The Duke Center for the Study of Aging celebrated its 60th Anniversary on September 25, 2015, at the Trent Semans Center. The celebration combined a Maddox keynote lecture by Stephanie Studenski, MD, PhD, with presentations of the 2015 Busse Awards.

Studenski, who is Chief of the Longitudinal Studies Section of the National Institute on Aging, spoke on “A Longitudinal Perspective on the Longitudinal Studies of Aging.” She pointed out the several advantages of longitudinal studies of aging, as opposed to cross-sectional studies, and reviewed some of the main findings of the Duke Longitudinal Studies of Aging.

Harvey Cohen, MD, presented a Busse Award to Sean Curran, PhD, who gave a lecture on “Dietary Adaptation, Stress, and Aging: Does your Diet Fit Your Genes?” Linda George, PhD, presented a Busse Award to Briana Mezuk, PhD, who gave a lecture on “(Re)Conceptualizing Continued on page 3
As a geriatric medicine fellow working in the hospital and nursing home, I was alarmed by the large number of older adults I encountered with a recent hip fracture. Despite good medical care and rehabilitation, a majority of these individuals never fully recovered their prior level of walking and independence. Even more concerning, a substantial number experienced multiple complications, additional fractures, continued decline and death within the next 1-2 years. My research has focused on finding ways to prevent or interrupt the terrible consequences of fractures in older adults.

With outstanding mentorship from Aging Center Faculty including Kenneth Lyles and Kenneth Schmader, and training from the Duke Clinical Research Training Program, I have conducted a number of studies focused on fall and fracture prevention, particularly in the nursing home setting. I co-wrote the study which showed that a once-a-year medication, zoledronic acid, prevents additional fractures and reduces death by 28% after a hip fracture. I developed and tested health service interventions to improve osteoporosis care in skilled nursing facilities following a fracture. I led the development of a regional service to identify older Veterans at high risk of fracture, and ensure that they are appropriately tested and treated for osteoporosis.

I currently have 2 large funded projects focused on fall and fracture prevention. The first is a NIH-funded intervention study in nursing homes, testing 2 different approaches to training staff to implement fall prevention programs. This is important because nursing homes have the highest rates of falls and fractures in older adults. While prior studies have shown that fall prevention programs work when implemented by study staff, it has not been shown that such programs reduce falls when the nursing home staff themselves try to use them.

The second is a Department of Defense funded study which has allowed us to assemble a large database of over 5 million men over age 50 years, including their Medicare, VA, and pharmacy records. This database will allow us to determine the benefits, costs, and harms of osteoporosis screening in men. There is no current consensus across professional societies about whether men should be screened for osteoporosis, and if so how to select those at highest risk; this will be the largest study of screening in men ever conducted. If we can identify and treat osteoporosis in men, we can prevent many fractures from ever occurring.

I am currently an Associate Professor of Medicine with Tenure, a Senior Fellow for the Duke Center for Aging and Human Development, and the Assistant Director of the Geriatric Research Education and Clinical Center at the Durham VA Medical Center. I completed undergraduate work in Biology at Cornell University, and received my medical degree from the Johns Hopkins School of Medicine in 1994. I have been at Duke ever since, completing a residency in internal medicine, a chief residency, a Masters of Health Science in clinical research, and a fellowship in geriatric medicine. I am excited to have just received a K24 mid-career mentoring award from the National Institute on Aging, which will allow me to mentor early investigators who like me are passionate about preventing falls and fractures in older adults.
EDITORIAL*  
Proposals to Strengthen Medicare

Since this year marks the 50th Anniversary of Medicare, it is appropriate to devote this editorial to proposals to strengthen this health care system. In 1965, more than half of Americans 65 and older did not have health insurance. Today nearly all do, thanks to Medicare. However, there continue to be concerns about Medicare's financial future. I would like to propose the following modifications to strengthen Medicare and make it fairer.

- Let Medicare negotiate bulk discounts for Part D prescriptions. Medicare is banned by law from applying its market power to negotiate lower prices for bulk purchases. Medicaid already can do this and according to the Congressional Budget Office, its average drug prices are 27 to 38 percent lower than those in Medicare. If those lower prices were adopted for the 11 million people who get low-income subsidies for Part D drugs, Medicare could save $123 billion over 10 years.

- Notify everyone by mail about Medicare options as they approach their 65th birthday. At present most people are on their own figuring out the tangle of rules, rates, and deadlines that govern Medicare enrollments. As a result, many may get basic things wrong and do major harm to their finances and/or health.

- Let late-comers get coverage right away. If you're late signing up Medicare you may be hit with late penalties that permanently raise your premium. Also if you miss the Jan. 1 to Mar. 31 annual general enrollment, your coverage won't begin until July 1. That can mean months with no insurance leading to a drained bank account or unattended illness.

