THE BLIND CALIFORNIAN

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In accepting material for THE BLIND CALIFORNIAN, priority will be given to articles concerning the activities and policies of the California Council of the Blind and to the experiences and concerns of people who are blind or have low vision. Recommended length is 900 words, 1800 max.

The deadline to submit material for the Spring, 2022 issue of THE BLIND CALIFORNIAN is noon, March 15, 2022.

Non-members are requested and members are invited to pay a yearly subscription fee of $10 toward the production and support of THE BLIND CALIFORNIAN.

Shop at Amazon, donate to CCB. Access smile.amazon.com/, log on to your account and select California Council of the Blind as your charity.

Please send all address changes to the Executive Office.

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Editor’s Corner

By Mike Keithley

Welcome to the Winter, 2022 Blind Californian. This is my seventh year as editor. Through my tenure I’ve had a fun time editing this magazine, and with the help of Associate Editor Susan Glass, we've been able to bring to you a good mix of material from different modes of living. We hope that you’ll continue to enjoy the Blind Californian for years to come.

Most of you know that Bernice Kandarian passed away October 2. Bernice was an important member of CCB, and an Obituary written by Roger Petersen is included in this issue. Unfortunately, Bernice’s memorial is not included here but will be covered in the Spring BC.

We feature two articles on the phase of life that some call old age. Your Associate Editor Susan Glass prefers to call it Age of Elders Wisdom. The first article is Robert Acosta’s new feature column, “Seniors Corners.” We follow it with the article “The Way We Age Now” which is quite long but well written. It introduces us to the needs elderly people have, how they’re underserved, and the urgency of facing a time when this population will be quite large. And lest I forget, my turn is visible around the corner. So please read this and excuse the length.

And then check “My Favorite Resource Teacher” and “Why Restructure ADA Paratransit,” both by Daveed Mandell, and more!

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Looking Back and Looking Forward

By Gabe Griffith

As I write this, it’s a somewhat sunny Saturday afternoon in late November here in northern California. By the time you read this, it will be mid December. That means it’s time to get ready for the holiday season. When I was a kid in Washington state, that meant looking forward to snow, and therefore sledding and snowball fights with friends. As a teenager it meant helping my dad with getting the lights on the house. Later it meant figuring out how Becky and I were going to split family obligations between my family and hers. Even now that she’s gone, I still find myself splitting the holidays between my parents and sister’s family and my in-laws. Of course, all these activities included the

pleasure of spending time with family and friends.

As CCB President, there is so much else to be looking at as well. As I'm sure everyone knows by now, we've been working on getting our nonprofit status straightened out. As of this writing, we have submitted all the information needed for our reinstatement application. Thanks to the hundreds of hours put in by our amazing treasurer Lisa Thomas, everything has been submitted and we are now waiting to hear back from the Franchise Tax Board to see if they have any questions.

What does this all mean for CCB? I'm so glad you asked. While it means we haven't been able to raise funds, we have continued our advocacy work. We have been working on scooter legislation and advocating for rehab services on the state level, and have continued to monitor and advocate for services on the national level. Sometimes that means signing on to support letters, and sometimes it means writing letters or making phone calls of our own. Thanks to Alice Turner and Ardis Bazyn, who are our co-chairs of the Governmental Affairs Committee, and to Jeff Thom, Governmental Affairs Director, and Regina Brink, Deputy Director of Governmental Affairs for keeping all these efforts moving forward and for letting me know when there are

letters needing my attention. We’ve been working on plans for a new CCB web site and will continue that work. We are continuing our partnership with OnTheMuV and are continuing to promote that product.

We have a wonderful group of folks working on these things, but other than when we ask Nicole Pacheco to submit letters or for other assistance, this is all done on a volunteer basis. This means we really need your help. Our main channels of communication are our email lists, mainly ccb-l and the presidents lists. We really need your assistance with distributing the information that is sent to these lists even further. Please, if you are on one of these lists, share the information that is sent through them with your chapters and affiliates. Presidents, when information about legislation or CCB activities is sent, please forward it to your members who may not be on one of the other lists. Often there is legislation and information on how to submit your personal support, and we can only get it out so far. In the future we may have other avenues for distributing information, but at least for now these email lists are our best ways of getting the information out, but we need your help. Talk about it in your chapter and affiliate meetings and ask your presidents what

information is being shared.

Ok, now let's talk about what 2022 will bring. First and foremost, we believe it will bring our long-awaited nonprofit reinstatement. That means we will be able to go back to fundraising, both on the state level and for our chapters and affiliates. Hopefully it will also bring more in-person gatherings. I know some groups have already started having small gatherings, but I'm very hopeful CCB will be able to have more of these. I for one miss hanging out with friends and getting together. Of course, we also have our convention coming up in May. The Convention Planning Committee is hard at work putting together another great virtual convention, and the information will be shared as it is available.

So, to bring this message full circle, just as the beginning of the holiday season gave me things to look forward to when I was a kid, I think we have plenty to look forward to as members of CCB. I thank you all for your support, encouragement, and for holding me to the standards that you deserve in your CCB President. As always, please reach out to me whenever you have questions or comments on anything CCB related. Merry Christmas, happy holidays, and I look forward to us all working together in the new year.

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Bernice Kandarian Obituary

By Roger Petersen

Bernice Mae Kandarian: December 5, 1946-October 2, 2021.

Bernice was born in Fresno, California, first child of Harry Aram Kandarian, son of Armenian immigrants and Jennie Bernita Hewette Kandarian, daughter of an Arizona Mother of the Year with ten children (thus, 23 cousins for Bernice on her mother's side). She became visually impaired at age five from uveitis, apparently resulting from a black widow bite combined with measles and chickenpox. She graduated from Litchfield Park Elementary School and Agua Fria High School in the western suburbs of Phoenix, and attained a Bachelor's degree from Arizona State University in Tempe. Her family had moved to Litchfield Park, Arizona when she was 7 years old and to Tempe, Arizona after she graduated from high school.

Bernice's work life began when she went to work for the Arizona State University Law School, where she duplicated articles for the students. It is said that some professors referred to "getting things Berniced for their classes". Then, her rehab counselor sent her to Los Angeles to train to be a Service Representative for the Social Security Administration. She worked for Social Security in California, Washington, DC and Arizona for a total of 14 years. Finally, for a brief time, she worked in the Disabled Students office at Stanford University.

