruled out first. Because depression is so stigmatized, some patients fight treatment or won’t take those medications when needed.”

At a follow-up visit, Fields slowly introduces cognitive testing using a standardized one-page test that won’t cause unnecessary anxiety. She also looks at cognitive reserve: level of education, occupation and lifestyle. She does bloodwork, another part of the assessment where issues can mimic dementia. She orders a brain scan to see if there is any atrophy or shrinkage; some is normal, but is it age-appropriate? Or is there evidence of brain vascular disease such as old strokes?

“The possibilities are endless when it comes to causes of cognitive impairment and dementia – or what appears to be dementia,” Fields explains. “There are many contributing factors and they tend to be cumulative, so it’s a process of weeding them out or going down a checklist, sometimes one by one.”

In addition to reviewing all medications, Fields looks at thyroid function, vitamin levels, blood pressure and cholesterol. She checks for dehydration, a major cause of disorientation. When it comes to pills, anything containing Diphenhydramine (commonly known as Benadryl) is bad for cognition, and this includes over the counter remedies such as Tylenol PM or Advil PM. You should also limit the use of alcohol and substances.

What if it is dementia? “It’s progressive, so it will get worse,” says Fields. “Fix what can be fixed. Manage what can be managed. Right now, the approved medications are not disease-modifying, so they won’t change the prognosis, but they may stave off some deterioration. In the future, it will probably be about prevention, but, meanwhile, we work on what can be controlled and what can be done to slow the progression.”

What can you do today? “Lots of things. Healthy body, healthy brain,” Fields says. “Shake things up, stretch your mind as much as possible. Add activities that employ language. If it’s enjoyable, odds are you’ll do more of it. Address any physical issues like high blood pressure and cholesterol. Control your diabetes. Exercise regularly. Eat a healthy Mediterranean diet. Stay hydrated. It makes a big difference with energy, fatigue, and memory. And get enough sleep.

Fields wrapped this up with some final observations. “Gaining insight into this condition can be incredibly painful, but an evaluation can help. With age, even if you’re completely healthy, multitasking tends to go out the window for just about everyone. Do one thing at a time. Figure out how to compensate. Make lists and start using a weekly pill box. Set yourself up for success. Let go of what you ‘used to able to do.’ Above all, be kind to yourself. It’s much better that way.” •
Medication from page 15

to curtail overprescribing and reduce medication overload, the harm from adverse drug events will only worsen. The Lown Institute estimates that adverse drug events will be responsible for at least 4.6 million hospitalizations of older people in the U.S. and as many as 150,000 premature deaths over the next decade. Medical care to treat ADEs will cost taxpayers, patients, and families an estimated $62 billion,” according to its report.

For your health and well-being, schedule these actions as soon as possible. Create a list of every medication and OTC supplement you take and keep a copy in your wallet or on your phone. Provide this list to all the physicians you see. Update it whenever there is a change. Safely dispose of medications you no longer take. And schedule an appointment with a pharmacist to review your drugs. There are more than enough reasons for our health to decline. Make sure your drugs aren’t one of them.

Questions About Your Medications You Should Ask Your Doctor or Pharmacist

It’s important to know as much as possible about the medicines you’re taking. Here are some examples of questions you might ask your doctor or pharmacist:

• What can you tell me about this medicine?
• How will I know that this medicine is working? How long will it take before I notice anything?
• Will I need any tests while I’m on this medicine?
• Is an older or less expensive generic version available? Will it work for me?
• Why am I taking it?
• Why is this the right medicine for me?
• Is there something I can do instead of taking this medicine?
• Is there a medicine that could be better for someone my age? For a man or woman?
• When and how do I take it?
• How long will I have to take it? What if I begin to feel better?
• When do I take it (e.g., early, late, morning, evening, before bed, once a day, other instructions)?
• What if I miss a dose? Do I take two doses the next time? Do I take the missed dose right away?
• What about food and drink?
• Do I take this medicine with or without food or water? Can I use grapefruit juice? Should I avoid any food or drink when I take it?
• How long before or after eating do I take it? Does it matter?
• Is it OK to drink alcohol while I’m taking this medicine?
• What about side effects and interactions?
• What side effects can I expect, and how soon might they appear?
• Will they go away on their own? How long will it take? Can I do anything to prevent or manage them?
• When should I call about side effects?
• Do any of my medicines cause a bad reaction with another one?
• What else do I need to know?
• Can I take this medicine at the same time as other medicines?
• How do I store this medicine? Do I need to put it in the refrigerator?
• If I have trouble swallowing, can I split the pill or crush it in food or drink?

The Agency for Healthcare Research and Quality, an official website of the Department of Health and Human Services (www.ahrq.gov) has downloadable forms you can use to track your medications including a Medication Wallet Card to keep with you.

Thanks to Ilene Harris, Pharm.D., Ph.D., of IMPAQ International (www.impaqint.com), for providing this information.

Fitness from page 14

tively? Experts have these recommendations.

First, figure out what your normal routine, your normal activity quota, looks like. Set a baseline, a starting point, looking at what you normally do and your physical status, like how many steps you take daily and how much you weigh. Keep a record for a week or two before you change your routine.

Next, decide on some reasonable goals. Most people walk around 5,000 steps a day, so be realistic about what you can do. Then, set a goal for 2,000 to 3,000 steps higher. When you look back at your numbers, use a weekly total rather than a daily count. Some days we have more time to exercise, while at other times, work or family can get in the way of activities. You’ll also see that days you do less are anomalies, not the norm, a good way to spur you to keep up what you’re doing.

And, if weight loss is a goal, as your activity increases, don’t reward yourself with treats. Be mindful of what you’re ingesting.

If it’s an option, work with a partner, a family member, or some version of a support network. It helps keep you motivated and energized to accomplish your goals. Daily texts or reminders also help you stay on track to reach your goals. Many trackers connect to your smartphone and have software that sends out a nudge to remind you to move, to get up and get going.

For avid sports enthusiasts – runners, bikers, swimmers and the like – fitness trackers specific to their sport can be helpful. They are already motivated to get better at their chosen sport, so these can help them assess their improvements.

It all comes down to what you want, what works for you, what you want to accomplish. Smartphone apps are a good place to start and if you find that beneficial, then you can move up to a fitness tracker that provides more in-depth information. We only have one body. We should do our best to take care of it. Exercise and activity are the right ways to start.
When it comes to retirement, the difference between being second or first could be the difference between taking what you can get or living where you really want, like The Village at Providence Point—A National Lutheran Community. This is a brand-new, maintenance free, 60+, full continuum of care, senior living community coming to beautiful Annapolis, Md. Be one of the first to join our Priority Club, which allows you to get in on the ground floor, or top floor if you prefer, and have a hand in shaping things just the way you’ll want them. Call today to find out how you can stand in the winner’s circle of senior living.

Call 410-849-6891 or visit www.thevillageatprovidencepoint.org today!