Ending Ageism: “How Not to Shoot Old People”

In a telephone interview, Gullette discussed the subtle differences between age bias and racism or sexism in America. But she also revealed the surprising influence of her experience with adult education in rural Nicaragua on her fundamental belief that people at any age can discover “a new sense of possibility” when offered opportunities too often denied them based on their years.

“The Violence of Ageism”

Instances of age bias in Gullette’s book range from an 80-year-old retired CEO she knows, who was “shoved down a subway stairs” and hospitalized by a young person in a hurry, to numerous examples of internet hate speech she cites. Particularly striking was a post by one young man who complained, “God forbid these miserable once-were-people ... survive if possible to burden the rest of us.” Gullette explained, “The law and society recognize that sexism and racism can be violent. But we also need to recognize the violence of ageism. Sometimes the attacks are invisible—they go unseen. And too often the victims are silent.”

Behind such arrogance and invasiveness, Gullette wrote, lie “fantasies, laws, practices, disdain, avoidances, invisibility and hypervisibility, intolerance of our appearance, lack of audiences for our grievances, underestimation of our trials, dislike of our alleged characteristics or disgust at our apparent weaknesses, and unwillingness to look us in the eye or spend time in our company.”
Additionally, she stated, “Ageism makes every other bias worse. It can make homophobia worse, such as within the gay community—I mean, aging is not looked on positively within the male gay community. It makes sexism worse. Since Susan Sontag, we’ve known about the double standard of aging,” whether on the job or in Hollywood.

In medicine, she added, “If you get breast cancer, the odds of your surgeon not recommending chemotherapy for a woman over 65 are seven times greater than for women under 50.” And in business, outsourcing and downsizing measures routinely deny employment, promotions and other work opportunities to those in midlife or older, despite extensive research showing that older workers are more reliable and are usually not more costly than younger workers.

Even democracy is taking a hit from ageism. Gullette observed, “The new search for fraudulent voters has asked old people to get forms of identification that would satisfy their local voting registration board. This is damaging to old people. It is liable to take away voting rights.”

Even before the recent wave of voter suppression laws, Gullette became aware of the limited options many elders must document their citizenship. Several years ago, her mother, a devoted lifelong voter, discovered in her 90s that she no longer had a valid driver’s license—her only valid ID—since she had stopped driving. Also, although she was born in America, her birth certificate showed her traditional Jewish name, and later documents showed her married name.

Even though the motor vehicles bureau in Florida, where she lived, issued Gullette’s mother a new ID in time for an upcoming election, the tighter restrictions in many states have toughened access to the polls, especially limiting voting rights for older naturalized citizens or ethnic elders who were born in rural areas, where birth certificates were not common earlier in the 20th century.

**Inspiration in Nicaragua**

What inspired Gullette to devote decades to puncturing American culture’s framing of our advancing years as a long and depressing decline? “I think my mother and my family had a lot to do with it,” said Gullette.

“My mother was a funny source for my interest in ageism because she was totally optimistic. She instilled in me a theme I call ‘the progress narrative.’” Rather than seeing our added years as a slide into decrepitude, Gullette realized that, given a positive attitude and opportunities for development, people can progress both for themselves and their communities—and not only just in late life.

She and her husband began visiting the community of San Juan del Sur, in southwestern Nicaragua near the Pacific Coast, in the late 1980s, after the town became a Sister City of the Gullettes’ hometown of Newton, Mass. Friends they made ran a literacy program that had graduated 300 women with sixth-grade diploma’s—but those wishing to continue learning were blocked from attending regular high schools.

Gullette explained, “When we started there were no high schools for adults. If you were over 18, or if you were a woman or had a baby, you couldn’t go. Our earliest students were in their 40s and 50s, and they hadn’t had any schooling. We gave them a second chance to go to high school.”

In 2001, she recalled, they got permission (but no government funding, only private donations) to create the Free High School for Adults, which Gullette cofounded with Dr. Rosa Elena Bello. “Now 16 years and a 1001 graduates later, we have a grandmother, a mother and a daughter, three generations. (We have men too, of course.) They say, ‘This wasn’t possible—I couldn’t go anywhere.’ Their lives were stymied. Now they feel this great sense of possibility. Now they know how to learn; they didn’t know what education could bring them.”

Gullette learned to speak Spanish in order to teach during her frequent trips there, as well as help conduct research by interviewing current and past students. After graduating, she said, “Most of them want more. Over a third of our graduates go on and do higher education, technical school or, if they can afford it, university. And they sacrifice. It’s just an amazing story.” She remembered one woman who said beforehand, “Oh, I can’t do this.” However, Gullette went on, “Now she says, ‘I can do it, I can do anything. Who knows what’s going to happen next? I could learn English, I could become an accountant.’ That happened repeatedly. And they have absolutely changed the culture of our region of Nicaragua.”

