



**Psychologists in Long-Term Care
NEWSLETTER**

Volume 21, No. 4

Winter 2007

Introduction to this Issue

Suzanne Meeks, Ph.D.

Editor

smeeks@louisville.edu

IN THIS ISSUE:

Introduction to this Issue. <i>Suzanne Meeks</i>	1
The Geriatric Rehabilitation and Restorative Assessment System: Introducing an Integrated Evaluation for Long Term Care Settings. <i>Kristi Roper & Andrew Clifford</i>	2
PLTC Honor Roll.....	3
An Exploration of Differences Between Elopers & Non-elopers in LTC Settings <i>Susan E. Fisher, Raegan M. Radenheimer, Frederick J. Kier, & Kimberly A. Christensen.</i>	4
Jiska Cohen-Mansfield, Ph.D. Receives PLTC Outstanding Contributions to Long-Term Care Award.....	7
PLTC Welcomes New Officers, Thanks Departing Board Members.....	8
PLTC Membership Report. <i>Mary Lewis</i>	9
PLTC Seeks New Newsletter Editor and Membership Coordinator.....	9

PLTC Board

Michael Smith, Ph.D., *President*
Margie Norris, Ph.D., *Past President*
Merla Arnold, Ph.D., RN, *Treasurer*
Mary Miller Lewis, Ph.D., *Membership*
Shannon Gould, Ph.D., *Secretary*
Suzanne Meeks, Ph.D., *Newsletter Editor*
Erin Woodhead, M.A., and Amanda Schafer Johnson, *Student Representatives*
Associate Editors, Volume 21:
Amanda L. Sacks, Ph.D. *Consulting Issues*
Laura Phillips, M.A. *Research Issues*
Tom Reid, Psy.D., and Susan Fisher, Ph.D., *Clinical Issues*

In this issue we continue our general theme of “hot topics” in long-term care, with two special topics articles. The first, from Kristi Roper and Andrew Clifford, describes work to develop a comprehensive assessment system for use in a variety of long-term care settings. Many of us have expressed frustration about the lack of appropriate measurement instruments for the unique clinical population we see in nursing homes and assisted living. This work appears very promising, and the authors offer the opportunity for others to get involved in the validation of the instruments. In the second article, Susan Fisher and her colleagues at the Pittsburgh VA describe a recent analysis of data related to elopement risk in a nursing home sample. This research highlights the relevance of medical illness burden to understanding elopement risk, as well as the importance of assessing prior elopement behavior and monitoring smoking. I look forward to future work in this area with longitudinal data. In addition to our featured articles, this issue contains important highlights of the PLTC year, including the PLTC Outstanding Contribution award, a summary of membership growth, recognition of the PLTC Honor Roll, and welcome of new officers.

With this issue, my stint as Editor comes to

an end, although I will assist the incoming Editor with the Spring 2008 issue. I again would like to thank the Associate Editors Susan Fisher and Tom Reid, who were issue editors for the current issue, and Amanda Sacks (Consulting) and Laura Phillips (Research) for their critical contributions to the quality and vitality of this publication. They helped make this job a fun one.

The Geriatric Rehabilitation and Restorative Assessment System: Introducing an Integrated Evaluation for Long Term Care Settings

Kristi D. Roper, Ph.D.

Mind Body Wellness PC, Dallas, TX
drroper@mindbodywellnesspc.com

Andrew P. Clifford, Ph.D.

Mind Body Wellness PC, Dallas, TX
drclifford@mindbodywellnesspc.com

People live in Long Term Care (LTC) facilities because they are unable to live independently due to medical and psychological conditions. More than 90% of LTC patients suffer from a minimum of one chronic medical condition that, in some way, limits their functional capacity. Providing geriatric psychological services in long-term care (LTC) facilities and inpatient medical settings typically involves the assessment and treatment of dysfunctional moods and behaviors associated with these psychiatric and medical comorbidities. The Mind Body Wellness Geriatric Rehabilitation and Restorative Assessment System (GRRAS) presents a standardized assessment protocol that delineates emotional, interpersonal, and behavioral dysfunction associated with medical and psychiatric comorbidities, common in patients being treated in LTC and inpatient settings.