Meanwhile, another aspect of Bernice's life was taking shape. This was her career as an organizer and advocate among blind people and those with low vision. While at Arizona State University, she was recruited for the developing Arizona Council of the Blind by Judge John Van Landingham, a law schoolmate of Rees Robrahn, the second president of the American Council of the Blind. Then she got involved with the organized blind in California during her Social Security training. She played hooky from her training in July, 1973 and attended the ACB National Convention in Knoxville, Tennessee. She was hooked! She attended forty more ACB national conventions before missing one!

This was an era in ACB when there was a lot of experimentation with the organization of special interest affiliates, those centered around an interest rather than a state. Bernice helped to organize the Council of Citizens with Low Vision International, ACB Students and ACB Governmental Employees, not to mention the Silicon Valley Council of the Blind. And she combined administrative skills with policy interest. In 1978 in Salt Lake City, she was tapped to be the chair of the Resolutions Committee. So as health issues gradually began to interfere with her full-time employment, she began to spend much of her time on organizational matters. Besides ACB affiliates, she worked with local agencies such as Vista Center for Blind and Low Vision, and the San Francisco Lighthouse. She answered information lines for the Council of Citizens with Low Vision and became a general information source. And practically from her deathbed, she identified some good new board members for CCLVI!

Recognition for these feats came in the form of a National Community Service Award from ACB and a place in the California Council of the Blind Hall of Fame. Now the CCLVI is establishing an annual service award to be named for Bernice.

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Announcing The 2022 CCB Virtual Conference And Convention

From The CPC

The Convention Planning Committee is excited to announce the dates for the 2022 Virtual Conference and Convention Main Event. The Main Event will run from Thursday, May 12- Sunday, May 15, 2022. Stay tuned for opportunities to give input, instructions of how to schedule Affiliate and Committee meetings, as well as important dates to remember. This information will be on the CCB Website and in The Happenings.

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A Shining Star Amongst Us, Dharini Dobbins

By Linda Samulski

One of the best things about becoming a member of CCB is that of making new friends, and keeping them for life. This has been my experience as the co-chair of the Membership Committee of the newest affiliate: Inclusive Diversity of California.

I have met six other people who serve with me, and they are truly amazing. One of them is actually a shining star amongst us.

Dharini Dobbins is the president of the CCB High Desert Chapter. Her presidency started around 2018, when the chapter only had nine members. Since then the membership has increased to 36. Upon visiting one of the chapter's virtual meetings, I felt like I was at a fun get together. I almost expected refreshments to pop out of my phone; I actually felt as if I was there in person. The meeting was informational, but also very social.

On September 18, 2021, Dharini was one of nine lady honorees who was given an award for excellence in the community. The categories of the awards were leadership in education, and health and wellness. Sponsored by the Today's Woman Foundation, the gala was held at the Hilton Gardens Hotel in Victorville.

For people who are blind, and with other disabilities, The High Desert in Southern California is an underserved area. Dharini also serves in her Lions Club, in a food distribution project. She has been passionate about advocating for

accessibility in her town, as well as creating conference calls for people with disabilities. She has done this for her High Desert CCB chapter as well, especially at this time of Covid. Regularly, she announces her chapter meeting, and other events that are going on in the community on the radio.

As a young adult, Dharini immigrated to the United States from Sri Lanka. It was around this time that she also started to experience vision loss and was diagnosed with glaucoma. On top of these challenges, she also had a baby to care for, but was determined to remain independent. “You just have to keep on going. You cannot give up.” Since that time, she has raised three children that work, live and go to school near her.

Furthermore, she was also determined to do good in her community. “You have to be out there going to resource fairs, meetings, etc. to show people that a disability, particularly vision loss shouldn’t stop you from living your life. You have to have a passion and a purpose.” These are the things that make Dharini Dobbins a “shining star” in the community, and in CCB.

If you would like to make new friends, and live your purposeful life, you should think about joining a chapter or affiliate of CCB. Check out IDC for example, we’d love to

have you see what we are about.

If this is the first time you are reading the Blind Californian, and don’t know much about the California Council of the Blind, you can visit the web page at ccbnet.org. There you will find chapters and affiliates listed. Whether you are already a member, or you are new, we hope to meet you on this journey we are traveling on together with the commonality of vision loss and/or blindness. Together we can make our world a better place like Dharini is doing.

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YMCA Camp, A Rat’s Nest, And Tree Climbing: My Favorite Resource Teachers

By Daveed Mandell

For the most part, I enjoyed going to school with sighted kids. My resource teachers were always there for me and gave me much support and encouragement along the way. Three of them were very special, and I will always be indebted to them for the experiences they afforded me.

Ernie Kimball was an energetic man with low vision. He was my resource teacher during third grade. As summer approached, Mr. Kimball told me that he was going to work as a counselor at a YMCA camp in Southern California and asked me if I wanted to attend a two-week session. Excitedly, I told my parents about Mr. Kimball's offer to work with me at YMCA Camp, and they agreed to let me go with him.

Thanks to Mr. Kimball, both staff and kids welcomed and accepted me. I hiked, played sports, participated in arts and crafts, went horseback riding, swam in both the pool and the lake, enjoyed overnight camp-outs in the woods, and roasted hotdogs and marshmallows around many a campfire. I did it all, thanks to Mr. Kimball's guidance, patience, and support.

After that fantastic summer, I met Denise Huston in the fourth grade, and she worked with me through the sixth grade. Miss Huston was very strict. She didn't fool around or mince words when I wasn't paying attention, or following directions, or organizing my possessions and books.

One day Miss Huston asked my parents to allow me to stay after school. She offered to drive me home, and my parents agreed. Miss Huston proceeded to enter my classroom and greeted me somewhat bruskly. "What's your jacket doing on the floor, young man?

Hang it up!" Opening my desk, she said, "Just look at this rat's nest! What a mess!" So saying, Miss Huston promptly threw everything on the floor. Needless to say, I was horrified!

Miss Huston watched as I neatly hung my coat on the back of my chair and began to organize all of my books and other items and return them to my desk. She then gave her approval, while at the same time chiding me for my inattention to neatness. She made it very clear that I had better work on always being tidy and organized.

That strict teacher cried when I finished sixth grade. Miss Huston told me that I had a lot of potential and wished me nothing but continued success. Even now I appreciate everything she taught me.