- Eliminate the cap on earnings taxed for Social Security and Medicare. At present earnings are taxed only on the first $118,500. If this cap were removed and all earnings were taxed, it would make Social Security and Medicare solvent far into the future. This is most important because it would eliminate the need to reduce benefits or increase the tax rate.

* Based on “6 Ideas to Strengthen Medicare” published in AARP Bulletin, July-August, 2015. The opinions expressed are those of the editor and do not necessarily reflect Center on Aging policy.

60th Anniversary Celebrated, continued

Psychiatric Comorbidity in Later Life: The Example of Depression and Frailty.” Presentations were also made by Carl Eisdorfer, PhD, MD, Former Center Director, who spoke about the Center's Past; Harvey Jay Cohen, MD, who spoke about the Center’s Present; and Heather Whitson, MD, Senior Fellow of the Aging Center, who spoke about the Center’s Future.

It was pointed out that our center is the oldest continually funded center on aging in the nation.

The celebration was opened by greetings from:

- Richard Brodhead, PhD, President, Duke University (via a letter)
- Keith Whitfield, MD, Vice Provost for Academic Affairs;
- Eugene Washington, MD, Chancellor for Health Affairs;
- Nancy Andrews, MD, Vice Chancellor for Academic Affairs and Dean of the School of Medicine; and
- Elizabeth Merwin, PhD, RN, Executive Vice Dean, School of Nursing.

The celebration was closed with a reception.
Lisa Gwyther, Bobbi Matchar and Janeli Smith, social workers pictured above, thank their anonymous donor for the $1.1 million gift to transform the scope and reach of Early-Stage Alzheimer’s Community Programs. Dr. Harvey Cohen announced this gift on September 25, 2015 at the 60th anniversary celebration of the Duke Center for the Study of Aging. This is the largest single gift to this Duke Family Support Program in its 35-year history.

Lisa Gwyther, founder and director of the Duke Family Support Program, says “this gift will expand the scope, depth, breadth and reach of our Alzheimer’s services.”

Under the leadership of Bobbi Matchar, the Early-Stage Alzheimer’s Community has been growing since the first program was offered in the spring of 2012. The Early-Stage Community program currently includes an eight-week education and support group, a monthly social gathering for graduates of the eight-week group, a monthly arts program in partnership with the Nasher Museum of Art at Duke, and direct links to the Duke Bryan Alzheimer’s Disease Center Couples Support Group and Jewish Family Services’ Memory Cafe.

As early-stage participants progress, this gift will connect them to ongoing Duke Family Support Programs like our state-level gateway to individualized information and support, including the Program’s Caregiver newsletter, the Triangle monthly e-news, local support groups and regional educational programs.

The gift will:

- Expand the scope and reach for Duke’s Alzheimer’s early-stage community programs
- Support individuals and families who live with neurocognitive diseases
- Sustain, enrich, and expand education and support programs for individuals with new and progressing early-stage Alzheimer’s disease and their families
- Expand collaborative partnerships beyond continuing early-stage Alzheimer’s partnerships with the Alzheimer’s Association, the Durham-Chapel Hill Jewish Family Services, Duke’s Bryan Alzheimer’s Disease Center and Clinic, and the Nasher Museum of Art at Duke
- Develop innovative strategies to prepare other professionals and communities outside of Durham to offer quality information and support to individuals and families
- Expand programs for people who live with mild cognitive impairment and for people with early-stage dementia who live alone

For more information about our programs, please visit [www.dukefamilysupport.org](http://www.dukefamilysupport.org). Call 919-660-7510 or email DukeFamilySupport@duke.edu
**FREQUENTLY ASKED QUESTIONS**

*Do all five senses diminish?*

**See no evil, hear no evil, speak no evil. – Japanese proverb**

Older people could add: taste no evil, smell no evil, and touch no evil, because all five senses do tend to weaken in old age. Taste sensitivity tends to gradually diminish in normal aging primarily because of changes in the taste cell membranes, as well as the loss of some taste buds. However, a major cause is medication that can reduce taste sensitivity. Studies have implicated over 250 drugs that alter taste sensations.

Losses in odor perception result primarily from anatomic and physiological changes in the nose, olfactory bulbs, and certain brain structures. However, loss of both taste and odor sensitivity may be caused by disease, smoking, viruses, head trauma, surgery, and pollution in the environment.

Touch sensitivity also tends to diminish after age 45, but the good news is that so does sensitivity to pain. The ability to detect vibration normally declines only in the lower extremities.

Vision is the major way most of us perceive our environment and it tends to decline with age for several reasons: changes in the lens, the pupil, and light adaptation. However, the good news is that at age 80, 70 percent of drivers are still qualified for unrestricted driving, and another 15 percent are qualified to drive in the daytime only. Fortunately, eye glasses and improved lighting can correct most age-related vision problems.

