

# Board & Care Quality

## F O R U M

Published by Reisacher Petro and Associates

Vol. 13 No. 1 January/February 2010

### L'Arche: Communities Undergirded by Mutually Transforming Relationships

In 1964, Jean Vanier first became aware of the thousands of men and women with intellectual disabilities who were living in institutions throughout France. He felt moved by God and his concern for these adults to invite two men to move from the institution where they had been residing to live with him in a house in Trosly-Breuil, France. Since that time, L'Arche (French for "the Ark") has grown and flourished, with homes (referred to as "communities" by L'Arche) forming in countries around the world, and with the first L'Arche community being established in the United States in Erie, Pennsylvania in 1972.

Today, the International Federation of L'Arche consists of 133 communities in 35 countries around the world which are organized into nine zones. L'Arche USA is one of these nine zones. Each L'Arche community in each country and each zone operates independently, but all are united in their commitment to the L'Arche Statement of Identity and Mission:

Statement of Identity: We are people, with and without developmental disabilities, sharing life in communities belonging to an International Federation. Mutual relationships and trust in God are at the heart of our journey together. We celebrate the unique value of every person and recognize our need of one another.

Our Mission is to:

- \* Make known the gifts of people with developmental disabilities, revealed through mutually transforming relationships;
- \* Foster an environment in community that responds to the changing needs of our members while being faithful to the core values of our founding story; and
- \* Engage in our diverse cultures, working together toward a more human society.

In this interview, Vicki Washek, R.N.-- Executive Director of the L'Arche Erie organization--gives an in-depth look into the life of L'Arche communities. Vicki, who holds bachelor's degrees in biology and in nursing, has worked professionally in the field of nursing as well as within the L'Arche Erie community. She has recently completed 30 years with L'Arche, including several years spent as the L'Arche Coordinator for the Eastern United States. Vicki talks about how L'Arche communities operate and what makes them so unique. She also shares ideas about how adult residential care settings of any type can implement some of the philosophies and principles that undergird the L'Arche communities around the world.

**Please start by talking a little bit about the L'Arche communities, including how they are structured and the philosophy--as well as the theology--that is behind all of L'Arche.**

"L'Arche communities are individual communities throughout the world that share in the same common vision, identity, and mission at the core of what we do. The communities are linked together in a federation that supports one another and are on the journey of carrying forth this mission together. We are not legally linked beyond being under the umbrella of L'Arche and sharing this common mission.

"There is an accountability to living that mission, and visits by regional coordinators and national coordinators provide supports and resources to help each community do that. But each community is its own legal entity and is incorporated as a non-profit within the state where it is located. A community has its own board of directors that is responsible for the community's financial well-being and to monitor that the community is following the L'Arche mission, keeping us accountable to that as well as to state regulations relative to reimbursement for the services we provide.

"When I am asked what L'Arche is, I like to say that I see

*Continued on Page 3: SEE L'ARCHE*

### What's Inside, January/February 2010

Vigilance Hormone Linked to Panic Attacks.....	6
Just Over Half of Americans Diagnosed with Major Depression Receive Care.....	7
Amyloid Deposits in Brains of People with Normal Cognition May Predict for Future Alzheimer's Disease.....	8
National Survey of Residential Care Facilities (NSRCF) to Begin in April, 2010.....	8
Resource Corner: The Heart Truth.....	9

**Board and Care Quality FORUM**

**EDITORIAL BOARD**

January 2010 through December 2011

**Todd W. Bartimole, J.D.**

Elder Law Office of Todd Bartimole  
Beachwood, OH

**Barbara Castle**

Family Member  
Lake Forest, CA

**Sandra A. Coyle, M.S.S.A., L.I.S.W.**

Clinician in Private Practice  
Specialty in Geriatric Mental Health  
Westlake, OH

**Katherine Foley, L.S.W.**

Program Director, Center for Personal Assistance  
Linking Employment, Abilities and Potential (LEAP)  
Cleveland, OH

**Mary Fouche, R.N., BSN**

Community Based Long Term Care Clinical Manager  
PASSPORT Program  
Cleveland, OH

**Mary Pat Frey**

Director of Stewardship  
Diocese of Cleveland, OH

**Jane Johnson, RN, BSN**

Owner, Silver Hills Assisted Living  
Montgomery, TX

**Marcella Hamner**

Owner, The House by the Side of the Road  
Cincinnati, OH

**Carol Mills, Ph.D.**

Psychologist  
Psychological Transitions, Inc.  
(serves residents of retirement communities)  
Beachwood, OH

**Renee Sanders**

Long Term Ombudsman  
Georgia Legal Services Program  
Community Ombudsman Program  
Atlanta, GA

The development, preparation, and publication of this newsletter have been undertaken with great care. However, the publisher and agents of the publisher are not responsible for any errors contained herein, or for consequences that may ensue from use of materials, services, or information contained, listed, or advertised in this work. Opinions expressed by the authors are not necessarily those of the publisher. Nothing in this newsletter should be considered medical or legal advice. Individual health matters should be referred to appropriate health professionals. Because laws regulating board and care homes vary greatly from state to state, consult the laws of your own state for specific regulatory information and parameters.

All rights reserved, Sally A. Reisacher Petro, Ph.D., DBA Reisacher Petro and Associates, publisher. © 2010. Requests for permission to re-print articles should be directed to:

Reisacher Petro and Associates  
1728 Holly Lane  
Pittsburgh, PA 15216

Voice: (412) 563-7330  
Fax: (412) 563-7331  
E-Mail: bcqf@msn.com

www.bcqf.net

**Copyright © 2010 by Reisacher Petro and Associates.** Photocopying or reproduction of any part or all of this publication is prohibited without the express written permission of the publisher. Unauthorized reproduction is prohibited. To report any violations of copyright, call (412) 563-7330 collect. All reports will be confidential.

The Board and Care Quality Forum is published six times per year by **Reisacher Petro and Associates, 1728 Holly Lane, Pittsburgh, PA, 15216** (Telephone: 412-563-7330; FAX: 412-563-7331; E-Mail: bcqf@msn.com). Publisher/Editor is Sally A. Reisacher Petro, Ph.D.

**To subscribe:** Complete form below, making check to **Reisacher Petro and Associates**, and mail to address above. **One-year subscription rates:** facility of 1-5 residents, \$25; facility of 6-20 residents, \$35; Facility of 21+ residents, \$45; professional/agency, \$50. Special rates are available for multiple subscriptions of ten or more, or for individual residents desiring personal subscriptions. For additional subscription information, or to give notice of a change of address, please contact Reisacher Petro and Associates at the address or telephone number listed above.