Three years of Junior High passed enjoyably. When I was 14, I began learning how to use a long white cane, just in time to start the tenth grade and meet Judy Karosen. She was 26 years young, extremely friendly, and supportive. Miss Karosen thought blind kids could do anything and everything. The word "impossible" wasn't in her vocabulary. As far as she was concerned, anything was possible for blind people to accomplish. I was thrilled with her openness and sincere belief in my abilities and skills.

One day I asked Miss Karosen what our school’s mock Greek theater looked like. She described it in detail. I then asked her to describe the many trees that outlined the area. To which she replied: “Well, go climb them and find out for yourself!” Which I did. That was one of the most enjoyable moments of my high school career—climbing those trees and shimmying from tree to tree.

However, unbeknownst to me, the trees faced the administration building. I was in full view of the Boy’s Vice Principal, all of the counselors, and even the Principal got a peek at me checking out all those trees. Now, these people didn’t have as much confidence in blind people as did Miss Karosen. In fact, watching me move smoothly from tree to tree, they were frightened, terrified!

Needless to say, Miss Karosen was nearly fired that day. But thanks to me and my parents, she continued to work with me through my senior year. I will always be grateful for the many exciting and invigorating experiences she afforded me.

Not only did Mis Karosen encourage me to climb trees. She also loaned a Perkins brailler to my sighted girlfriend who wanted to learn braille. One of the most unforgettable events in my life went from dream to reality, when she spoke on my behalf during a

meeting at the Los Angeles Bureau of Jewish Education. I wanted to travel to Israel with sighted kids on a ten-week work-study tour during the summer after finishing the tenth grade. Of course the Bureau said “No!” Mis Karosen said “Yes!” Guess who won!

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10 Best Cooking Oils Good For Diabetics

https://www.diabetesselfcaring.com/best-cooking-oils-for-diabetics/

December 2, 2017

It is very important to choose the right oil for your diabetes. When you are a diabetic, you need to be very careful about what you eat, and what you should not eat as part of your daily diet. The same goes for cooking oil. You should be aware of the oil’s health benefits for your diabetes. In this article, we will discuss the 10 best cooking oils good for diabetics.

1. Canola Oil:

Canola oil has a lot of health benefits and has been hugely recommended for all diabetics. Not only is the oil a rich source of an omega-3 fatty acid such as the alpha-linolenic acid, but it also contains

monounsaturated fats. This is a type of fat that is considered good and healthy for diabetics. This goes a long way toward helping reduce the risks of cardiovascular diseases, stabilizing the levels of blood pressure, smoothing digestion, and reducing the levels of bad cholesterol in the body.

2. Olive Oil:

This oil is considered to be the healthiest of all the cooking oils. And why not? Rich in antioxidants and monounsaturated fats, olive oil is packed with health benefits. The presence of Tyrosol ensures that those who suffer from diabetes can benefit from olive oil, as it helps to improve the sensitivity of the body towards insulin, and also helps to reduce the risks of heart-related conditions which a diabetes patient is very likely to experience.

3. Almond Oil:

Another cooking oil that can be used for frying and sauteing when you are a diabetic is almond oil. This oil has long been recommended for diabetic patients because it is a rich source of nutrients such as potassium, zinc, vitamin E, as well as monounsaturated fats that help to deal with diabetes in an efficient manner. You can use this oil for different types of preparations as well as outside the kitchen.

4. Walnut Oil:

Rich in omega-3 fatty acids, walnut oil is one of the most recommended oils for all diabetics. It is

also a good source of polyunsaturated fats. It helps you maintain a good balance of triglycerides, thereby reducing the risks of being affected by several cardiovascular conditions. Finally, walnut oil benefits a diabetic as it helps the body by improving its sensitivity to the all-important hormone, insulin.

5. Flaxseed Oil:

Another oil on the list of the top 10 cooking oils good for diabetics is flaxseed oil. The oil is a rich source of fiber, and that is how it slows digestion. Slow digestion, as we know, helps to maintain stable levels of blood glucose in the body. It also helps in improving the sensitivity of the body towards insulin. One thing to remember while using flaxseed oil is that you should not use it under direct heat. You can use it as a dressing for your salad, or add it after the meal has been cooked.

6. Coconut Oil:

Known for its strong smell, coconut oil is another recommended oil for all diabetics. The oil contains minerals and vitamins that go a long way in helping to manage diabetes in an effective manner by lowering levels of triglycerides and bad cholesterol, and by stabilizing blood pressure. However, the oil is known to contain saturated fat. As such, it should be consumed only in moderation. If you include more than the recommended quantity of

this oil in your daily diet, your diabetes can get even worse.

7. Sesame Oil:

Sesame oil has long been considered a great source of vitamin E and well as other antioxidants that are helpful to diabetics. Having a high smoking point ensures that the oil can be used for different types of cooking purposes. Besides, the monounsaturated fats contained herein make it a good choice for diabetes cooking. Some research suggest that combining sesame oil with rice bran oil can help diabetics by reducing bad cholesterol in their bodies and by stabilizing the required levels of blood glucose.

8. Rice Bran Oil:

As mentioned above, rice bran oil, in combination with sesame oil is actually great to control your diabetes as you will have reduced levels of bad cholesterol in your body. Rich in both monounsaturated as well as polyunsaturated fats, this oil is great for those who want to keep heart diseases at bay. Not only that, studies conducted by experts suggest that regular use of rice bran oil can lead to the reduction in increased levels of blood glucose.

9. Sunflower Oil:

Another oil on the list of the best oils for diabetics is sunflower oil. The high smoke point of the oil ensures that you can use the same without much hesitation in pretty much everything you cook. This

includes sauteing as well as frying or simply roasting vegetables. What makes sunflower oil a recommendation for diabetics is the fact that it has very low levels of saturated fat on one hand, and high levels of the recommended polyunsaturated fats on the other.

10. Grape Seed Oil:

Finally, we have the oil that, as the name suggests, is made from grapes. Not only is the oil a rich source of polyunsaturated fats, it also contains a good amount of omega-3 fatty acids, considered great for all diabetics. The flavors are subtle and the high smoking point ensures that you can easily use the oil in all the different types of cooking that you do. You can also use the oil as your salad dressing.

The above are the best recommended oils that are safe to use when you have diabetes. Having said this, you should not overuse these oils, but include only the recommended quantity in your diet. Also, do not forget to consult your doctor before including the same.