The GRRAS contains three distinct but integrated measures of psychiatric and behavioral functioning, designed to be administered at the initial assessment and then repeatedly as a re-evaluation tool during the course of treatment in order to monitor the effectiveness of treatment. The GRRAS consists of the Psychosocial

Resistance to Activities of Daily Living Index (PRADLI; Clifford, Ciper, & Roper, 2003), the Geriatric Multidimensional Pain and Illness Inventory (GMPI; Clifford, Ciper, & Roper, 2005a), and the Geriatric Level of Dysfunction Scale (GLDS; Clifford, Ciper, & Roper, 2005b). These instruments are to be used together as part of a comprehensive rehabilitation and restorative assessment evaluation, or in some cases as stand alone instruments. The GRRAS is to be used by psychologists, clinical social workers, psychiatrists, psychiatric nurse practitioners, and appropriately trained or supervised psychotherapists working in LTC settings or in medical settings.

The GRRAS scales and items are constructed to be utilized with cognitively intact residents and with patients with varying levels of dementia and cognitive impairment. Each instrument of the GRRAS utilizes a clinical interview and behavioral observations of the resident as well as structured interviews with family members, care-takers and health care providers to determine clinical ratings.

The Psychosocial Resistance to Activities of Daily Living Index (PRADLI) is an eight-item clinician-rated instrument that assesses the resident's level of functional independence and cooperation with eight psychosocially related activities of daily living (ADL). The eight domains are (a) time spent out of bed, (b) eating habits, (c) dressing, (d) toileting, (e) bathing, (f) medical/treatment compliance, (g) rehabilitative/restorative functioning, and (h) participation in hygiene/social/recreational activities. These items are rated on a 7-point scale, with 1 representing the lowest levels of independence and cooperation and 7 representing the highest levels of independence and cooperation.

The Geriatric Multidimensional Pain and Illness Inventory (GMPI) is a 14-item instrument designed to assess pain and other noxious illness symptoms (e.g., nausea, weakness, shortness of breath, dysphagia) and their functional, social, and emotional consequences. In the absence of pain *per se*, the GMPI assesses the severity of the resident's primary medical symptom (e.g., tremors, fatigue, sedation, dizziness) and its functional and emotional consequences. All

items are rated on a 10-point scale, with each point associated with specific behavioral criteria. The scaling of the items is behaviorally oriented because the GMPI is completed by a clinician whose ratings are based on both what the resident reports and on behaviors the clinician or medical/nursing staff observe.

The Geriatric Level of Dysfunction Scale (GLDS) is a measurement of dysfunctional behaviors associated with (a) chronic pain or other noxious symptoms, (b) dementia, (c) physical disability, and (d) chronic/acute medical or psychiatric conditions. The GLDS is a clinician-rated instrument that assesses the intensity, frequency, and duration of each of 20 possible dysfunctional behaviors, including but not limited to: depression, wandering, verbal aggression, withdrawal, weight loss, yelling, disinhibition, and physical aggression. All ratings are made on an 8-point scale.

The GRRAS behavioral anchors on the various scales can be utilized to generate goals in treatment planning and then assess the efficacy of specific interdisciplinary interventions over time. The GRRAS is intended as a measure of rehabilitation and restoration for residents who present with emotional and behavioral dysfunction that is judged to be below the potential of the individual resident.

Medical and nursing care in assisted living facilities is often provided by outpatient services or home health services. The GRRAS can be used by or in collaboration with home health service providers and can support the Outcome and Assessment Information Set (OASIS; U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 2006) used by home health service providers. The GRRAS allows for a seamless interface with OASIS documentation. In the nursing home setting, where psychological care is provided in collaboration with the primary physician and nursing staff, GRRAS can support the Minimum Data Set ratings (MDS; U.S. Department of Health and Human Services, Centers For Medicare & Medicaid Services, 2002).