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Facility Name / Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Amount Enclosed: \_\_\_\_\_ Number of Residents: \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

*Continued from Page 1: L'ARCHE*

the government regulations as being there for the health, safety, and well-being of the individuals who live in our homes. That is like a black-and-white picture. The L'Arche philosophy, then, for me, puts the color into that picture. As we live out the core values of our mission and vision, it enriches the health and safety of those who live in the communities, and it brings the colors to the lives and the homes that we have.

“The basic philosophy of L'Arche is to create relationships and a family-like atmosphere in each of the homes based on core values of mutual respect and tending to the strengths, gifts, and growth of every individual in the home. This is for both assistants (what other homes might refer to as staff) and the individuals with disabilities who also reside in the community. The relationship between the people in the home is at the core of that mutual respect and the bringing to life of the family environment.

“We have a lot of traditions, ongoing ways of operating, and expectations that support and nourish those relationships and help them to flourish. Relationship building is at the heart of L'Arche, because the transformation of people then occurs through that family-like environment. The individuals with disabilities have their growth points and experience the transformation. But the core value of L'Arche that adds that color occurs when the assistant--the person who originally came to be of service--discovers he or she is being transformed because of recognizing, appreciating, and benefitting from the giftedness of the individual with the disability.”

*[L'Arche] Community members are transformed through relationships of mutuality, respect, and companionship as they live, work, pray, and play together.*

*L'Arche USA Website:  
Who We Are © 2008*

**So, L'Arche is not just about providing services or developing relationships from a top-down model--it appears that it is a very egalitarian model, with assistants being equal to the persons with disabilities with whom they live and work.**

“The best way to think about it is living life in a circle, or as St. Paul uses the analogy of the body in Corinthians. In either of those perspectives, it is recognized that each person within the circle or within the body has certain roles and responsibilities that add to the life and the gifts of the home.

“My role and responsibility right now as community leader here in Erie comes from my gift of leadership. But we don't view that as any more important than the particular gift of any of the individuals in our homes. One of the core members (what other homes might call residents) in one of our homes could

teach anybody in the world how to welcome somebody to his home. His gift of welcome is every bit as important as my gift to provide leadership to the organization.”

*The belief in the inner beauty of each and every human being is at the heart of L'Arche...and at the heart of being human...We do not discover who we are, we do not reach true humanness, in a solitary state; we discover it through mutual dependency, in weakness, in learning through belonging.*

*Jean Vanier in his book, Becoming Human  
From L'Arche USA Website: Spirituality © 2008*

**These core principles are so important, and they require assistants and core members to all be very active in identifying and recognizing each others' gifts. How are these core principles conveyed to assistants and core members, and how are they helped to grow into the living out of these core principles in daily life within a L'Arche community?**

“When a new core member or assistant comes, we verbally introduce the concepts that underlie L'Arche communities. Every person has a journey in learning what it means, understanding it, and accepting it; or choosing to say, ‘No, this is not for me.’

“So, initially, it is just to explain our traditions and home life in whatever way the person can understand it. We discuss that this is the way we live and this is how life is within one of our homes. Then we answer any questions they might have.

“Then, to support growth in understanding, we have a mentoring process of ‘accompaniment.’ People are accompanied by someone who is further along in his or her journey and who has been participating in L'Arche for a longer period of time. That mentor accompanies them and meets with them on a regular basis to see how things are going, to answer questions, to provide insight, and to guide them in their development of living within the community.

“There are weekly meetings for the assistants from individual homes, as well as weekly house meetings. At the house meetings, the functional elements of the week are discussed, such as the schedule for the week, who is doing the grocery shopping, and who is doing other tasks. These are the necessary organizational pieces of those meetings. During those gatherings, however, we may also take the opportunity to share with one another about a specific topic; answer a question together and consider how it affects us; or discuss various writings of Jean Vanier and Henri Nouwen, different L'Arche publications, and other relevant publications and resources that help us to deepen those core values.

“One of L'Arche's core values is trusting in God and the providence of God. Our faith life is a big part of who each of us is

*Continued on Page 4: SEE L'ARCHE*

*Continued from Page 3: L'ARCHE*

as an individual. L'Arche is not its own faith or church, but our goal is to support every individual in the faith that he or she has chosen.

“Here in Erie, we have time every Friday afternoon when people--assistants, core members, and administrators--come together in a space we have for worship, and it is led by different members of our community--members of a pastoral team. It is not the worship of any one denomination, but it does have a certain format to it. We sing a song together; share a reading from scripture or another spiritual text; and engage in a gesture of some kind together, whether to share a word or to say a prayer. One time, we made a link of love, in which each person identified how he or she wanted to be loving in the coming week. We took all the paper links on which they wrote their goals for being loving and made a big chain that was hung around the room.

“We have different traditions and ways that we try to bring people along and help them deepen in those core values. We also use modeling for this--being very conscious of our core values and inviting assistants and core members to model and teach those core values to new people as they have come in. We had a new core member come to one of our homes a little over a year ago; he had been living with his family, and he had a little trouble figuring out how to relate with the others in his home. Part of his transition and his integration into the home included talking with the other core members--the other three people who had been living in that home for a number of years--and inviting them to participate in helping him to understand and learn about the home's traditions. At the same time, those core members learned about his traditions and found ways to blend his traditions within the community. We try to include everybody in those discussions to help with the transitions that occur.”

**Can you talk about who Jean Vanier is and how he came to found L'Arche?**

“Jean Vanier came from a wealthy, political family in Canada. His father had been a Governor-General, and Jean had joined the English Navy at the age of 13. These were his roots.

“When he was in his 20's, Jean discovered that he was no longer interested in staying in the military and instead began more of a spiritual journey, which included earning a doctorate in philosophy. He grew close to a Dominican priest, Pere Thomas Philippe, who was living in France. Through Jean's conversations with and through the leadership of Pere Thomas, Jean came to realize that he was meant to live out the Beatitudes by dwelling among those who are in poverty. Pere Thomas at the time was connected with a small institution for men with intellectual disabilities. That was Jean's introduction to persons with this type of disability.

“Originally, Jean simply invited two men to move out of the institution and into a house with him. This was how he was going to serve the poor. Immediately, the transformation for Jean began to take place when the two men with whom he was

living insisted that they be treated with respect, emphasizing that they had something to say, too. It was easy for Jean to come to this arrangement from a military background, believing he would be in charge and give the orders and that the others would do what he said to do. But through the relationship building of friendship with these men, he discovered that they also had a part to play and gifts to give within this family as it was growing.