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Why Restructure ADA Paratransit?

By Daveed Mandell

(Reprinted, with some slight modifications, from the October 2021 issue of ACB E-Forum, the official magazine of the American Council of the Blind.

Daveed Mandell is a member of ACB’s Transportation Committee. He also represents the San Francisco Chapter of the California Council of the Blind on Voices for Public Transportation, Senior and Disability Action’s Transit Justice Group, Genesis’ Transit Disability Task Force, East Bay Gray Panthers, and the Bay Area Cross-Disability Coalition. In 2018, thanks to a $75,000 grant from the San Francisco Foundation, Mandell founded the [Bay Area] Transit Justice Project under the auspices of the East Bay Center for the Blind in Berkeley.)

Here in the San Francisco Bay Area, Genesis, a local interfaith organization focused on various progressive issues, has created a Disability Justice Task Force. It has “married”, if you will, this task force with its transportation efforts. Genesis recently invited several public transit advocates with disabilities to conduct a workshop on paratransit.

Christine Fitzgerald, Community Advocate with the Silicon Valley Independent Living Center, talked about how complicated and arduous planning a paratransit trip can be. She delivered a slide presentation about a hypothetical trip from San Jose to Berkeley, and back to San Jose, that involved arranging four rides from two paratransit operators with completely different approaches to fare collection and service provision.

At the conclusion of the workshop, we were challenged to offer a call to action. One of our requests to workshop participants was to sign, and spread the word about, HR3744, the Johnson operating funds-focused transportation bill now before Congress.

Then the question came up, what was to be our call to action regarding paratransit? If paratransit is such a complicated, unworkable and unequal system as just portrayed, what are we going to do about it? How are we going to change it to make it more equal, more equitable, fairer, and easier to navigate? How are we going to get rid of paratransit's glaring inequalities?

We discussed these serious and provocative questions for quite a while and finally decided to launch a petition on the website change.org, calling for the restructuring of ADA

paratransit as a regional same-day, on-demand service linked to the inability to drive, not to fixed-route transit. After all, paratransit riders have to make advance reservations. We’re denied freedom of movement—a fundamental human right guaranteed under the United Nations Universal Declaration of Human Rights. Unlike some 95% of Americans who drive, we paratransit riders are also denied access to the nation’s intricate system of highways and roads.

The amazing thing is that this petition came about, because Genesis—an organization which is not primarily comprised of people with disabilities—joined with the disability community as allies and helped us launch it. The organization challenged us to make a bold move, to take a strong position.

We explained to Genesis that the federal government would have to restructure ADA paratransit. However, a number of people contended that we have to begin pressuring our local transit agencies now. Otherwise, they said, nothing will change. Public transit agencies have to understand that nothing prevents them from providing service that goes above and beyond the minimum ADA requirements.

This is just the beginning. We have a lot of work ahead of us. We know that many people will say that this petition should never have been

launched on the local level. However, we think it’s time to act now. Time is on our side. Several public transit agencies throughout the country—in Massachusetts, Florida, Arizona and other states—have begun to realize that the current ADA paratransit model does not meet the needs of most paratransit riders, and that it is extremely expensive for transit agencies to operate.

People with disabilities throughout the Bay Area are in the midst of establishing what we have called the Bay Area Cross-Disability Coalition (BAXDC). We very much appreciate the encouragement that Genesis has given us to move forward, work toward integrating people with disabilities on fixed-route transit, and make ADA paratransit a much more equal and equitable system. You can view the petition at tinyurl.com/nbbxejy6.

It’s time for the American Council of the Blind and its state affiliates to begin taking bold action. Yes, it will probably take a long time to achieve our goal. Be that as it may, now is the time to wage a strong national campaign to restructure ADA paratransit for everyone’s benefit.

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Seniors Corners

November, 2021

By Robert Acosta

We welcome you to read Senior Corners. This column is an attempt to give our senior blind and low vision friends practical tips on how to survive during the Covid era and after.

We shall feature two items for your consideration. First, an article from Larry Johnson on Standing up to the Fear of Falling.

Also, Mom's Meals which will deliver healthy daily breakfast, lunches and dinners to us all.

If you wish to give us some valuable daily tips or just to write: Please send a note to me at: boacosta818@gmail.com.

Larry Johnson is a leader and an activist across this Nation on behalf of the senior blind and visually impaired. I wish to begin this column with an article by Larry on the subject: Standing up to the Fear of Falling.

STAND UP TO THE FEAR OF FALLING

By Larry P. Johnson

If you are a person over 65 like me, I'm going to share with you some rather startling and really scary statistics about being a senior. According to the U.S. Centers for Disease Control and Prevention, every 13 seconds an older adult is treated in the emergency room for a fall, and every 20 minutes, an older adult dies from a fall.

One out of every three Americans over 65 will fall this year and the risk of falling increases with age. What’s more, those who fall are two to three times more likely to fall again. As alarming as these statistics are, the CDC says they actually don’t tell the whole story since many falls are unreported by seniors and unrecognized by family members or caregivers.

Falls are the leading cause of fatal injury and the most common cause of nonfatal trauma-related hospital admissions among older adults. They result in more than 2.5 million injuries treated in emergency departments annually, including over 734,000 hospitalizations and more than 21,700 deaths. Over half (53%) of older adults who are discharged for fall-related hip fractures, according to the CDC, will experience another fall within six months.

Okay, so that’s the bad news, now here’s a bit of good news. 80% of all reported falls could have been prevented, if we eliminate the causes.

What are some of the causes? Tripping hazards or poor lighting in the home. 60% of all falls occur at home. Wearing unsafe footwear (such as flip-flops). Failing to wipe up wet spots on the floor in the kitchen or bathroom. Dizziness from standing up too quickly. And, this is a huge one, a decrease in our muscle tone and balance from adopting a more sedentary, less active lifestyle.

Six years ago I was at a conference in Denver and attended a workshop on a program called A Matter of Balance. It’s a nationally recognized program developed at the Roybal Center at Boston University. It’s a program designed to reduce the fear of falling and increase activity levels among older adults. Participants learn to view falls and the fear of falling as something they can control. They set realistic goals to increase physical activity, change their environment to reduce fall risk factors and learn an exercise regimen to increase their strength and balance. A Matter of Balance is an evidenced-based certification program administered through the Maine’s Partnership for Healthy Aging. Their website is

www.mainehealth.org/mh_body.cfm?id=432.