The rates of medical and psychiatric



THE HONOR ROLL

PLTC would like to thank the following people for their generous donations in 2007

Frank Fee
Lynn Horne-Moyer

comorbidities are high in both assisted living and nursing home settings. Comorbidity is associated with higher levels of emotional and behavioral dysfunction, disability, and medical utilization (Cipher & Clifford, 2004; Cipher, Clifford, & Roper, 2006; Gottlich, 2003) and is responsive to multidisciplinary interventions involving cognitive-behavioral therapy (Cipher, Clifford, & Roper, 2007). The GRRAS provides appropriate documentation of emotional and behavioral dysfunction levels using several comparison groups, which help the clinician establish medical necessity and effectiveness of care.

The clinician who uses the GRRAS scales can utilize specific behavioral anchors or composite scores on the GLDS, GMPI, and PRADLI in the development of meaningful behavioral treatment goals that indicate an improvement in resident functioning and measure progress and efficacy of pharmacological and non-pharmacological interventions.

The GRRAS scales also are useful in (a) inpatient rehabilitation hospitals, (b) geropsychiatric inpatient hospitals, (c) long-term acute care hospitals, and (d) skilled nursing facilities (SNF). The GRRAS scales can help delineate patient-specific emotional and behavioral needs to appropriately place them within a LTC setting or at home with home health services and other family or paid custodial care.

The GRRAS will be released and available January 2008 from Psychological Assessment Resources, Inc. (PAR; 1.800.331.8378, www.parinc.com). The Mind Body Wellness (MBW) Institute has opportunities for a collaborative project involving GRRAS clinical trials with clinicians, academics, and students. For more information, please contact the authors at www.mindbodywellnesspc.com.

References

- Cipher, D. J., & Clifford, P. A. (2004). Dementia, pain, depression, behavioral disturbances, and ADLs: Toward a comprehensive conceptualization of quality of life in long-term care. *International Journal of Geriatric Psychiatry, 19*, 741-748.
- Cipher, D. J., Clifford, P. A., & Roper, K. D. (2006). Behavioral manifestations of pain in the demented elderly. *Journal of American Medical Directors Association, 7*, 355-365.
- Cipher, D. J., Clifford, P. A., & Roper, K. D. (2007). The effectiveness of geropsychological treatment in improving pain, depression, behavioral disturbances, functional disability, and health care utilization in long-term care. *Clinical Gerontologist, 30*, 23-40.
- Clifford, P. A., Cipher, D. J., & Roper, K. D. (2003). Assessing resistance to activities of daily living in long-term care. *Journal of American Medical Directors Association, 4*, 313-319.
- Clifford, P. A., Cipher, D. J., & Roper, K. D. (2005a). The Geriatric Multidimensional Pain and Illness Inventory: A new instrument assessing pain and illness in long-term care. *Clinical Gerontologist, 28*, 45-61.
- Clifford, P. A., Cipher, D. J., & Roper, K. D. (2005b). Assessing dysfunctional behaviors in long-term care. *Journal of American Medical Directors Association, September/October*, 300-309.
- Gottlich, V. (2003, January). *Medical necessity determinations in the Medicare program: Are the interests of beneficiaries with chronic conditions being met?* [PLTC Dec 2007.doc](http://www.pltc.org/PLTC%20Dec%202007.doc) Retrieved September 5, 2007, from <http://www.partnershipforsolutions.org/DMS/files/MedNec1202.pdf>.
- U.S. Department of Health and Human Services,

Centers for Medicare and Medicaid Services. (2002). *Minimum Data Sets Version 2.0*. Retrieved on September 5, 2007, from http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp

U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. (2006). *Outcome and Assessment Information Set (OASIS): Implementation manual*. Retrieved on September 5, 2007, from http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHOIOASISUserManual.asp

An Exploration of Differences Between Elopers & Non-elopers in LTC Settings

**Susan E. Fisher, Ph.D., Raegan M.
Radenheimer, Psy.D., Frederick J. Kier, Ph.D.,
& Kimberly A. Christensen, Ph.D.**
VA Pittsburgh Healthcare System
Susan.Fisher3@va.gov

Background and Purpose

Effective elopement management is a key component for ensuring patient safety within medical and psychiatric inpatient settings, including long-term care (LTC) environments. We recently completed a research project exploring the characteristics of individuals who eloped or attempted to elope from two VA medical facilities compared to individuals who did not elope. The goal of this project was to promote better identification and assessment of veterans at risk for elopement in general medical and tertiary care settings that included several LTC units. For purposes of this article, we will present data pertaining to veterans who resided on LTC units.