“His original vision was just something he wanted to start for himself, but he found that other people were attracted to it as well, and it just took off from there. It started to grow and, within a few years, there were communities being founded in India and in Canada, then in other countries, such as the United States.

“It became an international and an interfaith movement. Jean Vanier and Pere Thomas were both Roman Catholic, so L'Arche had Roman Catholic roots in France. But when L'Arche went to India, it was welcoming people who were Hindu and Muslim. The Daybreak community in Toronto, Canada, was founded in an Anglican tradition. So, as I said, we are not a church, but we are faith-based because the communities were founded on the basis of various faiths. We have that ecumenical aspect to us as well.

“L'Arche was founded out of respect for others, and a lot of people were attracted to this way of living. As a result, communities started growing up all over the world.”

*L'Arche believes that these qualities, expressed through vulnerability and simplicity, actually make those with a disability our real teachers about what is most important in life: to love and be loved.*

*L'Arche USA Website:  
Welcome to L'Arche USA © 2008*

**What have been some of your personal experiences of the power of the mutually transforming relationships that develop and thrive within the L'Arche communities?**

“One powerful story is of a woman who is currently in her 70's; I will call her Mary. She moved into one of our homes in 1986, coming directly from Polk Institution here in Pennsylvania.

“I was an assistant on the team that was welcoming Mary to L'Arche. She came with a great deal of anxiety that we could actually observe because when she was anxious, she was always fiddling with something in her hands. When she was very anxious, she would walk in a circle around the dining room table. She also engaged in a lot of negative self-talk, saying ‘She can't have no dolls,’ ‘She can't have no gift.’ We interpreted it as a painful reaction to Mary feeling rejected by her family when she was placed in an institution.

“Within a few years, she was developing strong

*Continued on Page 5: SEE L'ARCHE*

*Continued from Page 4: L'ARCHE*

relationships with different individuals within the community. She started to thrive a little bit more with those relationships, and suddenly, after about six years, this woman who had always said, 'She can't cry,' and 'She ain't going to cry,' was crying at everything. It was as though years of pent-up emotion and holding back her tears suddenly began to overflow, and for a few years, she cried 'at the drop of a hat.'

"She finally was able to ask people to be in relationship with her. If she saw people who had been assistants in her home in past years, she would ask, 'Did you miss me?' She would ask people if they were going to bring her a present. Mary finally got to the point of wanting to receive gifts whereas in the early years here, she couldn't even accept a present.

"Now, Mary is the most peaceful and loving woman. She is proud of herself and she smiles all the time. When she comes to see us here in the office, she'll say, 'Did you hear about it? I went shopping!' or 'How are you feeling?' Her capacity to be part of a relationship has grown, and that transformation has occurred because she is in an environment where she is valued for her friendship and as a person."

**How have you received from your involvement with the core members at L'Arche Erie?**

"I was in a highly competitive major my first time in college: I was in a pre-med program. I have always been achievement oriented, and I think one of the big changes in me has been to learn to value things that don't have 'achievement' written all over them. Working with someone, learning how to be patient, learning better how to express my own feelings--these are ways that L'Arche has changed me."

**You comment on the gifts that all members of the L'Arche community--including core members--bring to their homes. What are some of the gifts that you have experienced from the core members of L'Arche Erie?**

"One man, who died several years ago, had the most beautiful faith life and prayer life. I learned so much from how Joe trusted in God and prayed to Jesus, as well as his praying of the rosary and deep faith in Mary. That was a gift that Joe had. There is another gentleman who lives in one of our homes who is non-verbal and who uses a wheelchair; his peacefulness is so evident; assistants will just sit next to him to experience the peacefulness and acceptance that radiates from his eyes.

"Yet another gentleman has the gift of teaching us how to accept trials and challenges in our lives. He also uses a wheelchair and has now moved to his own apartment, but he is still a part of our community. He takes his struggles and 'makes lemonade out of lemons.' Another gentleman who lives here has amazing forgiveness that comes on like a light switch. He can be struggling with you, such as when he is experiencing fear about something like his TB test. There may be fear and anger and

frustration, but as soon as the incident is over, he is immediately able to forgive and forget the situation and move on to the next thing. People learn a lot from that--instead of holding on to grudges, we should instead let go and forgive. We have thirty-three different core members, so I could go on and on about the gifts they bring to our community."

**What can the owners and operators of more traditional board and care homes take from the L'Arche model and apply to their own residential care settings?**

"One of the easiest things to take from what L'Arche has learned over the years about how to interact with each other in the home and create the kinds of growth and relationships that we experience is to be very conscious of listening well to each other. That is a key place where we keep calling ourselves and each other back to our basic principles--to truly listen to what each person is saying. That is where heart meets heart and where relationships are really developed with each other.

"Nobody really grows from being told where they have deficiencies. But when you accept somebody else's weaknesses and struggles and appreciate their gifts and strengths--and when you really do that, without faking it or being insincere--that's where we discover that people really grow. People do not grow when you tell them, 'You are doing that wrong, let me show you the right way.' People grow more when they are recognized for the gifts they have to give. People can then grow past their struggles and flourish into those relationships.

"It all comes down to those heart to heart listening moments, and appreciating the values and the gifts of everyone authentically. You don't make something up; you look for what is there, because God has put something there in each person to be discovered and celebrated."

*The secret of L'Arche is relationship: meeting people, not through the filters of certitudes, ideologies, idealism, or judgments, but heart to heart; listening to people with their pain, their joy, their hope, their history, listening to their heart beats.*

Jean Vanier  
L'Arche Founder  
L'Arche USA Website: Who We Are © 2008

For more information about L'Arche USA, go to their website at [www.larcheusa.org](http://www.larcheusa.org). This website offers information about L'Arche, resources to identify communities throughout the country, an application for persons interested in becoming assistants, and links to *Letters of L'Arche* Magazine and letters written by Jean Vanier. The L'Arche USA office can also be contacted at 1130 SW Morrison Street, Suite 230, Portland, Oregon, 97205