Classes are 8 sessions of two hours each, taught by certified volunteer trainers, and they are free. They are available nationally at local senior centers and through most Area Agencies on Aging.

Once we experience a fall we develop the fear of falling again. As a consequence, we may limit our physical activity, which results in muscle weakness which makes our risk of falling even greater. Program Master Trainers claim that after completing the program, many participants demonstrate significant improvements in their level of falls management, falls control, level of exercise, and their level of social interactions.

I believe that fall prevention classes for seniors can help avoid painful injuries and greatly extend our lives.

From Denise Weddle: Mom’s Meals

877-508-6667

“Everything we do is guided by our desire to be the leading partner and provider of nutritious, high-quality, fully-prepared meals. Every department and process is driven by our core values and the end goal of providing the proper nutrition for our customers. At Mom’s Meals, we know that what you eat can make a big difference in your health. Meal by meal and bite by bite, our program delivers nutritious, high quality food to your doorstep. You can choose every meal, in every delivery - so you get more of what you want to eat.”

They offer meals to recipients under certain Medicaid and Older American Act programs. Eligibility for meals varies by state and by program. If you have a Case Manager, he or she will be able to tell you if home-delivered

meals are part of your benefits. If you don’t know or don’t have an assigned Case Manager, you can get in touch with your local Area on Aging, www.payingforseniorcare.com/find_aging_agencies_adrc_aaa, who may be able to help.

Many Medicare Advantage plans offer meals as part of their post-discharge or chronic care support programs. To see if yours does, consult your plan materials or call the phone number on the back of your insurance card.

They also offer a self-pay program for those without an eligible health plan or who don’t qualify for government assistance, but still want the convenience of home-delivered meals for themselves or a loved one. This program offers nine health-condition menus with a variety of meal options. You choose every meal, every delivery. Affordable at only $6.99/meal. Renal-friendly, Pureed and Gluten Free $7.99/meal. Flat rate shipping fee applies.

Mom’s Meals can deliver to any U.S. address. They deliver your meals to your doorstep refrigerated (not frozen), so they’re easy to heat and eat.

Robert Acosta, President Helping Hands for the Blind

(818) 9980044

www.helpinghands4theblind.net

Vehicle Donation Program

careasy.org/nonprofit/helpinghandsfortheblind

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The Way We Age Now

Atul Gawande, Annals of Medicine, New Yorker Magazine, April 30, 2007

www.newyorker.com/magazine/2007/04/30/the-way-we-age-now

Description: an older man holds magnifier in hand as he pecks with one finger at his keyboard.

The hardest substance in the human body is the white enamel of the teeth. With age, it wears away nonetheless, allowing the softer, darker layers underneath to show through. Meanwhile, the blood supply to the pulp and the roots of the teeth atrophies, and the flow of saliva diminishes; the gums tend to become inflamed and pull away from the teeth, exposing the base, making them unstable and elongating their appearance, especially the lower ones. Experts say they can gauge a person’s age to within five years from the examination of a single tooth-if the person has any teeth left to examine.

Scrupulous dental care can help avert tooth loss, but growing old gets in the way. Arthritis, tremors, and small strokes, for example, make it difficult to brush and floss, and, because nerves become less sensitive with age, people may not realize that they have cavity and gum problems until it’s too late. In the course of a normal lifetime, the muscles of the jaw lose about forty percent of their mass and the bones of the mandible lose about twenty percent, becoming porous and weak. The ability to chew declines, and people shift to softer foods, which are generally higher in fermentable carbohydrates and more likely to cause cavities. By the age of sixty, Americans have lost, on average, a third of their teeth. After eighty-five, almost forty percent have no teeth at all.

Even as our bones and teeth soften, the rest of our body hardens. Blood vessels, joints, the muscle and valves of the heart, and even the lungs pick up substantial deposits of calcium and turn stiff. Under a microscope, the vessels and soft tissues display the same form of calcium that you find in bone. When you reach inside an elderly patient during surgery, the aorta and other major vessels often feel crunchy under your fingers. A recent study has found that loss of bone density may be an even better predictor of death from atherosclerotic disease than cholesterol levels. As we age, it’s as if the calcium flows out of

our skeletons and into our tissues.

To maintain the same volume of blood flow through narrowed and stiffened blood vessels, the heart has to generate increased pressure. As a result, more than half of us develop hypertension by the age of sixty-five. The heart becomes thicker-walled from having to pump against the pressure, and less able to respond to the demands of exertion. The peak output of the heart decreases steadily from the age of thirty. People become gradually less able to run as far or as fast as they used to, or to climb a flight of stairs without becoming short of breath.

Why we age is the subject of vigorous debate. The classical view is that aging happens because of random wear and tear. A newer view holds that aging is more orderly and genetically driven. Proponents of this view point out that animals of similar species and exposure to wear and tear have markedly different life spans. The Canada goose has a longevity of 23.5 years; the emperor goose only 6.3 years. Perhaps animals are like plants, with lives that are, to a large extent, internally governed. Certain species of bamboo, for instance, form a dense stand that grows and flourishes for a hundred years, flowers all at once, and then dies.

The idea that living things shut down and not just wear down has received substantial support in the past decade. Researchers working with the now famous worm C. elegans (two of the last five Nobel Prizes in medicine went to scientists doing work on the little nematode) were able to produce worms that live more than twice as long and age more slowly by altering a single gene. Scientists have since come up with single-gene alterations that increase the life spans of Drosophila fruit flies, mice, and yeast.

These findings notwithstanding, scientists do not believe that our life spans are actually programmed into us. After all, for most of our hundred-thousand-year existence—all but the past couple of hundred years—the average life span of human beings has been thirty years or less. (Research suggests that subjects of the Roman Empire had an average life expectancy of twenty-eight years.) Today, the average life span in developed countries is almost eighty years. If human life spans depend on our genetics, then medicine has got the upper hand. We are, in a way, freaks living well beyond our appointed time. So when we study aging what we are trying to understand is not so much a natural process as an unnatural one. Inheritance has surprisingly little influence on longevity. James

Vaupel, of the Max Planck Institute for Demographic Research, in Rostock, Germany, notes that only six percent of how long you’ll live, compared with the average, is explained by your parents’ longevity; by contrast, up to ninety percent of how tall you are, compared with the average, is explained by your parents’ height. Even genetically identical twins vary widely in life span: the typical gap is more than fifteen years.