Clearly, elopement places both patients and facilities at risk for serious negative consequences. Residents who elope from LTC facilities are at significant risk for injury due to falls, exposure to danger from a variety of sources, and death (Aud, 2004; Foxwell, 1993-94; Kiely, Morris, & Algase, 2000).

Characteristics associated with elopement and/or wandering in community LTC samples include specific types and degree of cognitive impairment, “discomfort or unsettled” states, medication use, and other general clinical factors (Kiely, Morris, & Algase, 2000; Algase, 1999; Algase, Beattie, & Therrien, 2001; Algase, Kupferschmid, Beel-Bates, & Beattie, 1997). Additionally, treatment facilities face significant legal liability if a patient elopes. According to Foxwell (1993-94), 10% of total claims against health care facilities are a result of liability claims related to resident elopements, and the average claim costs the facility approximately \$100,000 in insurance and defense costs. Moreover, such costs may detract from the financial investment needed to ensure good quality of care.

Although wandering is acknowledged as a significant risk factor for elopement among individuals with cognitive impairment in LTC facilities, we did not measure wandering in this study because it was not the primary focus of the larger study. Instead, the value of the data presented below is best conceptualized as an exploration of factors, regardless of this high risk behavior, that may help distinguish elopers from non-elopers in LTC-type settings. Because there is often little clinical guidance on assessment of elopement risk (other than history of wandering), these data may help promote better overall elopement risk assessment.

Methods

Data were collected via retrospective chart review on all patients who eloped or attempted to elope over a five-year period from LTC units within a VA tertiary care facility. Data were also collected on matched comparisons (veterans who did not elope or attempt to elope) who resided on the eloper’s LTC unit during the same time period. Veterans who were not independently mobile were excluded from this study. To explore possible differences on demographic and other variables, dichotomous data were analyzed using Chi-Square statistics and continuous data were analyzed using t-tests.

Results

From the sample of 52 veteran elopers in the larger study, 23 of these (44%) were from LTC units at one of the two sampled VA facilities. Combined with their comparison group peers, the total LTC sample was 46. As Table 1 shows, elopers and non-elopers were similar in age, ethnicity, marital status, and overall psychiatric disease burden. Although we did not have the statistical power to analyze significant differences on types of medical, psychiatric, and cognitive diagnoses, descriptively it appears that elopers and non-elopers were fairly similar, with a few notable exceptions.

With respect to medical diagnoses, musculoskeletal conditions were the most common diagnoses for veterans in both groups, and metabolic disorders and diabetes were also among the top diagnoses for both groups. Notably, cardiovascular disease was almost twice as prevalent in the non-eloper group, and kidney disease was present in about half of the non-eloper group but present in only 13% of the eloper group. Gastrointestinal disorders, cancer, vascular disease NOS, and infectious diseases were among the most prevalent medical diagnoses in the eloper group, but not in the non-eloper group. These findings probably reflect the significantly higher overall chronic medical burden found in the non-eloper group (non-eloper mean = 2.5 vs. eloper mean = 1.7, $t = 1.46$, $p < .01$). Overall chronic medical burden was defined as the sum of major chronic medical illnesses documented in the VA medical record (examples include but are not limited to diabetes, chronic obstructive pulmonary disease, cardio/cerebrovascular disease, cancer, liver disease).

Rates of psychiatric disorders were similar among both groups, although psychotic disorders were more than twice as prevalent in the non-eloper group (22%) than in the eloper group (9%). Although not statistically significant, the higher percentage of elopers with a cognitive impairment diagnosis (70%)

compared to non-elopers (48%) was notable. Among veterans with cognitive impairment diagnoses, the types of cognitive diagnoses were generally similar among the 2 groups, although vascular dementia was more prevalent in the eloper group (13%) than the non-eloper group (4%). The category “cognitive impairment NOS” was used as a catch-all term for clear indicators of cognitive impairment found in the medical record without a formal diagnosis of such.