*Continued on Page 6: SEE L'ARCHE*

### Discussion Questions for Managers and Staff

1. Ask staff to identify unique gifts that each resident brings to the life of your home. Be specific in identifying the gifts and the positive impact that each has on the home and those who live and/or work there. Identify ways that staff can engage in an ongoing process of discovering and authentically, sincerely celebrating each resident's gifts, and encourage staff to be intentional about identifying those gifts.
2. Discuss among staff what special gifts each brings to the home. This can be done verbally, or consider having each staff member write down what unique gifts each of his or her co-workers shares in the life of your facility. Then for each staff person, write down all the positive comments made about him/her by the other staff. Managers, consider how you can reinforce the positive skills, gifts, and talents that each staff member offers to the home.
3. Discuss with staff and residents what kinds of mentoring they would have liked to have had when they first came to your home. Using those ideas, develop a process of accompaniment that can be used to assist new staff and new residents. Be sure to discuss the core values of your home and include in your mentoring system opportunities for sharing and reinforcing those values. If you already use a mentoring system, ask staff and residents to critique its usefulness and effectiveness and make changes to enhance its value to them.
4. Examine with staff the power structure of your home. Are staff and residents considered equally valuable and important contributors to the home's daily life, or are staff in a position of power over residents? Identify ways that the relationship of staff and residents can be made more positive, affirming, and mutually respectful, and develop a plan for implementing those steps.
5. Consider when and how residents, staff, and administration come together to talk, share, and plan. Using input from all of these groups, develop a plan for regular meetings that will include not only organizational planning and "housekeeping" elements, but also opportunities for shared activities, discussion, and brainstorming.
6. Discuss the importance of conscious listening with staff, residents, and administration. Ask for their input about the aspects of current communication within the home that they feel are effective and respectful, resulting in them feeling heard and understood. Inquire about elements of communication in the home that they feel are not effective or respectful, and seek their input about how to implement a more positive, considerate, and healthy standard of communication for all persons involved in the life of the home.

### Vigilance Hormone Linked to Panic Attacks

A new study has linked panic disorder to a wayward hormone in a brain circuit that regulates vigilance. While too little of the hormone, called orexin, is known to underlie narcolepsy, the new study suggests that too much of it may lead to panic attacks that afflict 6 million American adults. "Targeting the brain's orexin system may hold promise for a new generation of anti-anxiety treatments," said Thomas R. Insel, M.D., Director of the National Institute of Mental Health (NIMH), part of the National Institutes of Health.

NIMH grantee Anantha Shekhar, M.B., Ph.D., and colleagues at Indiana University and Lund University, report on their findings online Dec. 27, 2009 in the journal *Nature Medicine*. They showed that blocking orexin gene expression or its receptor prevented panic attack-like responses in rats. The study also revealed that panic disorder patients have excess levels of the hormone.

Orexin, also called hypocretin, is secreted exclusively in a circuit emanating from the brain's hypothalamus, known to regulate arousal, wakefulness, and reward. Panic attacks can be experimentally-induced by infusing susceptible humans with a normally innocuous salt called sodium lactate. The salt similarly triggers panic-like anxiety behaviors in susceptible rat strains, suggesting that something is altered in their arousal circuit. Since sodium lactate activated orexin-secreting neurons in panic-prone rats but not in control rats, the researchers hypothesized that the "something" might be orexin.

The investigators first discovered that increased gene expression in orexin-secreting neurons correlated with increases in anxiety-like behavior in panic-prone rats following sodium lactate infusions. Using a technique called RNA interference, they then protected the panic-prone rats from developing anxiety behaviors following the infusions by first injecting them with a genetically-engineered agent that prevented orexin genes from turning on. Blocking orexin receptors with a drug that specifically binds to it also blocked the anxiety like behavior following the infusions. This mirrored effects, seen in both rats and humans, of benzodiazepine medications used to treat panic disorder. Finally, by measuring orexin in cerebrospinal fluid of 53 patients, the researchers showed that those with just panic disorder had higher levels of orexin than those with both panic disorder and depression.

Taken together, these results and other evidence suggest a critical role for an overactive orexin system in producing panic attacks, say the researchers. They add that medications that block the orexin receptor may provide a new therapeutic approach for the treatment of panic disorder.

#### Reference

A key role for orexin in panic anxiety. Johnson PL, Truitt W, Fitz SD, Kelley PE, Dietrich A, Sanghani S, Traskman-Bendz L, Goddard AW, Brundin, L, Shekhar A. *Nature Medicine*. Epub 2009 Dec 27.

(From National Institute of Mental Health, "Science Update: Runaway Vigilance Hormone Linked to Panic Attacks: Translational Experiments in Rats, Human Suggest New Medication Target," December 29, 2009, <http://www.nimh.nih.gov/science-news/2009/runaway-vigilance-hormone-linked-to-panic-attacks.shtml>. This page last reviewed: February 5, 2010)

## Just Over Half of Americans Diagnosed with Major Depression Receive Care

Overall, only about half of Americans diagnosed with major depression in a given year receive treatment for it, and even fewer—about one fifth—receive treatment consistent with current practice guidelines, according to data from nationally representative surveys supported by NIMH. Among the ethnic/racial groups surveyed, African Americans and Mexican Americans had the lowest rates of use of depression care; all groups reported higher use of past-year psychotherapy vs. medication for depression.

Depression is a leading cause of disability in the United States. Past research has found that many people with depression never received treatment, and that the percentage of those receiving treatment varies with ethnicity and race. In order to provide comprehensive and up-to-date information on depression care, with a particular emphasis on minority groups, NIMH's Collaborative Psychiatric Epidemiology Surveys initiative (CPES) has combined data from three nationally representative studies: the National Survey of American Life, the National Comorbidity Survey-Replication, and the National Latino and Asian American Study.

Scientists at Wayne State University, MI; the University of Michigan, Ann Arbor; the University of California, Los Angeles; and the Harvard School of Public Health, carried out the current study, which reports on data from CPES collected between February 2001 and November 2003 from 15,762 residents 18 years and older. The size of the sample makes it possible to examine health care use in ethnic/racial groups with a new level of detail, distinguishing between groups often surveyed as one population. The investigators were able to break out types of care used, and to assess to what extent the care used was consistent with the American Psychiatric Association (APA) *Practice Guidelines for the Treatment of Patients with Major Depressive Disorder*. Finally, they examined how factors enabling healthcare access—insurance, education, and household income—influenced rates of care.

A central finding was that overall, 51 percent of all those in the study who met criteria for major depression during the prior year received some kind of treatment for it, with only 21 percent receiving care that was consistent with the APA Guidelines. Other key study findings addressed disparities, types and quality of care received, and factors that enable access to healthcare.

\* Prevalence and severity of major depression was similar among the five studied ethnic/racial groups—Mexican Americans, Puerto Ricans, Caribbean Blacks, African Americans, and non-Latino Whites. However, African Americans and Mexican Americans were least likely to receive any care or care consistent with practice guidelines. Compared with non-Latino Whites for example, of whom 54 percent with depression received care, 40 percent of African Americans and 34 percent of Mexican Americans did. The rate of care for Puerto Ricans was close to that of Whites, 50 percent.