If our genes explain less than we imagined, the wear-and-tear model may explain more than we knew. Leonid Gavrilov, a researcher at the University of Chicago, argues that human beings fail the way all complex systems fail: randomly and gradually. As engineers have long recognized, many simple devices do not age. They function reliably until a critical component fails, and the whole thing dies instantly. A windup toy works smoothly until a gear rusts or a spring breaks, and then it doesn’t work at all. But complex systems-power plants, say—have to survive and function despite having thousands of critical components. Engineers therefore design these machines with multiple layers of redundancy: with backup systems, and backup systems for the backup systems. The backups may not be as efficient as the first-line components, but they allow the machine to keep going even as damage accumulates. Gavrilov

argues that, within the parameters established by our genes, that's exactly how human beings appear to work. We have an extra kidney, an extra lung, an extra gonad, extra teeth. The DNA in our cells is frequently damaged under routine conditions, but our cells have a number of DNA repair systems. If a key gene is permanently damaged, there are usually extra copies of the gene nearby. And, if the entire cell dies, other cells can fill in.

Nonetheless, as the defects in a complex system increase, the time comes when just one more defect is enough to impair the whole, resulting in the condition known as frailty. It happens to power plants, cars, and large organizations. And it happens to us: eventually, one too many joints are damaged, one too many arteries calcify. There are no more backups. We wear down until we can't wear down anymore.

It happens in a bewildering array of ways. Hair grows gray, for instance, simply because we run out of the pigment cells that give hair its color. The natural life cycle of the scalp's pigment cells is just a few years. We rely on stem cells under the surface to migrate in and replace them. Gradually, however, the stem-cell reservoir is used up. By the age of fifty, as a result, half of the average person's hairs have gone gray.

Inside skin cells, the mechanisms that clear out

waste products slowly break down and the muck coalesces into a clot of gooey yellow-brown pigment known as lipofuscin. These are the age spots we see in skin. When lipofuscin accumulates in sweat glands, the sweat glands cannot function, which helps explain why we become so susceptible to heat stroke and heat exhaustion in old age.

The eyes go for different reasons. The lens is made of crystalline proteins that are tremendously durable, but they change chemically in ways that diminish their elasticity over time—hence the farsightedness that most people develop beginning in their fourth decade. The process also gradually yellows the lens. Even without cataracts (the whitish clouding of the lens caused by excessive ultraviolet exposure, high cholesterol, diabetes, cigarette smoking, and other unhelpful conditions), the amount of light reaching the retina of a healthy sixty-year-old is one-third that of a twenty-year-old.

I spoke to Felix Silverstone, who for twenty-four years was the senior geriatrician at the Parker Jewish Institute, in New York, and has published more than a hundred studies on aging. There is, he said, "no single, common cellular mechanism to the aging process." Our bodies accumulate lipofuscin and oxygen free-radical damage and random DNA

mutations and numerous other microcellular problems. The process is gradual and unrelenting. “We just fall apart,” he said.

This is not an appealing prospect, and people naturally prefer to avoid the subject of their decrepitude. There have been dozens of best-selling books on aging, but they tend to have titles like “Younger Next Year,” “The Fountain of Age,” “Ageless,” “The Sexy Years.” Still, there are costs to averting our eyes from the realities. For one thing, we put off changes that we need to make as a society. For another, we deprive ourselves of opportunities to change the individual experience of aging for the better.

For nearly all of human existence, people died young. Life expectancy improved as we overcame early death-in particular, deaths from childbirth, infection, and traumatic injury. By the nineteen-seventies, just four out of every hundred people born in industrialized countries died before the age of thirty. It was an extraordinary achievement, but one that seemed to leave little room for further gain; even eliminating deaths before thirty would not raise over-all life expectancy significantly. Efforts shifted, therefore, to reducing deaths during middle and old age, and, in the decades since, the average life span has continued upward.

Improvements in the treatment and prevention of heart disease, respiratory illness, stroke, cancer, and the like mean that the average sixty-five-year-old can expect to live another nineteen years—almost four years longer than was the case in 1970. (By contrast, from the nineteenth century to 1970, sixty-five-year-olds gained just three years of life expectancy.)

The result has been called the "rectangularization" of survival. Throughout most of human history, a society's population formed a sort of pyramid: young children represented the largest portion—the base—and each successively older cohort represented a smaller and smaller group. In 1950, children under the age of five were eleven percent of the U.S. population, adults aged forty-five to forty-nine were six percent, and those over eighty were one percent. Today, we have as many fifty-year-olds as five-year-olds. In thirty years, there will be as many people over eighty as there are under five.

Americans haven't come to grips with the new demography. We cling to the notion of retirement at sixty-five—a reasonable notion when those over sixty-five were a tiny percentage of the population, but completely untenable as they approach twenty percent. People are putting aside less in savings for old age now than they have in any decade since the Great Depression. More than half of the very old now live without a spouse, and we have fewer children than ever before—yet we give virtually no thought to how we will live out our later years alone.

Equally worrying, and far less recognized, medicine has been slow to confront the very changes that it has been responsible for—or to apply the knowledge we already have about how to make old age better. Despite a rapidly growing elderly population, the number of certified geriatricians fell by a third between 1998 and 2004. Applications to training programs in adult primary-care medicine are plummeting, while fields like plastic surgery and radiology receive applications in record numbers. Partly, this has to do with money—incomes in geriatrics and adult primary care are among the lowest in medicine. And partly, whether we admit it or not, most doctors don’t like taking care of the elderly.

“Mainstream doctors are turned off by geriatrics, and that’s because they do not have the faculties to cope with the Old Crock,” Felix Silverstone, the geriatrician, explained to me. “The Old Crock is deaf. The Old Crock has poor vision. The Old Crock’s memory might be somewhat impaired. With the Old Crock, you have to slow down, because he asks you to repeat what you are saying or asking.

And the Old Crock doesn't just have a chief complaint—the Old Crock has fifteen chief complaints. How in the world are you going to cope with all of them? You're overwhelmed. Besides, he's had a number of these things for fifty years or so. You're not going to cure something he's had for fifty years. He has high blood pressure. He has diabetes. He has arthritis. There's nothing glamorous about taking care of any of those things."