**The Longevity We Deserve**

Gullette said her rural Nicaraguan experience demonstrated how her idea that people can feel they are progressing in some way at any stage of their lives, instead of merely declining with the years, is “not just an elite narrative” of the urban middle class. She added, “People, as much as possible, can decide what they want to call progress, and they sometimes find some small thing that is a positive about their life that makes them feel like getting up in the morning.”

Meanwhile, Gullette emphasized, “It’s a harsh fact that ageism has grown much worse, while the public is yet to learn what the word means.” Like sexism and racism in the mid-20th century, change will only occur when people recognize and call out ageist prejudice in many domains of American life. That will bring us the decent longevity that all generations deserve,” she said.
Financial Circumstances Have People Over 50 Working Longer

Washington Informer Reporter, Kevin McNair reported, today’s life expectancy rate for United States citizens stands at 76.5 and 81.2 years for men and women, respectively, according to recent data provided by the world’s leader of medical research, Imperial College London. But before we celebrate, it’s important to note that these levels are among the lowest of the world’s richest countries — a list of “lows” that includes places like Croatia and Mexico.

Why? Because, among other factors, America lacks universal health insurance and has the highest child, maternal, homicide and body-mass index rates of any high-income country. What’s more, many Americans 50 years of age or more have discovered that living longer often requires them to work longer to keep up with their financial obligations and personal desires.

Faking Normal’ Over 50

That’s what one Washington, D.C., resident, Elizabeth White, a former chief operating officer for a midsize nonprofit organization, once-celebrated entrepreneur and MBA graduate of Harvard Business School, learned while struggling on the edge of a financial precipice for years, despite her outward appearances.

White, now in her 60s, chronicles the pain she experienced as her flourishing career and upper-middle class lifestyle came to a grinding halt in her 2017 self-published book, Fifty-Five, Unemployed and Faking Normal. She says that while she "pretended" that things were going great, in truth she feared the future — and soon discovered that she had a lot of company. “There’s a lot of pressure to act like you’re doing well. That’s why I describe my personal reflections as an act of ‘faking normal,’” she said while speaking to media at the World Congress of Gerontology and Geriatrics in San Francisco last July.

White admits that the townhouse she purchased years ago now has a rental rate that she couldn’t begin to afford today. Nor can she afford to pay the fee for private parking.

Meanwhile, and in terms of how she reached her unexpected financial crisis, White says that after making her mark as one of only a handful of black women employed by the World Bank, she took a huge piece of her retirement savings to fund her own business. Her enterprise promoted African-inspired products — a venture that had tremendous potential but which eventually failed. “We were doing well, but I could see that we were not going to be able to grow the business into a national chain as we were already struggling with volume,” she said. “One day I just closed my stores.”

From $200K a Year to $0

For a while, White survived on receiving consistent consulting work. Then, as the 2008 economic crash occurred, she went from close to $200,000 a year to zero. “The jobs of the past weren’t there anymore,” she said. “And I found it harder to get hired than I did years earlier — probably due to age discrimination. It didn’t matter how great I may have looked. I learned that early; being in one’s 50s was no longer considered ‘young’ in the workplace. I realized I was in trouble.”

Recent data from several social research organizations indicate that from ages 45 to 55, wages decline by nine percent or more — then dropping by an additional nine percent for those between 55 and 64. And most experts say age discrimination starts at around 35 with women bearing the brunt much sooner and more intensely than men.

“Maybe it was too many bottled waters and too many visits to Starbucks,” White says with a laugh. “I was embarrassed to admit to my friends what was going on in my life. But it was those same friends who helped me make it. I realized I had to come to terms with my new reality and deal with life on new terms.”

In her book, White provides over 100 online resources and offers ways to deal with the emotions she faced after landing in financial ruin. “We’re amid a massive paradigm shift,” she states in the book’s conclusion. “Much of what we know has been turned on its head. We’re going to make mistakes. Learn from them. Forgive yourself. Focus on what is working. Throw the rest away.”
Malnutrition May Be Hiding in Plain Sight

According to Dr. Peggi Guenter, Senior Director of Clinical Practice, Quality, and Advocacy from the American Society for Parenteral and Enteral Nutrition (ASPEN), there are many misperceptions about malnutrition. For example, the idea that someone who is overweight can’t possibly be malnourished. Or that those living in countries like the U.S. have enough food to avoid this condition.

The truth is, malnutrition is far more common than you might think. It can happen to people of any weight and to those in both developed and developing countries. And it occurs in various settings – some of which may never even have occurred to you.