\* Across these population groups, psychotherapy was used more frequently than medications (pharmacotherapy). Overall, 34 percent received pharmacotherapy; 45 percent psychotherapy. Use of psychotherapy was more likely to be consistent with APA guidelines than was pharmacotherapy, suggesting that adherence—the extent to which patients completed the recommended therapy—was greater for psychotherapy than pharmacotherapy. The contrast between the rates of *Guideline-consistent* psychotherapy and pharmacotherapy use was greatest among Caribbean Blacks, African Americans, and Mexican Americans.

\* Puerto Ricans had rates of treatment use, and treatment that was consistent with care guidelines, that were similar to, or higher than, non-Latino Whites.

\* Differences in factors enabling healthcare access appeared to contribute substantially to disparities in mental healthcare use, particularly for Mexican Americans. When differences in these enabling factors were controlled for statistically—so in effect, the population groups being compared had the same rates of enabling factors—the degree of disparities in use of care by Mexican Americans was reduced. For Caribbean Blacks and African Americans, statistical control of enabling factors reduced disparities in psychotherapy use, but not use of pharmacotherapy.

\* Health insurance coverage was associated with a greater likelihood of depression care, but not guideline consistent care. The pattern with education was reversed: education was associated with a greater likelihood of care that was consistent with the APA *Guidelines*, but not with greater use of care in general.

This study, with its large sample size and emphasis on minority groups, provides a more nuanced and detailed picture of the care received for major depression among different ethnic/racial groups and of factors that contribute to disparities. Lead author Hector González at Wayne State University said that Mexican-Americans make up over two-thirds of Latinos in the U.S.: “We found in our study that there are some really distinctive differences in mental healthcare use between Mexican Americans and other Latino subgroups that have not been previously reported.” Estimates suggest that Latinos will make up close to one-third of the U.S. population by mid-century; the study findings suggest that Mexican Americans should be a focus of efforts to reduce health disparities to ensure the nation's health in coming decades.

All groups were more likely to have received psychotherapy than pharmacotherapy. Caribbean Blacks and African Americans were particularly unlikely to receive pharmacotherapy consistent with APA guidelines; enabling factors such as education, health insurance, and income did not explain the lower rates of medication use. The authors note possible reasons for this, including research indicating that perceived discrimination can impact health care seeking behaviors. They speculate that the non-immigrant status of Puerto Ricans—and with that, greater predominance of English language use within this group—may be factors in their relatively high rates of health care use.

Findings from this study will inform future research on adherence to various depression therapies, and the factors that shape differences in care among racial/ethnic groups. “Future studies,” say the authors, “should explore the extent to which patients' subjective experiences of racial bias may affect their access and utilization of mental healthcare.”

### Reference

González, H.M., Vega, W.A., Williams, D.R., Tarraf, W., West, B.T., and Neighbors, H.W. *Archives of General Psychiatry* 2010;67(1):37-46.

(From National Institute of Mental Health, “Science Update: Just Over Half of Americans Diagnosed with Major Depression Receive Care,” January 4, 2010, <http://www.nimh.nih.gov/science-news/2009/just-over-half-of-americans-diagnosed-with-major-depression-receive-care.shtml>. This page last reviewed: January 04, 2010)

## Amyloid Deposits in Brains of People With Normal Cognition May Predict Risk for Future Alzheimer's Disease

Two recent studies have shown that persons who do not currently have dementia, but who have abnormal deposits of beta-amyloid (a protein associated with Alzheimer's disease) in their brains, are at increased risk of developing the symptoms of this progressive brain disorder. The studies, conducted by researchers at Washington University in St. Louis, were primarily funded by the National Institute on Aging (NIA), part of the National Institutes of Health. Scientists leading these projects found that higher amounts of these protein deposits in dementia-free people were linked with a greater risk for developing dementia, as well as with loss of brain volume and subtle declines in cognitive abilities.

The two studies are reported in the Dec. 14, 2009, online issue of *Archives of Neurology*. The scientists used brain scans and other tests to explore the relationship between levels of beta-amyloid, a sticky protein that forms the hallmark plaques of Alzheimer's disease, and dementia risk in cognitively normal people. John C. Morris, M.D., who directs the NIA-supported Alzheimer's Disease Research Center at Washington University in St. Louis, and his team conducted the research. Martha Storandt, Ph.D., also of Washington University in St. Louis, directed one of the studies.

"Previous studies of brain pathology, cognitive testing, and brain imaging have for some time suggested that Alzheimer's pathology causes changes to the brain many years before memory loss, confusion, and other symptoms of the disease are apparent. But it remains difficult to accurately predict whether a cognitively normal person will--or will not--develop the disease," said NIA Director Richard J. Hodes, M.D. "These new studies suggest that beta-amyloid measured in the brains of cognitively normal individuals may be a preclinical sign of disease."

Morris' team used a variety of measures to look for changes in the brain in the two studies, including positron emission tomography (PET) imaging using a radioactive form of Pittsburgh Compound B (PiB), an agent specially developed to detect levels of beta-amyloid protein in the living brain; magnetic resonance imaging (MRI) to measure brain volume; and standardized clinical tests of memory and thinking abilities to determine cognitive health. Previously, the link between beta-amyloid load and Alzheimer's disease could only be confirmed at autopsy.

The studies indicated that beta-amyloid might be present in the brain even in symptom-free people:

— Between 2004 and 2008, researchers used PiB scans to track 159 volunteers ages 51 to 88, all of whom started the study with no signs of cognitive impairment, to see if there was a correlation between beta-amyloid levels and cognitive health. Over time, 23 participants developed mild impairments, and nine were eventually diagnosed with clinical Alzheimer's disease. Compared with participants who remained cognitively normal, the nine who were eventually diagnosed clinically with Alzheimer's disease had high levels of PiB binding in the brain and experienced cognitive decline as well as volume loss in the parahippocampal gyrus, a part of the brain that controls memory. However, not every person who had beta-amyloid deposition in the brain developed cognitive impairment. Beta-amyloid deposition may be a risk factor for developing Alzheimer's disease but its presence does not constitute a diagnostic finding.

— In 135 cognitively normal older adults aged 65 to 88, the level of beta-amyloid as measured by PiB binding correlated with atrophy, or shrinkage, in many parts of the brain and to declines on memory and thinking tests over many years.