There is, however, a skill to it, a developed body of professional expertise. And until I visited my hospital's geriatrics clinic and saw the work that geriatricians do, I did not fully grasp the nature of that expertise, or how important it could be for all of us.

The geriatrics clinic—or, as my hospital calls it, the Center for Older Adult Health—is only one floor below my surgery clinic. I pass by it almost every day, and I can't remember ever giving it a moment's thought. One morning, however, I wandered downstairs and, with the permission of the patients, sat in on a few visits with Juergen Bludau, the chief geriatrician.

"What brings you here today?" the doctor asked Jean Gavrilles, his first patient of the morning. She was eighty-five years old, with short, frizzy white hair, oval glasses, a lavender knit shirt, and a sweet, ready smile. Small but sturdy in appearance, she had come in walking steadily, her purse and coat clutched under one arm, her daughter trailing behind her, no support required beyond her mauve orthopedic shoes. She said that her internist had recommended that she come.

About anything in particular? the doctor asked.

The answer, it seemed, was yes and no. The first thing she mentioned was a lower-back pain that she'd had for months, which shot down her leg and sometimes made it difficult to get out of bed or up from a chair. She also had bad arthritis, and she showed us her fingers, which were swollen at the knuckles and bent out to the sides with what's called a swan-neck deformity. She'd had both knees replaced a decade earlier. She had high blood pressure "from stress," she said, and handed him her list of medications. She had glaucoma and needed to have eye exams every four months. She never used to have "bathroom problems," but lately, she admitted, she'd started wearing a pad. She'd also had surgery for colon cancer and, by the way, now had a lung nodule that the radiology report said could be a metastasis—a biopsy was recommended.

Bludau asked her to tell him about her life. She said that she lived alone, except for her Yorkshire

terrier, in a single-family house in the West Roxbury section of Boston. Her husband died of lung cancer twenty-three years ago. She did not drive. She had a son living in the area who did her shopping once a week and checked on her each day— "just to see if I'm still alive," she joked. Another son and two daughters lived farther away, but they helped as well. Otherwise, she took care of herself quite capably. She did her own cooking and cleaning. She managed her medicines and her bills. "I have a system," she said. She had a high-school education, and during the war she'd worked as a riveter at the Charlestown Navy Yard. She also worked for a time at the Jordan Marsh department store in downtown Boston. But that was a long time ago. She stuck to home now, with her yard and her terrier and her family when they visited.

The doctor asked her about her day in great detail. She usually woke around five or six o'clock, she said—she didn't seem to need much sleep anymore. She would get out of bed as the back pain allowed, take a shower, and get dressed. Downstairs, she'd take her medicines, feed the dog, and eat breakfast. Bludau asked what she had for breakfast. Cereal and a banana. She hated bananas, she said, but she'd heard they were good for her potassium, so she was afraid to stop.

After breakfast, she'd take her dog for a little walk in the yard. She did chores—laundry, cleaning, and the like. In the late morning, she took a break to watch "The Price Is Right." At lunchtime, she had a sandwich and orange juice. If the weather was nice, she'd sit out in the yard afterward. She'd loved working in her garden, but she couldn't do that anymore. The afternoons were slow. She might do some more chores. She might nap or talk on the phone. Eventually, she would make dinner—a salad and maybe a baked potato or a scrambled egg. At night, she watched the Red Sox or the Patriots or college basketball—she loved sports. She usually went to bed at about midnight.

Bludau asked her to sit on the examining table. As she struggled to climb up, her balance teetering on the step, the doctor held her arm. He checked her blood pressure, which was normal. He examined her eyes and ears and had her open her mouth. He listened to her heart and lungs briskly, through his stethoscope. He began to slow down only when he looked at her hands. The nails were neatly trimmed.

"Who cuts your nails?" he asked.

"I do," Gavrilles replied.

I tried to think what could be accomplished in this visit. She was in good condition for her age, but she faced everything from advancing arthritis and incontinence to what

might be metastatic colon cancer. It seemed to me that, with just a forty-minute visit, Bludau needed to triage by zeroing in on either the most potentially life-threatening problem (the possible metastasis) or the problem that bothered her the most (the back pain) But this was evidently not what he thought. He asked almost nothing about either issue. Instead, he spent much of the exam looking at her feet.

“Is that really necessary?” she asked, when he instructed her to take off her shoes and socks.

“Yes,” he said. After she’d left, he told me, “You must always examine the feet.” He described a bow-tied gentleman who seemed dapper and fit, until his feet revealed the truth: he couldn’t bend down to reach them, and they turned out not to have been cleaned in weeks, suggesting neglect and real danger.

Gavrilles had difficulty taking her shoes off, and, after watching her struggle a bit, Bludau leaned in to help. When he got her socks off, he took her feet in his hands, one at a time. He inspected them inch by inch-the soles, the toes, the web spaces. Then he helped her get her socks and shoes back on and gave her and her daughter his assessment.

She was doing impressively well, he said.

She was mentally sharp and physically strong. The danger for her was losing what she had. The single most serious threat she faced was not the lung nodule or the back pain. It was falling. Each year, about three hundred and fifty thousand Americans fall and break a hip. Of those, forty percent end up in a nursing home, and twenty percent are never able to walk again. The three primary risk factors for falling are poor balance, taking more than four prescription medications, and muscle weakness. Elderly people without these risk factors have a twelve-percent chance of falling in a year. Those with all three risk factors have almost a hundred-percent chance. Jean Gavrilles had at least two. Her balance was poor. Though she didn't need a walker, he had noticed her splay-footed gait as she came in. Her feet were swollen. The toenails were unclipped. There were sores between the toes. And the balls of her feet had thick, rounded calluses.

She was also on five medications. Each was undoubtedly useful, but, together, the usual side effects would include dizziness. In addition, one of the blood-pressure medications was a diuretic, and she seemed to drink few liquids, risking dehydration and a worsening of the dizziness. Her tongue was bone dry when Bludau examined it.

She did not have significant muscle weakness, and that was good. When she got out of her chair, he said, he noted that she had not used her arms to push herself up. She simply stood up—a sign of well-preserved muscle strength. From the details of the day she described, however, she did not seem to be eating nearly enough calories to maintain that strength. Bludau asked her whether her weight had changed recently. She admitted that she had lost about seven pounds in the previous six months.