Hospitals

It might seem counterintuitive that, in a facility designed to return patients to health, the risk of malnutrition is substantial. However, it is estimated that at least one-third of patients in developed countries are already malnourished upon admission to the hospital. It often continues to be underdiagnosed during stays and, if left untreated, approximately two-thirds of those patients will experience a further decline in their nutrition status during their hospitalization.

Malnutrition also is associated with an increased risk of pressure ulcers and impaired wound healing, immune suppression and higher infection rates, higher treatment costs, and increased mortality. It leads to longer hospital stays and an increased risk of readmission. A statistical brief developed by ASPEN shows that, of the nearly 2 million hospital inpatient stays involving malnutrition in 2013, a significant percentage occurred among seniors, particularly those who were 85 years or older.1

Nursing homes

Seniors living in long-term care facilities are particularly vulnerable to malnutrition due to a variety of factors.

Poor dental health can make it difficult for some residents to chew comfortably and, therefore, it’s harder to eat. In addition, some residents may require a caregiver to help feed them, while others may need a feeding tube to receive adequate nutrition.

The Community

For seniors in the broader community, malnutrition can compromise independence and quality of life. Some older adults may experience a loss of appetite, while others face feelings of isolation and depression. These factors limit their desire to eat.

Further, those with decreased mobility may struggle to shop for groceries, finding themselves unable to stock their own pantries. Those who are older and malnourished are also more likely to require health and social services and experience more hospitalizations.

Identifying and Preventing Malnutrition

The prevalence of malnutrition, particularly among an aging population, is deeply concerning. Adding to the challenge, many of the most common symptoms of malnutrition — such as unplanned weight loss, ability to eat only in small amounts, weakness, fatigue, and fluid accumulation — mirror the “normal” signs of aging.

So, what can be done to prevent, identify, and treat malnutrition across the various settings in which it might occur?

• First and foremost, careful monitoring is required to identify the condition. Older adults and those who care for them must be aware of the potential risks, ask their health care provider about their nutrition status, and actively advocate for optimal care.

• Health care teams must be vigilant in promptly diagnosing and treating malnourished patients in the hospital setting to expedite healing. It is equally important, however, for patients and their families to be knowledgeable and speak up when they feel something is amiss.

• Hospitals should also, in short order, offer on-site nutrition interventions and education and provide a plan for ongoing nutritional support for patients after they are discharged.

• The establishment of a nutrition quality measure would help to promote optimal nutrition care in the U.S. Such a measure, combined with a series of specific actions to address disease-related malnutrition, has the potential to improve patient outcomes by reducing readmissions, morbidity, mortality, and costs.
Caregiving Is Hard Enough. Isolation Can Make It Unbearable

For years, Marcy Sherman-Lewis went to a beauty salon in St. Joseph, Mo., every few weeks for a haircut and highlights. It had become something of an ordeal to prepare her husband, Gene Lewis, for this outing; he has Alzheimer’s disease, at 79, and helping him shower and dress, insert hearing aids and climb into the car was a very slow process.

But she could no longer leave him at home alone. And once at the salon, “he just sat, watched TV, slept — didn’t bother anybody,” said Ms. Sherman-Lewis, 62. Her stylist kindly trimmed his hair, too.

Marcy Sherman-Lewis is the primary caregiver for her husband, Gene Lewis, who has Alzheimer’s

Then last month, the salon owner took Ms. Sherman-Lewis aside. “Marcy, he makes my other patrons awfully uncomfortable,” she said. “I was dumbfounded,” Ms. Sherman-Lewis said. “It’s O.K. for other people’s little grandchildren to be running around sometimes. What am I supposed to do, keep him in a crate in the car?”

Like so many caregivers, she has discovered that along with the abandoned career, the hands-on tasks, the medical scheduling, the insurance tussles and the disrupted sleep, she faces another trial: social isolation.

“It’s hurtful,” she said. “You need friends more than ever.”

But where are they? Betsey Brairton, 48, cares for her mother, Sue, in rural Olean, N.Y. The elder Ms. Brairton, 79, suffers from spinal stenosis, arthritis and lingering damage from a stroke, so she has limited mobility. “We hardly go anywhere, and nobody comes here,” said her daughter. When she does leave for an hour or two, she’s afraid to put down her cellphone.

Though a couple of friends occasionally invite her out for dinner, “I can’t commit to anything, in case my mom is having a bad day,” Ms. Brairton said. She has begun to worry that when she does spend time with others, her narrowing life leaves her with nothing interesting to say.

Those who work with caregivers know this phenomenon well, especially when the cared-for person has dementia, a particularly arduous responsibility. “Caregiving is done with a lot of love and affection, but there’s a lot of loss involved,” said Carey Wexler Sherman, a gerontologist at the University of Michigan Institute for Social Research. “People talk about friends disappearing, about even family members not wanting to be involved. It’s a lonely business.”