TABLE 1: Demographic and Medical Characteristics

	<i>Elopers</i>	<i>Non-Elopers</i>
Age (average)	72	72
<u>Ethnicity:</u>		
White/Caucasian	87%	96%
Black/African-American	13%	4%
<u>Marital Status:</u>		
Not Currently Married	83%	70%
Married	17%	30%
Overall percent of sample with a cognitive impairment diagnosis	70%	48%
Medical disease burden* (average; range = 0 - 6)	1.7	2.5
Psychiatric disease burden (average; range = 0 - 3)	1.0	1.0

* $t = 1.46, p < .01$

Elopers and non-elopers were relatively more different on behavioral characteristics (see Table 2) than demographic characteristics, although only 2 behavioral characteristics were significantly different statistically. A significantly higher percentage of elopers had a previous elopement from a VA facility (25% of elopers versus 0% of non-elopers) and a significantly higher percentage of elopers currently smoked (39%) compared to non-elopers (13%). Although the difference was not statistically significant, a higher percentage of elopers (62%) compared to non-elopers (33%) had documented behavior problems secondary to a cognitive diagnosis (e.g., most typically wandering behavior). Substance abuse immediately prior to current admission was similar between the two groups and there were equal numbers of veterans in both groups with documented aggressive behavior regardless of

cognitive status.

TABLE 2: Behavioral Characteristics

	<i>Elopers</i>	<i>Non-Elopers</i>
Previous elopement**	25%	0%
Current smoking habit***	39%	13%
Behavior problem secondary to cognitive impairment diagnosis	62%	33%
Substance abuse problem immediately preceding admission	13%	9%
Aggressive behavior regardless of cognitive impairment diagnosis	17%	17%

** $\chi^2 = 6.51, p < .05$

*** $\chi^2 = 4.06, p < .05$

Conclusions and Clinical Implications

In sum, elopers were different from non-elopers in that they were more likely to have an elopement history, current smoking habit, and lower chronic medical disease burden. Not surprisingly, the finding that previous elopement history distinguished elopers from non-elopers is consistent with prior studies. We hypothesize that smoking was a distinguishing characteristic of elopers in this sample because smokers are now required to smoke outside of the facilities sampled in this study, making elopement easier to accomplish if unsupervised or otherwise unmonitored. The generalizability of this finding is clearly influenced by the environmental structure of other LTC facilities. Although it makes intuitive sense that an individual with greater medical disease burden is less likely to elope for numerous reasons, this quantitative finding is a new one in the research literature. Each of these 3 variables yielded significant differences between groups in the larger study (including non-LTC units) as well. Interestingly, however, substance abuse problem preceding admission and psychiatric disease burden further distinguished between elopers and non-elopers in the larger sample, but not in this LTC sample. It may be that we were underpowered to detect a difference between these variables with our smaller sample size or that the greater likelihood of cognitive impairment in LTC units compared to non-LTC units decreases the likelihood of being able to maintain a substance abuse problem and

makes diagnosis of psychiatric conditions more difficult.

Although prevalence rates of a cognitive impairment diagnosis and co-occurring behavioral disturbance were not significantly different between elopers and non-elopers, descriptively the difference was notable. Again, it may be that we were underpowered statistically with our small sample size or that our data on cognitive impairment do not well represent all types of cognitive impairment in actuality. For example, our data collection methods yielded rare diagnoses of delirium and, although we captured some observations/notes about delirium (“mental status change”) in our “cognitive impairment NOS” category, this is likely an under-representation of delirium in these settings.

Despite these informative conclusions, it is important to recognize that our research was not designed to evaluate the power of these demographic and behavioral characteristics for predicting elopement. For example, although previous elopement history significantly discriminated between elopers and non-elopers, 75% of elopers had no such history and would not have been identified as high-risk based on this characteristic alone. To better address predictive power of these characteristics, larger prospective studies are needed. Therefore, use of any individual characteristics for identifying high-risk individuals should only be implemented within the context of other approaches for minimizing elopement risk, such as environmental safeguards, appropriate staff training and vigilance, and sound clinical judgment. Nonetheless, it may be clinically useful to formally include information on elopement history, wandering behavior among individuals with cognitive impairment, cigarette use, and overall chronic medical disease burden in initial and ongoing comprehensive resident assessments in order to further minimize elopement risk.