Hearing is the second major sense and as people grow older they tend to have more difficulty hearing high-pitched sounds and low intensity sounds. However, hearing aids are usually able to overcome at least some of this hearing loss. Here again, “Prevention is the best cure.” Avoid abusing your ears with prolonged deafening noises such as rock concerts, high fidelity speakers turned up to their maxim, chain saws, and industrial noise (without ear plugs).

---

*Adapted from Palmore, Older Can Be Bolder, (Amazon, 2011).

---

**Quantification of Biological Declines in Young Adults**

A research team led by Dan Belsky, Avshalom Caspi, and Terrie Moffitt at the Center for the Study of Aging reports that the declines associated with aging is already highly variable among people still in their 20s and 30s. Some young people are already showing signs of physical and cognitive decline in their 30s.

Major findings:

- As we age, our risk for diseases rises. These diseases affect many different organs. This implies that improving health in later life will require interventions that can slow these biological decrements.
- Age is associated with decline in the functioning of many organs simultaneously. This research shows that these declines are already happening in some young adults.
- Accelerated declines in young adults predict the same symptoms we see in older adults: Deficits in physical and cognitive functioning, subjective feelings of ill-health, and even looking older to others.

The study participants were members of the Dunedin Multidisciplinary Health and Development Study, which tracks the development of a birth cohort of 1,037 children born in 1972-1973 in Dunedin, New Zealand. The examination used 18 different biomarkers over a 12 year period.

For further information contact Dan Belsky at dbelsky@duke.edu.

---

* Based on an article in Proceedings of the National Academy of Sciences of the USA, July, 2015.
With Age Comes Wisdom, and Some Concerns for Candidates*

The Constitution has a lower age limit of 35, but no upper age limit. Even one of the 55,000 American centenarians alive today could still legally run for president.

Risks of mental impairment can increase with the years, but effects are variable and many gain in knowledge and resilience as they get older.

Some have expressed concern that an older president could become cognitively impaired, forgetful and inattentive. Indeed, aging — as well as age-related diseases including hypertension, mini-strokes and diabetes — can be associated with reductions in brain volume and changes in the connections between brain cells. This can lead to a decline in mental quickness, attention, memory and the capacity to learn new information.

Even among high functioning subjects over 65, new scans suggest that about 20 percent, usually those with a family history of dementia, have early signs of Alzheimer’s in their brains. Moreover, this subset of individuals, despite their high scores on memory and attention tests, seem to have an increased risk for developing mild cognitive impairment — in one preliminary study that risk is almost 25 percent over 18 months.

While candidates usually release their physical health reports, should they be required to undergo and disclose cognitive test results? At this time, there is no perfect predictive test for dementia but many are in development. And new programs that can analyze people’s speech patterns may soon make it possible for early signs of dementia to be detected passively simply by analyzing transcripts of debates or media interviews.

The good news is that the effect of age on the brain is highly variable and many other individuals, due to their genes and healthy lifestyles, show very little change.

“What are the odds of a president’s cognitive abilities declining substantially while in office?”

Murali Doraiswamy is a professor of psychiatry and behavioral sciences, and medicine, at the Duke University School of Medicine, director of the neurocognitive disorders program at the Duke University Medical Center and a researcher at the Duke Center for the Study of Aging.


Blazer Receives Hargrove Award

Dan Blazer, MD, PhD, will receive the annual Eugene Hargrove award at the annual meeting of the North Carolina Psychiatric Association on October 5.

Eugene A Hargrove, MD, who died in 1978, was Director of the North Carolina State Department of Mental Health, Developmental Disabilities and Substance Abuse Services from 1958 until 1973. This annual award is in commemoration of Dr. Hargrove’s contributions to mental health care in North Carolina and his recognition of and support for research in the public mental health system. The Psychiatric Foundation of North Carolina now presents this award to an individual who has been recognized by colleagues for exceptional contributions in the field of Mental Health Research.
Galanos Raises Awareness About Prostate Cancer*

Galanos, who specializes in geriatric and palliative medicine at Duke, participated in November, when he and other Duke doctors grew moustaches to raise awareness about prostate cancer and men’s health. He gave TV interviews to reporters and even shared details of his 2009-10 biopsy and treatment with his internal medicine residents.

“Women aren’t the only ones who have healthcare issues,” Galanos said. “We need to pay attention to men’s health and not be so macho about it, and particularly men who have people depending on them.”

September is National Prostate Cancer Awareness Month, when men over 40 are encouraged to examine their family medical history and get checked for prostate cancer. Prostate cancer is the most common non-skin cancer in America, affecting 1 in 7 men, according to the Prostate Cancer Foundation. Around 2 million men in the U.S. are currently living with prostate cancer.