Sometimes, caregivers isolate themselves. Barbara Moscovitz, senior geriatric social worker at Massachusetts General Hospital, hears clients lament that with a loved one whose dementia-related behavior can be startling, venturing out in public creates more apprehension than pleasure. “They say, ‘I’m exhausted trying to explain to people why she’s doing what she’s doing, why they shouldn’t be angry or afraid,’” Ms. Moscovitz said. “It’s just easier to stay home.”

Yet a habit of avoiding others — or watching them avoid you — collides with a growing body of research showing how damaging isolation and loneliness can be. They are associated with a host of ills, including heart disease and stroke. Among older people, isolation is linked to depression, even higher mortality. Lonely old people, Dutch researchers have found, are more apt to develop dementia.

We’ve long thought of these factors as dangers for the people being cared for. But they also imperil caregivers, who are often older adults as well. Years of caring for his wife, now deceased, who had early onset Alzheimer’s, left Les Sperling, 65, so despondent that “I’d stay in my room in the dark and sleep all day,” he said. “I didn’t want to come out.”

Mr. Sperling, of Lake Worth, Fla., went into therapy and took antidepressants until he felt able to function again. We know something about how to help caregivers feel less alone. Researchers have shown that even modest-sounding interventions can reduce their sense of isolation and improve their mental and physical health.

“Having someone outside who is paying attention and who cares is more important,” she said. Mary Mittelman, director of the Alzheimer’s Disease and Related Dementias Family Support Program at NYU Langone Health, has been conducting such studies for years. With federal and state grants, the program — involving several counseling sessions,
followed by support groups and phone access to counselors as needed — has inspired others that have been adopted throughout New York and in several other states. “The support is what leads to less stress, less depression, better health and delayed nursing-home admissions,” Dr. Mittelman said. Interestingly, her team has found that “instrumental support,” in which others help with tasks, has less impact than emotional support.

Other initiatives, like Savvy Caregiver and REACH, have demonstrated similar effectiveness. Because they are offered under various names in different states, Area Agencies on Aging can help besieged caregivers find free local programs. And since getting out of the house can be a struggle, program developers are also testing online versions.

Caregivers already gather in Facebook groups and on websites, but experts have mixed feelings about online chats and groups. “They provide anonymity, and that may permit more honesty,” said Dr. Wexler Sherman, the gerontologist. “Sometimes you need to vent at 2 a.m.” But we need skills, she said. “Being a caregiver is a job.”

Online, is the information passed along accurate and useful? Is there a trained, knowledgeable moderator? “It’s important to have a leader to monitor and validate,” said Ms. Moscowitz, who leads several support groups for Mass General employees and for community members. Besides, “there’s nothing like a real person to hug you.” On other fronts, we’re seeing more efforts to provide convivial social and cultural events for both people with dementia and their caregivers: Memory Cafes, museum programs, choruses.

The Dementia Friendly America campaign aims to make whole communities — including police forces, churches, restaurants and hair salons — more knowledgeable and accommodating. Individuals can also play a role. It’s too easy to let caregiving friends slip off our radar with a general call-if-you-need-anything. “Don’t put the pressure on the caregiver to tell you what to do,” Ms. Moscowitz said. She suggests asking what would be helpful, making a list of specific tasks and parceling out assignments. “Don’t invite me for lunch — you know I can’t go,” Ms. Sherman-Lewis said. “Just bring a pizza and a bottle of wine and come by.”

Though tangible help counts—and let’s acknowledge that an aging country can’t rely solely on families, friends and volunteers to provide everything dependent elders need, however well supported they are—so do regular texts, calls or visits. They help keep caregivers from feeling invisible and forgotten.

Counselors in the NYU program once had the friendly inspiration, since they kept caregivers’ information in their database, to send clients a card on their birthdays. It sounds sweet, if trivial. But often, Dr. Mittelman said, “they’d call up, so grateful, and say, ‘You’re the only one who remembered.’

**Seniors and HIV/AIDS**

The Statistics Might Surprise You

The Centers for Disease Control and Prevention (CDC) recently announced that the number of seniors who are living with HIV/AIDS is increasing. At present, over one-quarter of all HIV/AIDS patients are over 50. Yale Medical School experts project that by 2017, 50% of all people in the U.S. living with HIV will be over 50.

According to last year’s White House AIDS and Aging meeting, “Older age is not a safety net that protects people from getting HIV. Many issues surrounding HIV among older adults will only increase as our country faces the continuing graying of our nation’s HIV epidemic.” Two trends are behind this increase. First, the development of more effective HIV drug therapies in the 1990s has allowed many patients who contracted the virus decades ago to survive and thrive into their senior years.