REFERENCES

Algase, D. L. (1999). Wandering: A dementia-compromised behavior. *Journal of Gerontological Nursing*, 25(9), 10-16.

- Algase, D. L., Beattie, E. R. A., & Therrien, B. (2001). Impact of cognitive impairment on wandering behavior. *Western Journal of Nursing Research*, 23(3), 283-295.
- Algase, D. L., Kupferschmid, B., Beel-Bates, C. A., & Beattie, E. R. A. (1997). Estimates of stability of daily wandering behavior among cognitively impaired long-term care residents. *Nursing Research*, 46(3), 172-178.
- Aud, M. A. (2004). Dangerous wandering: elopements of older adults with dementia from long-term care facilities. *American Journal of Alzheimer's Disease and Other Dementias*, 19(6), 361-368.
- Foxwell, L. G. (Winter 1993-94). Elopement – exposure and control. *The Journal of Long-Term Care Administration*, Winter 1993-94, 9-12.
- Kiely, D. K., Morris, J. N., & Algase, D. L. (2000). Resident characteristics associated with wandering in nursing homes. *International Journal of Geriatric Psychiatry*, 15, 1013-1020.

Jiska Cohen-Mansfield, Ph.D. Receives PLTC Outstanding Contributions to Long-Term Care Award

Congratulations to Jiska Cohen Mansfield, our 2007 PLTC Award winner. Victor Molinari presented the award to Jiska at the PLTC Business Meeting at the Gerontological Society meeting in November, recognizing her contributions to understanding agitation and other behavioral symptoms of dementia seen frequently in long-term care settings. Jiska, who currently holds appointments as a Professor in Health Care Sciences, and Professor in Prevention & Community Health at the School of Public Health of George Washington University Medical Center, received her bachelor's and masters degree in Psychology and Statistics from Hebrew University in 1974, a masters in statistics from Hebrew University in 1976, and a Ph.D. in clinical psychology from State University of New York at Stony Brook in 1978. She is a licensed psychologist in Washington DC and the Director of the Research Institute of the Hebrew

Home of Greater Washington. As many people are aware, Jiska developed the widely used Cohen-Mansfield Agitation Inventory, and has written extensively on the humane and ethical psychological treatment of nursing home residents, particularly those with dementia. She has published over 125 articles, many of them in the top gerontological journals. For her research in long term care, she has received a number of grants from the National Institute of Aging and the Alzheimer's Association. She has received awards from the Alzheimer's Association and the Maryland Gerontological Association for her contributions to gerontology. In her comments upon receiving the award, she urged PLTC members to remember the unique contributions that psychology and psychologists can bring to patient care in a heavily medication-centered health-care system, and reminded us that behavioral approaches comprise the preferred and empirically-supported technology for treating behavior problems in dementia.



Victor Molinari Presents the PLTC Outstanding Contributions Award to Jiska Cohen-Mansfield

PLTC Welcomes New Officers, Thanks Departing Board Members

The PLTC Business Meeting at GSA was the last meeting officially presided over by Michael Smith, whose term as President ended at the end of December. Members thanked Michael for his dedication to the organization, and expressed the hope that he will continue to be involved. We have seen the organization continue to grow during Michael's tenure; significant accomplishments include implementation of a research grant program to stimulate research related to translating empirical findings to application in long-term care settings.

Effective January 1, Joseph M. Casciani replaces Michael as President. Joe is a co-founder and former president of a national group mental health practice delivering services to LTC facilities, where he worked for 16 years. He has worked in geropsychology since the early 1980s, when he was awarded several contracts by the California Department of Aging to develop aging and mental health training programs for nursing home staff. He is licensed in four states, and has been a member of PLTC since 1986. Currently, he is developing an education and training organization for professionals, emphasizing behavioral health collaboration in health care with older adults. Concept Healthcare is the new company (www.cohealth.org). We welcome Joe to the PLTC Board, and look forward to helping him continue the work of keeping PLTC a thriving organization.