"More study is needed in larger groups for longer periods, but these studies confirm the value of detecting and measuring amyloid load in the brains of living people as soon as possible," said Morris. "These imaging tools are an important part of ongoing effort to create a profile of Alzheimer's in its earliest stages, even before symptoms appear, by linking imaging results with other biomarkers and clinical evaluations."

### REFERENCES:

Morris JC, Roe CM, Grant EA, Head D, Storandt M, Goate AM, Fagan AM, Holtzman DM, Mintun MA. "Pittsburgh Compound B imaging and prediction of progression from cognitive normality to symptomatic Alzheimer's disease." *Archives of Neurology*, Dec. 14, 2009.

Storandt M, Mintun MA, Head D, Morris JC. "Cognitive decline and brain volume loss are signatures of cerebral amyloid beta deposition identified with PiB." *Archives of Neurology*, Dec. 14, 2009.

(From *NIH News, National Institutes of Health, Press Release, "Amyloid Deposits in Cognitively Normal People May Predict Risk for Alzheimer's Disease," Monday, December 14, 2009, <http://www.nih.gov/news/health/dec2009/nia-14.htm>*)

### National Survey of Residential Care Facilities (NSRCF) to Begin in April, 2010

The National Center for Health Statistics (NCHS), within the Centers for Disease Control and Prevention (CDC), is conducting a new study of assisted living and residential care homes including board and care homes, congregate homes, personal care homes, assisted living residences, enriched housing programs, and shared housing establishments. The National Survey of Residential Care Facilities (NSRCF) is a first-ever study designed to provide national estimates of these types of places. This study will collect information about their characteristics and the people who live there. The assisted living/residential care communities and a few of their residents (based on size of place) will be randomly selected for the study. In-person interviews will be conducted with directors and/or a caregiver/staff (not residents).

The NSRCF will provide information about services, staffing, and practices, and resident health, functional status, and use of services. This information will help policy makers, health care planners, and owners better understand, plan for, and serve the future long-term care needs of the aging population. Although data from this study will be publicly available, all data will be confidential and aggregated, so that the names of the places interviewed, respondents, and residents are not identifiable. About 2,250 assisted living/residential care communities will be selected for the national study beginning in April 2010. Your assisted living community/residence may be one of them. The power of this study depends on your participation. If your place is contacted, make your voice heard by participating in the study.

## Important Reminder!

These resources contain helpful and useful information and services for many of our readers. Please remember, however, that laws and regulations vary from state to state. Some ideas and suggestions provided in/by the resources listed may not apply to you. For instance, contents of some publications may apply to family caregivers, but not to board and care homes. Please check your local laws and regulations before implementing information obtained from these sources.

The following resources are not listed in any particular order. Many involve internet access; if you do not have a computer, remember that most public libraries make internet access available.

## The Heart Truth

Heart disease is the number one killer of women in our country today. Yet many women are not aware of the risks they face of developing heart disease, often because they assume that heart disease affects only men. To make women more aware of the danger of heart disease, the National Heart, Lung, and Blood Institute (NHLBI) and partner organizations are sponsoring a national campaign called *The Heart Truth*<sup>®</sup>. The campaign's goal is to give women a personal and urgent wakeup call about their risk of heart disease.

*The Heart Truth*<sup>®</sup> campaign is especially aimed at women ages 40 to 60, the time when a woman's risk of heart disease starts to rise. But its messages are also important for younger women, since heart disease develops gradually and can start at a young age—even in the teenage years. The information is important for older women as well, since it is never too late to take action to prevent and control the risk factors for heart disease. Even those women who already have heart disease can improve their heart health and quality of life.

Heart disease disproportionately affects women of color. African American and Hispanic women in particular have high rates of the major risk factors for heart disease, including obesity, physical inactivity, high blood pressure, and diabetes. *The Heart Truth*<sup>®</sup> Women of Color initiative, with its partners, focuses on extending *The Heart Truth*<sup>®</sup> messages and engaging in national and local activities to help more women of color understand *The Heart Truth*<sup>®</sup>—and inspire them to take action to reduce their risks for heart disease (*The National Heart, Lung, and Blood Institute, the National Institutes of Health, "About The Heart Truth*<sup>®</sup>, <http://www.nhlbi.nih.gov/educational/hearttruth/about/index.htm>).

It is important for all women, regardless of age, race, or ethnic background, to understand what heart disease is, the risk factors which increase the chances that they will develop heart disease, and techniques for minimizing risk and managing heart disease if it does occur. *The Heart Truth*<sup>®</sup> campaign encourages women to know and act on the following facts:

### What is Heart Disease?

Coronary heart disease, often simply called heart disease, is the main form of heart disease. It is a disorder of the blood vessels of the heart that can lead to heart attack. A heart attack

happens when an artery becomes blocked, preventing oxygen and nutrients from getting to the heart. Heart disease is one of several cardiovascular diseases, which are diseases of the heart and blood vessel system. Other cardiovascular diseases include stroke, high blood pressure, angina (chest pain), and rheumatic heart disease.

One reason some women are not concerned about heart disease is that they think it can be "cured" with surgery or medication. This is a myth. Heart disease is a lifelong condition; once a woman gets it, she will always have it. While it is true that procedures such as bypass surgery and angioplasty can help blood and oxygen flow to the heart more easily, the arteries remain damaged. This means that the person with heart disease is still more likely to have a heart attack. What's more, the condition of her blood vessels will steadily worsen unless she makes changes in her daily habits. Many women die of complications from heart disease or become permanently disabled. That is why it is so vital to take action to help residents prevent and control this disease.

### What Are the Risk Factors for Heart Disease?

Risk factors are conditions or habits that make a person more likely to develop a disease. They can also increase the chances that an existing disease will get worse. Important risk factors for heart disease include:

- \* High blood pressure
- \* High blood cholesterol
- \* Diabetes
- \* Smoking
- \* Being overweight
- \* Being physically inactive
- \* Having a family history of early heart disease
- \* Being age 55 or older (for women)

Some risk factors, such as age and family history of early heart disease, cannot be changed. For women, age becomes a risk factor at 55. After menopause, women are more apt to get heart disease, in part because the body's production of estrogen drops. Women who have gone through early menopause, either naturally or because they have had a hysterectomy, are twice as likely to develop heart disease as women of the same age who have not yet gone through menopause. Another reason for the increasing risk is that middle age is a time when women tend to develop risk factors for heart disease.

Family history of early heart disease is another risk factor that cannot be changed. If a resident's father or brother had a heart attack before age 55, or if her mother or sister had one before age 65, she is more likely to get heart disease herself.