Many of these patients are managing the disease successfully, though they face health challenges related to the disease and side effects of treatment. But new cases of HIV/AIDS are also on the rise in our senior population. What factors contribute to this increase?

"It Can’t Happen to Me"

Many people believe the stereotype that only young people need to worry about HIV/AIDS. But the truth is, seniors are also at risk. Today’s higher divorce rates, changing attitudes about sexuality and older adults, and the use of Viagra and similar drugs mean that seniors are now more likely than ever to be exposed to the virus. When they are exposed, they are more likely to become infected, for several reasons:

- As we age, our immune system is less able to fight off infection.
- Underlying health conditions can make us more likely to contract communicable diseases.
- Changes to the skin make it easier for the virus to enter the bloodstream.

Despite this higher risk of contracting the virus, seniors are least likely to understand the risks, take precautions against being exposed, get tested for the virus, or ask that a partner be tested.
They often find it embarrassing to bring up the subject with their healthcare providers, not wanting to admit to at-risk behavior, and fearing the stigma of the disease. Many doctors subscribe to the fiction that seniors aren’t sexually active and fail to bring up the subject. The U.S. Administration on Aging calls seniors “an invisible at-risk population.”

HIV/AIDS may be overlooked in the senior patient. It can be years before any symptoms appear, and the first signs can be minor. AIDS symptoms can mimic other age-related conditions. For example, the most common type of pneumonia in AIDS patients can be mistaken for congestive heart failure; HIV-related dementia may be misdiagnosed as Alzheimer’s or Parkinson’s; the fatigue and weight loss caused by AIDS might be interpreted as just “normal aging.” But early diagnosis is vital so that treatment can begin as soon as possible.

**Increasing Awareness**

We can’t afford to allow embarrassment to stand in the way of informing seniors about the risks. And we can’t allow the stigma of the disease to stand in the way of providing compassionate, competent care for seniors who are living with HIV/AIDS.

Healthcare organizations that serve seniors are urging older adults, their families and professional caregivers to educate themselves about the prevention and treatment of HIV in seniors.

**Resources to learn more include:**

- The Centers for Disease Control and Prevention (CDC) offers information about HIV/AIDS in people 50+, including information about protecting older adults from getting the virus and other consumer resources. – [www.cdc.gov](http://www.cdc.gov)

- The Act Against AIDS website offers consumer information and an HIV test finder - [https://www.cdc.gov/actagainstaids/index.html](https://www.cdc.gov/actagainstaids/index.html)

- Growing Older with the Epidemic: HIV and Aging is a comprehensive online booklet from the Gay Men’s Health Crisis.

- “AIDS: 30 Years Later”, AARP Magazine, for portraits of people over 50 who are living with the disease - [http://www.aarp.org/health/conditions-treatments/info-05-2011/aids-30-years-later.html](http://www.aarp.org/health/conditions-treatments/info-05-2011/aids-30-years-later.html)

---

**Testing is Easy**

Seniors can ask their healthcare provider for an easy, quick HIV/AIDS test. Local hospitals and health centers also offer the test. In most states the results are private, and the test can be given anonymously. To find HIV testing near you, visit the AIDS.gov website or the National HIV and STD Testing Resources test location finder. Medicare covers one HIV screening per year. Home test kits are also available. Only one home test is currently approved by the FDA.

**Aging with HIV**

Thanks to improved medical treatment, HIV-positive people can live well into their senior years. However, living with the virus complicates the management of other diseases that are common as we grow older.

Some conditions, such as heart disease, cancer, dementia and kidney disease, are likely to develop earlier in those with the virus, because of the virus and side effects of the powerful drugs used to keep it under control. HIV and the drug therapies that treat it can also worsen conditions such as diabetes, osteoporosis, arthritis and hypertension. The social and financial toll is also high. Seniors who are living with HIV face high medical bills. Many feel stigmatized and isolated, raising the risk of depression.

**HIV is Ageless.**

Get Tested.
Ailing Seniors Are Fastest-Growing Group Using Medical Marijuana

Karen Michel produced this story for NPR’s Here & Now with support of a journalism fellowship from New America Media, The Gerontological Society of America and The Silver Century Foundation.

NEW YORK--Larry Yokelson uses a walker and is on oxygen 24/7. “I am not a pothead,” he stated. Although he is age 87, Yokelson is familiar with the stuff—he used to be a driver for rock bands. “You want to know some of them,” he asked? “Led Zeppelin, Paul McCartney—I can’t even tell you the list.”

Yokelson said that just about all his passengers smoked pot.

But he didn’t like it. More recently, he didn’t like the opioids he’d been prescribed for his constant back pain, either. “You name it and I’ve been on it. You become so constipated on opiates you want to kill yourself,” he said.