December also closed Merla Arnold's term as Treasurer. Merla has kept PLTC fiscally responsible, kept up with the dues and expenditures, and faithfully reported on the financial standing of the organization. Anyone who has requested a reimbursement has appreciated Merla's efficiency! We also know that Merla will continue to be a major contributor to the work of the PLTC in the many other ways she has always been involved.

Dean Par t replaces Merla as Treasurer. Dean is the President and Chief Clinical Director for Senior Connections of Texas, P.L.L.C. He has provided clinical and consulting services for the past 10 years for in-patient and out patient hospital programs, including clinical coordinator for All Saints Health System Out-patient Mental Health Services and consultant to In-patient services, Clinical Director/Assistant Administrator Care Unit Hospital; Clinical Director Assistant Administrator CPC Oak Bend Hospital, and Consulting Psychologist to Hill

Regional Hospital for chemical dependency services and geriatric services. Dean has also taught at the junior college level. He has been actively involved in advocacy and professional service related to the mental health delivery system for older adults. His most recent commitments include serving on Practice Directorate Medicare Advisory Work Group, an informal APA committee/work group facilitated by the Director of Regulatory Affairs & Government Relations. Again, welcome, Dean, to the Board of the PLTC.

PLTC Membership Report

Mary Lewis, Ph.D.

PLTC Membership Chair

marylewis@earthlink.net

What follows is from the report Mary Lewis prepared for the PLTC Business Meeting at the November 2007 Gerontological Society of America annual meeting. Many thanks to Mary, who will be stepping down as Membership Coordinator, for her tireless efforts to organize and maintain the member database and keep us all up-to-date on our membership! --Editor

November 4, 2007 Statistics

200 members (Note: 13 asked not to be listed in the directory)

Detailed Statistics

- 7 affiliates (3 of those are new)
- 2 institutional
- 4 retired
- 49 Students (17 of those are new)
- 138 Professional (21 of those are new)

*Note: Because the PLTC Bylaws were changed, membership for 2007 ended 2 months earlier than it did in 2006, resulting in slightly lower membership numbers for the year.

Past Year Totals

2006: Total = 211 (141 Professional, 60 students, 3 institutional, 4 affiliates, 3 retired)

2005: Total = 199 (139 Professional, 50 students, 3 institutional, 4 Affiliate, 3 retired)

2004: Total = 155 (127 professional, 27 students, 1 institutional, 1 affiliate and 1 retired)

2003: Total = 150 (119 professional, 30 students, 1 retired)

2002: Total = 132 (118 professional, 14 students)

Be A Part of it All! Newsletter Editor and Membership Coordinator Wanted

Have you thought about becoming more involved in PLTC? Would you like to have "name recognition" with our 200+ members? New terms for newsletter editor and membership coordinator begin this month. Both of these are excellent opportunities for early career professionals seeking to become more active in the organization and/or wishing to increase their professional networks. Both positions are Board member positions, so in addition to the duties described below, involve periodic Board conference calls in addition to the Business Meetings at APA and GSA.

Newsletter Editor

This is a two-year commitment that involves coordination and editing of 4 annual issues of the PLTC newsletter. The first issue would be the spring 2008 issue, which would be jointly produced by the new and outgoing Editors. Newsletter formatting is done in Microsoft Word, and converted to PDF using Adobe Acrobat, so proficiency with and access to these two programs would be very helpful. The Editor is assisted (ably!) by a group of Associate Editors, each of which takes responsibility for the issue articles in each of 3 issues. Production of the newsletter takes approximately 8-10 hours per issue, including correspondence, writing, and editing, for an approximate maximum of 40 hours across a year.

Membership Coordinator

The membership coordinator maintains and updates the membership database, puts out the call for membership renewal, and handles renewal reminders. In addition, the Membership Coordinator maintains the PLTC website. These duties are spread across the year, with more intense commitment during membership renewal periods.

If you are interested in either of these positions, contact Joe Casciani at jmcasciani@att.net.

Contact the Editor:
Suzanne Meeks
smeeks@louisville.edu