While certain risk factors cannot be changed, it is important for women to realize that they do have control over many others. Regardless of their age, background, or health status, residents can lower their risk of heart disease, and it does not have to be complicated. Protecting their heart can be as simple as taking a brisk walk, enjoying a good vegetable soup that you have prepared, or getting the support they need to maintain a healthy weight.

*Continued on Page 10: SEE RESOURCE CORNER*

*Continued from Page 9: RESOURCE CORNER*

Residents, with your support, can make changes gradually, one at a time. What is important is that the changes are made. A woman may wonder: If I have just one risk factor for heart disease—say, I’m overweight or I have high blood cholesterol—aren’t I more or less “safe”? The answer is, absolutely not. Each risk factor greatly increases a woman’s chance of developing heart disease. But having more than one risk factor is especially serious, because risk factors tend to “gang up” and worsen each other’s effects. The message is clear: Every woman needs to take her heart disease risk seriously, taking action now to reduce that risk; and every board and care home operator needs to also be aware of that risk and provide services that help to reduce or eliminate risk factors.

**How Can a Resident Find Out if She Is at Risk for Heart Disease?**

The first step toward heart health is becoming aware of one’s own personal risk for heart disease. Some risks, such as smoking cigarettes, are obvious: every woman knows whether or not she smokes. But other risk factors, such as high blood pressure or high blood cholesterol, generally don’t have obvious signs or symptoms. As a result, each resident will need to gather some information to create her own personal “heart profile.”

A crucial step in determining heart disease risk is for each resident to see her doctor for a thorough checkup. The doctor can be an important partner in helping residents set and reach goals for heart health. Do not wait for the doctor to mention heart disease or its risk factors. Many doctors don’t routinely bring up the subject with women patients. To establish good, clear communication with her doctor, residents can follow these tips:

**Ask Questions:** Residents must tell their doctors that they want to keep their hearts healthy and would like help in achieving that goal. They should ask questions about their chances of developing heart disease and how they can lower their risk:

- \* What is my risk for heart disease?
- \* What is my blood pressure? What does it mean for me, and what do I need to do about it?
- \* What are my cholesterol numbers? (These include total cholesterol, LDL or “bad” cholesterol, HDL or “good” cholesterol, and triglycerides.) What do they mean for me, and what do I need to do about them?
- \* What are my body mass index (BMI) and waist measurement?
- \* Do they indicate that I need to lose weight for my health?
- \* What is my blood sugar level, and does it mean I’m at risk for diabetes?
- \* What other screening tests for heart disease do I need? How often should I return for checkups for my heart health?
- \* What can you do to help me quit smoking?
- \* How much physical activity do I need to help protect my heart?
- \* What is a heart healthy eating plan for me? Should I see a registered dietitian or qualified nutritionist to learn more about healthy eating?

\* How can I tell if I’m having a heart attack?

*(From “Questions To Ask Your Doctor” on page 17 of The Healthy Heart Handbook for Women, NIH Publication No. 07-2720, <http://www.nhlbi.nih.gov/educational/hearttruth/downloads/pdf/handbook-for-women.pdf>)*

In addition, residents should **ask for tests** that will determine their personal risk factors. These include:

\* **a lipoprotein profile**, which is a blood test that measures total cholesterol, HDL or “good” cholesterol, LDL or “bad” cholesterol, and triglycerides, another form of fat in the blood. The test is given after a 9- to 12-hour fast. This test can help determine if the resident has HDL cholesterol, or high triglyceride levels. All affect her risk for heart disease. All healthy adults should have their blood cholesterol levels checked at least once every 5 years. Depending on the results, the resident’s doctor may want to repeat the test more frequently.

\* **A blood pressure test**, used to find out if a resident has high blood pressure (also called hypertension) or prehypertension. Both are risk factors for heart disease. Blood pressure should be checked at least every 2 years or more often if she has high blood pressure or prehypertension.

\* **A fasting plasma glucose test**, used for diagnosing diabetes. After the resident has fasted overnight, she will get a blood test the following morning. This test is used to find out if the resident has diabetes or is likely to develop the disease. Fasting plasma glucose levels of more than 126 mg/dL on two tests on different days indicate the presence of diabetes. Levels between 100 and 125 mg/dL indicate that the resident has an increased risk for diabetes and may have prediabetes. Diabetes is an important risk factor for heart disease and other medical disorders. A fasting plasma glucose test should be given at least every 3 years, beginning at age 45. If the resident has risk factors for diabetes, she should be tested at a younger age and more often.

\* **A Body Mass Index (BMI) and Waist Circumference** are measures of weight in relation to height. Waist circumference is a measure of the fat around your middle. BMI and waist circumference can help determine whether one’s body type raises the person’s risk of heart disease. A BMI of 25 or higher means a resident is overweight. A BMI of 30 or higher means she is obese. Both overweight and obesity are risk factors for heart disease. For women, a waist measurement of more than 35 inches increases the risk of heart disease and other serious health conditions. These tests should be done every 2 years, or more often if the doctor recommends it.

\* **Other Tests:** There also are several tests that can determine whether a resident already has heart disease. She should ask her doctor whether she needs a stress test, an electrocardiogram (EKG or ECG), or another diagnostic test. *(From “Check It Out,” page 16 of The Healthy Heart Handbook for Women, NIH Publication No. 07-2720, <http://www.nhlbi.nih.gov/educational/hearttruth/downloads/pdf/handbook-for-women.pdf>.)*

...being treated for  
...should ask her doctor  
...resident should ask  
...recommendations? A  
...under control?  
...e, encourage the

**RESOURCE**

*Continued from Page 10: RESOURCE CORNER*

about its benefits and risks. Find out if she will need to be hospitalized and for how long, and what to expect during the recovery period.

When the doctor asks a resident questions, she must answer as honestly and fully as she can. While certain topics may seem quite personal, discussing them openly can help the doctor find out about her chances of developing heart disease. It can also help the doctor work with the resident and with staff within the home to reduce her risk. If she already has heart disease, the resident should briefly describe each of her symptoms, including when each symptom started, how often it happens, and

If your resident does not understand something her doctor says, she can ask for an explanation in simple language. She needs to be especially sure she understands how to take any medication she is given. If she is worried about understanding what the doctor says, or if she has trouble hearing, she may want to bring a friend, a relative, or a staff person from the home along with her to the appointment. She may want that person to write down the doctor's instructions for her so that she is clear about them and can review them later if she likes.