He told his daughter, Jan, he was ready to give up. She recalled, “He said he was done, put me in hospice, I’m done, I can’t live like this.” But Yokelson found a sympathetic doctor. “He gave me a prescription, and I was in agony up to that point,” Yokelson said. “So, I took it at night and I woke up in the morning and I said to everybody in the house I’m pain free in one dose.” He declared, “Medical marijuana to me is a miracle—and it actually saved my life.”

Legal in 29 States

With 29 states allowing medical marijuana, seniors have been increasingly seeking its curative powers. But there are many obstacles, ranging from paying for the herb to finding a doctor who is licensed to prescribe it.

Yokelson takes a tincture of medical marijuana under his tongue at night and a capsule during the day. In New York it’s not even possible to get something to smoke or eat. At his age, Yokelson is part of the fastest-growing group of medical marijuana users—old folks, according to a 2016 study at New York University (NYU) published in Addiction, journal of the Society for the Study of Addiction.

“This has been a really understudied issue,” said NYU geriatric physician Benjamin Han, the study’s lead researcher. “Previous generations have had a very low prevalence of using drugs and alcohol. But with the baby boomer generation this is really going to change dramatically,” he predicted.

Han is not using hyperbole here. In a sample of 47,000 people ages 65 and older, the prevalence of marijuana use—whether medically or recreationally, showed about a 250 percent increase between 2006 and 2013. For another study on seniors and medical marijuana, the University of Iowa’s Brian Kaskie found that state program directors reported a huge increase in applications from folks over 60.

“I’ve been in states from Colorado, Minnesota, Vermont, Missouri—we’ve been all over—and in those focus groups with medical cannabis the stories were just amazing,” Kaskie said. The study was published last January in the journal, The Gerontologist. Kaskie found the stories from what he calls “the more interesting bunch” were folks like Larry Yokelson, those with an aversion to marijuana, especially smoking it. But medical marijuana comes in many forms.

“You can take it as a pill or edible form,” Kaskie said. “You could rub in on your skin lesions. That’s what I saw one person with cancer doing, and it provided relief for him. And that just was what really struck me. It’s like, wow, there’s a whole population of older persons out there who actually see this as a medical benefit.” Kaskie noted that marijuana by federal law is a schedule one drug, along with heroin, making its acceptance more of a challenge for potential patients and their providers. That’s because “they don’t want the liability associated with dispensing something that hasn’t been approved by the federal government,” he explained.

Dispensaries (Now with Delivery)

Each state has its own medical marijuana regulations. New York is among the most restrictive. Columbia Care has its own marijuana dispensaries in several states, including New York.

Its dispensary in New York City is on a major, busy street that is considered a dividing line between uptown and downtown. There’s a guard in front checking patient ID’s, a card much like a driver’s license. Inside there’s a friendly receptionist and comfy seating. According to Columbia Care’s CEO Nicolas Vita, in New York State, the average age of a patient is 54.
“I think that the aging population is actually one of the fastest growing markets nationally for medical marijuana products,” Vita said. “And our view is the products we manufacture should separate themselves from the counterculture history and focus on the medicinal applications and the benefits.”

Studies and experience have shown there are many conditions of older people that are especially responsive to treatment with medical marijuana. Key among them are neuropathy (a malfunction of nerves that can cause numbness or pain), lack of appetite, pain and difficulty sleeping, conditions that can lead to serious illness. But there are many barriers to access beyond any legal concerns.

Yokelson observed, “Medicaid and Medicare does not pay for it, for reimbursement. So, it’s a very tough thing for the aging population to go through.” He relies on his daughter to drive 45 minutes to get medical marijuana for him. But recently, several dispensaries started offering home delivery. And dispensaries in New York and elsewhere now offer video consultations with home delivery. But it all comes at a price.

### Tips for Keeping Your Aging Mind Sharp and Avoiding Dementia

**Editor’s note:** New America Media Zea Tibisay posted this story on September 23, 2017.

Raise your hand if you have a friend or relative who suffers or has suffered from some form of dementia, such as Alzheimer’s disease.

The data suggest that this is one of the most common conditions in the world, bringing severe brain debilitation and other consequences associated with isolation and depression. The key question is, can we prevent this from happening? Fortunately, science tells us yes—and the sooner we start, the better.

A group of scientists, physicians and mental health experts from the Global Council on Brain Health recently met in Washington, D.C. to make recommendations on how to forestall mental deterioration as we age.

### Little Evidence on Brain Games

The Global Council also concluded that there are many popular but erroneous misconceptions about claims having little scientific basis. Most common are so-called brain games promising to help us improve mental abilities. However, there is little evidence on this. For instance, playing Sudoku or crossword puzzles over time will make us better at Sudoku or crosswords, but won’t necessarily keep our mind agile on other activities.