In recognition of National Prostate Cancer Awareness Month, Duke doctors and advocates share diagnosis stories, the importance of a healthy lifestyle, and what’s being done at Duke to advance prostate cancer treatment.

IN THE NEWS

The Lisa Gwyther, MSW, education director at Duke University’s Alzheimer’s Disease Research Center was quoted in the June 21, 2015, issue of Parade magazine as saying “A lot of unmet needs are being responded to spontaneously – to fill the needs for inclusion, for less stigma about the disease and for more focus on quality of life.”

The quote was in an article by Paula Spencer Scott on “People Power: How grassroots campaigns are easing the burden of caring for someone with Alzheimer’s—and improving patient quality of life.”

The articles also says, “After social worker Bobbi Matchar held an eight week education program at Duke University for people recently diagnosed and their care partners, the group grew so close nobody wanted it to end. So they called themselves ‘the Alphas’ and three years later, still meet monthly at a local restaurant, along with later graduates of the Duke class. ‘It creates a sense of community among people who didn’t choose to have the situation and who often have to quit their old communities at work and church,’ says Matchar.”

Matchar, MSW, is an assistant to Gwyther in the Duke Family Support Program.

Keith E. Whitfield, PhD, will be presented an award for Outstanding Mentorship in Minority Issues in Gerontology at the annual scientific meeting of the Gerontological Society of America in Orlando Florida in November, 2015.

See also the article by Doraiswamy in this issue and the award given Blazer.
MEET THE NEW GERIATRIC FELLOWSHIP CLASS

Bret S. Powell, D.O.

Joined the Geriatric Fellowship training program on July 1st of 2015, transferring from the Duke Family Medicine Residency Program where he was a Chief Resident. Originally from Iowa he attended Luther College for his Undergraduate work, the University of Iowa to earn his MPH and Des Moines University for his Medical training before joining the Department of Family & Community Medicine for his residency. His career interests and goals for medicine include clinical teaching, community medicine, working with underserved populations, women’s health, dementia and chronic disease management. In his future career, he hopes to incorporate the care of elderly adults within the community, including finding time for home visits.

Neema K. Sharda, MD

Dr. Sharda is from the High Point area of NC. She attended the University of NC in Chapel Hill for her Undergraduate work and St. George’s University School of Medicine for her Medical Training. She completed her Residency at Moses Cone Memorial Hospital where she was Chief Resident. For her career goals she aims to work in the long term care setting as a medical director with a focus on clinical education in this arena. In addition, she hopes to further investigate behavioral and non-behavioral interventions for patients with dementia in the long term care setting.

Memona Tazamal, MD

Dr. Tazamal joins the Fellowship training program after having completed her undergraduate education at the University of Virginia, her medical training at Ross University School of Medicine and most recently her residency at Lynchburg Family Medicine Residency Program in Virginia. She would like to be involved in academia through geriatric education and medicine and to gain in depth knowledge of early dementia diagnosis and management.

Vanessa R. Solar Alvarez, MD

Dr. Solar Alvarez is originally from Peru, completed her medical training at the Universidad Peruana Cayetano Heredia Facultad de Medicina Alberto Hurtado, in Peru and her residency at Metro West Medical Center in Framingham, MA. Her interest is mainly on the Outpatient Care of the elderly population, working with a multidisciplinary team and families, to keep them as independent as possible. As future plans she would like to be involved in Geriatric education and help to expand the field.

Welcome to you all!
Lisa Gwyther was awarded a one-year contract from the North Carolina Department of Health and Human Services. Assisted by two social workers, Bobbi Matchar and Janeli Smith, the program offers care management, consultations, fact-to-face visits, and educational sessions to caregivers of people with Alzheimer’s disease and related forms of dementia. The program also publishes and distributes the “Caregiver” newsletter.

Juliessa Pavon received an award from the Society of Hospital Medicine for the GEMSSTAR Career Development Award (Grants for Early Medical/Surgical Subspecialists’ Transition to Aging Research). The Society of Hospital Medicine partners with the Alliance for Academic Internal Medicine and the Association of Specialty Professors through the T. Franklin Williams Scholarship program to provide matched support over a two-year period.

Mitchell Heflin, in a collaborative effort with Duke’s School of Nursing, received the award, including a supplement, “Duke Geriatrics Workforce Enhancement Program (GWEP).” Sponsored by HRSA, this three-year project aims to strengthen capacity to provide patient-centered coordinated healthcare for a growing population of seniors locally, regionally, and nationally. The GWEP will bring together geriatrics training programs, primary care practices, community agencies, and healthcare organizations to implement a new model of workforce development that strives to improve outcomes for older adults in a sustainable, by implementing innovative interprofessional training models that emphasize accelerated transition of best practices into primary care.

Congratulations to all.
COMING EVENTS