### **Menopausal Hormone Therapy and Heart Disease**

Menopausal hormone therapy once seemed the answer for many of the conditions women face as they age. It was thought that hormone therapy could ward off heart disease, osteoporosis, and cancer, all while improving women's quality of life. But beginning in July 2002, findings emerged from clinical trials that showed this was not so. In fact, long-term use of hormone therapy poses serious risks and may increase the risk of heart attack and stroke. The findings come from the Women's Health Initiative (WHI), launched in 1991 to test ways to prevent a number of medical disorders in postmenopausal women. It consists of a set of clinical studies on hormone therapy, diet modification, and calcium and vitamin D supplements; an observational study; and a community prevention study.

The two hormone therapy clinical studies were both stopped early because of serious risks and the failure to prevent heart disease. Briefly, the estrogen-plus-progestin therapy increased women's risk for heart attacks, stroke, blood clots, and breast cancer. These risks diminished after stopping estrogen-plus-progestin. Estrogen-plus-progestin also doubled the risk of dementia and did not protect women against memory loss. The therapy did, however, have some benefits: it reduced the risk for colorectal cancer and bone fractures. Estrogen-alone therapy increased the risk for stroke and venous thrombosis (blood clot, usually in one of the deep veins of the legs). It had no effect on heart disease and colorectal cancer, and an uncertain effect on breast cancer. Estrogen alone gave no protection against memory loss, and there were more cases of dementia in those who took the therapy than those on the placebo, although the increase was not statistically significant. Estrogen alone reduced the risk for bone fractures.

While questions remain, the findings make possible some advice about using hormone therapy: Estrogen alone or with progestin should not be used to prevent heart disease. Residents can talk with their doctors about other ways of preventing heart attack and stroke, including lifestyle changes

and medicines such as cholesterol-lowering statins and blood pressure drugs.

\* If a resident is considering using menopausal hormone therapy to prevent osteoporosis, she should talk with her doctor about the possible benefits weighed against her personal risks for heart attack, stroke, blood clots, and breast cancer. The doctor can be asked about alternative treatments that are safe and effective in preventing osteoporosis and bone fractures.

\* Menopausal hormone therapy should not be taken to prevent dementia or memory loss.

\* If a resident is considering menopausal hormone therapy to provide relief from menopausal symptoms such as hot flashes, she should talk with her doctor about whether this treatment is right for her. WHI findings confirm that menopausal hormone therapy relieves menopausal symptoms. At the average age of menopause, the absolute risks (numbers) of heart attack, stroke, and blood clots are low and little affected by short-term menopausal hormone therapy. The current U.S. Food and Drug Administration recommendation for menopausal hormone therapy is that it should be used at the lowest dose for the shortest period of time to reach treatment goals.

Remember, a woman's risk for heart disease, stroke, osteoporosis, and other conditions may change as she ages. So, it is important for residents to review their health regularly with their doctors. New treatments that are safe and effective may become available. Residents and home operators alike should stay informed.

**If A Resident Has Heart Disease:** Menopausal hormone therapy was once thought to lower the risk of heart attack and stroke for women with heart disease. But research now shows that women with heart disease should not take it. Menopausal hormone therapy can involve the use of estrogen alone or estrogen plus progestin. For women with heart disease, estrogen alone will not prevent heart attacks, and estrogen plus progestin increases the risk for heart attack during the first few years of use. Estrogen plus progestin also increases the risk for blood clots, stroke, and breast cancer. (From National Heart, Lung and Blood Institute, National Institute of Health, "Lower Heart Disease Risk," <http://www.nhlbi.nih.gov/educational/hearttruth/lower-risk/index.htm>).

For more information on heart disease, please contact [womenshealth.gov](http://womenshealth.gov) at its website or by calling 1-800-994-9662, or contact the following organizations:

**National Heart, Lung, and Blood Institute (NHLBI)**  
**Phone Number: (301) 592-8573**  
**[www.nhlbi.nih.gov](http://www.nhlbi.nih.gov)**

The National Heart, Lung, and Blood Institute (NHLBI) offers consumers a wide variety of resources through each of the following programs as well as through its page "Heart and Vascular Diseases," (<http://www.nhlbi.nih.gov/health/public/heart/index.htm>) through which interested persons can link to numerous websites and publications. The programs under the auspice of NHLBI include:

*Continued on Page 12: RESOURCE CORNER*

*Continued from Page 11: RESOURCE CORNER*

**National Cholesterol Education Program**

[www.nhlbi.nih.gov/about/ncep](http://www.nhlbi.nih.gov/about/ncep)

A “10 Year Heart Attack Risk Calculator” is available for use, as are publications on lowering cholesterol.

**National High Blood Pressure Education Program**

[www.nhlbi.nih.gov/about/nhbpep/index.htm](http://www.nhlbi.nih.gov/about/nhbpep/index.htm)

Information available includes “Your Guide to Lowering High Blood Pressure”; pamphlets with information specific to older adults, African Americans, and Latinos; and details about the DASH® diet.

**Act In Time to Heart Attack Signs Campaign**

National Heart Attack Alert Program

[www.nhlbi.nih.gov/actintime](http://www.nhlbi.nih.gov/actintime)

Includes information about heart attack warning signs, surviving a heart attack, an “Act in Time” video that can be viewed, and a heart attack survival plan.

**The Heart Truth**

National Awareness Campaign for Women about Heart Disease

<http://www.nhlbi.nih.gov/health/hearttruth/index.htm>

Materials focusing on heart health in women, with specific materials for African Americans and Latinas.

**American Heart Association**

7272 Greenville Avenue

Dallas, TX 75231

American Heart Association: (800) 242-8721

American Stroke Association: (888) 478-7653

[www.americanheart.org](http://www.americanheart.org)

Consumers can access heart health and stroke information, including warning signs, diseases, and lifestyle and diet changes, at the website shown above or by calling the telephone numbers listed above.

***Watch upcoming issues of the Board and Care Quality Forum for the following:***

- Additional articles on services and supports that can assist residents with mental health problems in their journeys of recovery, including self-directed care and peer counselors.
- Consideration of the unique needs of residents who have severe, persistent mental illness as they age.
- An exploration into the unique needs and concerns experienced by board and care home residents during the nighttime hours.
- Advice from a physical therapist about how residents of any age and with any health condition can engage in physical activity to maintain flexibility and range of motion and to enhance health.

**Board and Care Quality Forum**

Published by Reisacher Petro and Associates

1728 Holly Lane

Pittsburgh, PA 15216

***Now in Our 13th year of service!***