In contrast, knowledge accumulated over time seems to play an important role in coping with the onset of dementia. “Frequent and continuous learning teaches the brain to modify its neural activity to meet the challenge of facing a new situation,” said Sarah Lock, senior vice president of policy at AARP.

According to Lock, learning a new skill, such as dancing, drawing, speaking a new language or playing an instrument, or training untapped cognitive functions, for example through brain training, gives the brain the ability to rewire its neural circuits.

The Alzheimer’s Association points out that in the United States more than 5 million Americans have dementia. By 2050 this figure could rise to 16 million. In addition, scientific research has confirmed that Latinos are more likely to suffer dementia than whites. Nearly 12 percent of older Hispanics have been diagnosed with dementia in the United States, according to the Alzheimer’s Association. Key factors are lower socioeconomic status, including low levels of education, higher poverty rates, and a greater tendency for early exposure to adversity and discrimination.

Medicare data show that 11.5 percent of Hispanics age 65-plus have been diagnosed with dementia, compared with 6.9 percent of whites, and 9.4 percent of African Americans. “Latinos have almost twice the risk of developing Alzheimer’s disease, which has no cure. The people who suffer from it will completely lose their memory,” said Yakeel Quiroz, a neuropsychologist from the Massachusetts General Hospital.

### What Can We Do?

The Global Council on Brain Health report issued a series of recommendations. They include:

1. Look for new activities that present a challenge and may help you develop new skills, then incorporate them into your day to day. Examples are practicing tai-chi, taking photography classes, learning a new language, playing an instrument, practicing a different physical activity.

2. Find someone else to do these activities with, such as a friend or family member. This is key to inspiring you to continue with your efforts. Generally, being with other people motivates you.

3. Do not wait long before you start challenging your mind with stimulating activities. The younger you start, the better your chance of having your brain in good shape as you get older.
4. Choose an activity you enjoy. This will make it easier to be motivated and committed for years to come.

5. Select activities that fit your schedule and are easily accessible, so you can be consistent.

6. Do things that involve both physical and mental activity. Physical activity has been shown to improve cognitive skills, for instance, dancing or playing tennis.

**Myths & Facts About Dementia**

**MYTH:** We were born with all the neurons that our mind will always have.

**FACT:** While many of the neurons are created before birth, some areas of the brain create new neurons throughout life in a process called neurogenesis. For example, some studies have shown that new neurons can be created in the brain region involved in learning and memory.

**MYTH:** You cannot learn something new when you are older.

**FACT:** There are many simple ways in which you can stimulate the mind to learn new things. For example, something as simple as meeting new people involves learning new names or other relevant information. Another idea might be to learn how to cook different dishes, which involves memorizing ingredients and being attentive to new cooking instructions.

**MYTH:** Only young people can learn a new language.

**FACT:** It is true that young people who are exposed to a new language can usually achieve faster and better results than older adults. However, people can learn a language at any age if they set their minds to it and find conditions conducive to learning.

**MYTH:** Dementia is an inevitable consequence of aging.

**FACT:** Although it is a very common condition, dementia cannot be termed as a "normal" element of aging. The loss of cognitive abilities is associated with age, but there is a distinction between that and some abnormal changes — which in some cases may progress to dementia.

---

**2018 Medicare Open Enrollment**

**When is the Medicare Open Enrollment Period?**

Every year, Medicare's open enrollment period is October 15 - December 7.

**What's the Medicare Open Enrollment Period?**

Medicare health and drug plans can make changes each year—things like cost, coverage, and what providers and pharmacies are in their networks. October 15 to December 7 is when all people with Medicare can change their Medicare health plans and prescription drug coverage for the following year to better meet their needs.

**How do people know if they need to change plans?**

People in a Medicare health or prescription drug plan should always review the materials their plans send them, like the "Evidence of Coverage" (EOC) and "Annual Notice of Change" (ANOC). If your plans are changing, you should make sure your plans will still meet your needs for the following year. If you’re satisfied that your current plans will meet your needs for next year and it’s still being offered, you don’t need to do anything.

**When can people get information about next year’s Medicare plans?**

Information for next year’s plans will be available beginning in October.

**Where can people find Medicare Plan information or compare plans?**

1-800-MEDICARE or Medicare.gov.
Here are just a few ideas:

- Encourage people to make small changes, like taking the stairs instead of the elevator.
- Talk to people in your community about getting regular checkups. They can get their blood pressure and cholesterol checked, and ask the doctor about their diabetes risk.
- Ask doctors and nurses to be leaders in their communities by speaking about the importance of healthy eating and physical activity.

For more information about the American Diabetes Association or activities commemorating, visit http://www.diabetes.org/.

The Rights of People with Diabetes in Emergency Shelters

Natural disasters can leave a devastating impact on those in the affected areas. People may be displaced from their homes and from their loved ones for extended periods of time. Cherished and valuable personal belongings may be destroyed or damaged. In such circumstances, people may find themselves temporarily living in emergency shelters. For people with diabetes, this can be especially daunting.

In addition to difficulties that might accompany securing necessary medications and supplies, people with diabetes may find themselves being turned away from shelters or refused necessary accommodations. This fact sheet provides information to people with diabetes about some of their key rights in emergency shelters.

New Medicare Cards

Medicare will mail new Medicare cards between April 2018 and April 2019. Your new card will have a new Medicare number that’s unique to you, instead of your Social Security number. This will help to protect your identity. The new card won’t change your coverage or benefits.

You don’t need to take any action to get your new Medicare card. Medicare will never contact you for your Medicare number or other personal information. Do not share your Medicare number or other personal information with anyone who contacts you by phone, email, or by approaching you in person, unless you’ve given them permission in advance.

For more information about the new Medicare cards, visit www.cms.gov.

Next Month: American Diabetes Month

Diabetes is one of the leading causes of disability and death in the United States. It can cause blindness, nerve damage, kidney disease, and other health problems if it’s not controlled. One in 10 Americans have diabetes — that’s more than 30 million people. And another 84 million adults in the United States are at high risk of developing type 2 diabetes.

The good news? People who are at high risk for type 2 diabetes can lower their risk by more than half if they make healthy changes. These changes include: eating healthy, getting more physical activity, and losing weight.

How Can American Diabetes Month Make a Difference?

We can use this month to raise awareness about diabetes risk factors and encourage people to make healthy changes.

F Y I
➢ Am I protected from being discriminated against because of my diabetes?

**YES.** Federal law prohibits discrimination based on a person’s disability. People with diabetes are protected against discrimination because diabetes meets the definition of a disability under federal law. Diabetes qualifies as a disability because it is a physical impairment that substantially limits one or more major life activity.

➢ Can I be turned away from an emergency shelter because of my diabetes?

**NO.** Most emergency shelters are considered places of public accommodation under Title III of the Americans with Disabilities Act (ADA). Under Title III of the ADA, people with disabilities must have an equal opportunity to enjoy the goods and services of a place of public accommodation. In practice, this means that a place of public accommodation, such as an emergency shelter, must not screen out or exclude you because of your diabetes.

In addition, the law requires that people with disabilities be housed in the most integrated setting appropriate to the needs of the person. So, people with diabetes generally should not be quarantined or segregated.

➢ Do emergency shelters must provide accommodations to people with diabetes?

**YES.** Title III of the ADA also requires that places of public accommodation modify their policies, practices and procedures that deny equal access to individuals with disabilities, unless doing so would fundamentally alter the nature of the services provided.

➢ What are some examples of accommodations that an emergency shelter should provide to a person with diabetes?

- Modification to “no sharps” policies so that people with diabetes can have access to their diabetes supplies, including insulin, syringes and pens.
- Modification to “no animals” policies so that diabetes dogs are allowed access.
- Modification to policies that may restrict the types or amounts of snacks or drinks allowed in.
- Allow unrestricted access to the bathroom.
- Allow for the safe and responsible administration of insulin and blood glucose testing.
- Provide refrigeration, as needed, for appropriate storage of medication.
- Remove structural barriers or provide alternative measures, as needed, for people with diabetes who suffer from neuropathy, amputations, etc.
- Provide appropriate aids for people whose vision is impaired due to retinopathy.
- Places of public accommodation are not required to provide diabetes supplies, food or drinks.

➢ Can an emergency shelter deny access to my diabetes dog?

An emergency shelter must modify its “no animals” policy for diabetes dogs. Generally, the ADA requires places of public accommodation to permit service animals to accompany people with disabilities. A place of public accommodation may only ask two questions to determine whether a dog is a “service animal” under the law:

- Is the dog a service animal required because of a disability, and;
- What work or task has the animal been trained to perform? Staff cannot ask about the person’s disability, require medical documentation, require a special identification card or training documentation for the dog, or ask that the dog demonstrate its ability to perform the work or task.

Allergies and fear of dogs are not valid reasons for denying access or refusing service to people using service animals. The ADA does require that service animals must be housebroken and kept under control.

➢ Who can I contact if I believe I am being discriminated against?

If you believe that an emergency shelter has discriminated against you, you may call the American Diabetes Association for information and guidance about your rights.

You may reach us by calling 1-800 DIABETES (800-342-2383) or by emailing AskADA@diabetes.org. The call center will conduct an intake of your issue, which will then be reviewed by our Legal Advocacy Attorneys for possible assistance.

The National Diabetes Association call center may also be able to provide information to you about locations of shelters and donated diabetes medications and supplies.