The job of any doctor, Bludau later told me, is to support quality of life, by which he meant two things: as much freedom from the ravages of disease as possible, and the retention of enough function for active engagement in the world. Most doctors treat disease, and figure that the rest will take care of itself. And if it doesn't—if a patient is becoming infirm and heading toward a nursing home—well, that isn't really a medical problem, is it?

To a geriatrician, though, it is a medical problem. People can't stop the aging of their bodies and minds, but there are ways to make it more manageable, and to avert at least some of the worst effects. So Bludau referred Gavrilles to a podiatrist, whom he wanted her to visit once every four weeks, for better care of her feet. He didn't see medications that he could eliminate, but he switched

her diuretic to a blood-pressure medicine that wouldn't cause dehydration. He recommended that she eat a snack during the day, get all the low-calorie and low-cholesterol food out of the house, and see whether family or friends could join her for more meals. "Eating alone is not very stimulating," he said. And he asked her to see him again in three months, so that he could make sure the plan was working.

Nine months later, I checked in with Gavrilles and her daughter. She turned eighty-six this past November. She is eating better, and has even gained a pound or two. She still lives comfortably and independently in her own home. And she has not had a single fall.

In the story of Jean Gavrilles and her geriatrician, there's a lesson about frailty. Decline remains our fate; death will come. But, until that last backup system inside each of us fails, decline can occur in two ways. One is early and precipitately, with an old age of enfeeblement and dependence, sustained primarily by nursing homes and hospitals The other way is more gradual, preserving, for as long as possible, your ability to control your own life.

Good medical care can influence which direction a person's old age will take. Most of us in medicine, however, don't know how to think about decline. We're good at addressing specific, individual problems: colon

cancer, high blood pressure, arthritic knees. Give us a disease, and we can do something about it. But give us an elderly woman with colon cancer, high blood pressure, arthritic knees, and various other ailments besides—an elderly woman at risk of losing the life she enjoys—and we are not sure what to do.

Several years ago, researchers in St. Paul, Minnesota, identified five hundred and sixty-eight men and women over the age of seventy who were living independently but were at high risk of becoming disabled because of chronic health problems, recent illness, or cognitive changes. With their permission, the researchers randomly assigned half of them to see a team of geriatric specialists. The others were asked to see their usual physician, who was notified of their high-risk status. Within eighteen months, ten percent of the patients in both groups had died. But the patients who had seen a geriatrics team were a third less likely to become disabled and half as likely to develop depression. They were forty percent less likely to require home health services.

Little of what the geriatricians had done was high-tech medicine: they didn’t do lung biopsies or back surgery or PET scans. Instead, they simplified medications. They saw that arthritis was controlled. They made

sure toenails were trimmed and meals were square. They looked for worrisome signs of isolation and had a social worker check that the patient's home was safe.

How do we reward this kind of work? Chad Boult, who was the lead investigator of the St. Paul study and a geriatrician at the University of Minnesota, can tell you. A few months after he published his study, demonstrating how much better people's lives were with specialized geriatric care, the university closed the division of geriatrics.

"The university said that it simply could not sustain the financial losses," Boult said from Baltimore, where he is now a professor at the Johns Hopkins Bloomberg School of Public Health. On average, in Boult's study, the geriatric services cost the hospital $1,350 more per person than the savings they produced, and Medicare, the insurer for the elderly, does not cover that cost. It's a strange double standard. No one insists that a twenty-five-thousand-dollar pacemaker or a coronary-artery stent save money for insurers. It just has to maybe do people some good. Meanwhile, the twenty-plus members of the proven geriatrics team at the University of Minnesota had to find new jobs. Scores of medical centers across the country have shrunk or closed their geriatrics units. Several of Boult's colleagues no longer advertise their geriatric training for fear that they'll get too many elderly patients. "Economically, it has become too difficult," Boult said.

But the finances are only a symptom of a deeper reality: people have not insisted on a change in priorities. We all like new medical gizmos and demand that policymakers make sure they are paid for. They feed our hope that the troubles of the body can be fixed for good. But geriatricians? Who clamors for geriatricians? What geriatricians do—bolster our resilience in old age, our capacity to weather what comes—is both difficult and unappealingly limited. It requires attention to the body and its alterations. It requires vigilance over nutrition, medications, and living situations. And it requires each of us to contemplate the course of our decline, in order to make the small changes that can reshape it. When the prevailing fantasy is that we can be ageless, the geriatrician's uncomfortable demand is that we accept we are not.

For Felix Silverstone, understanding human aging has been the work of a lifetime. He was a national leader in geriatrics for five decades. But he is now himself eighty-seven years old. He can feel his own mind and body wearing down, and much of what he spent his career studying is no longer abstract to him.

Felix has been fortunate. He didn’t have to stop working, even after he suffered a heart attack in his sixties which cost him half his heart function; nor was he stopped by a near-cardiac arrest at the age of seventy-nine. “One evening, sitting at home, I suddenly became aware of palpitations,” he told me. “I was just reading, and a few minutes later I became short of breath. A little bit after that, I began to feel heavy in the chest. I took my pulse, and it was over two hundred.” He is the sort of person who, in the midst of chest pain, would take the opportunity to examine his own pulse. “My wife and I had a little discussion about whether or not to call an ambulance. We decided to call.”

When Felix got to the hospital, the doctors had to shock him to bring his heart back. He’d had ventricular fibrillation, and an automatic defibrillator had to be installed in his chest. Within a few weeks, though, he felt well again, and his doctor cleared him to return to work full time. He stayed in medical practice after the attack, multiple hernia repairs, gallbladder surgery, arthritis that ended his avid piano playing, compression fractures of his aging spine that stole three full inches of his once five-foot-seven-inch height, and hearing loss. “I switched to an electronic stethoscope,” he said. “They’re a

nuisance, but they're very good."

Finally, at eighty-two, he had to retire. The problem wasn't his health; it was that of his wife, Bella. They'd been married for more than sixty years. Felix had met Bella when he was an intern and she was a dietitian at Kings County Hospital, in Brooklyn. They brought up two sons in Flatbush. When the boys left home, Bella got her teaching certification and began working with children who had learning disabilities. In her seventies, however, retinal disease diminished her vision, and she had to stop working. A decade later, she became almost completely blind. Felix no longer felt safe leaving her at home alone, and in 2001 he gave up his practice. They moved to Orchard Cove, a retirement community in Canton, Massachusetts, outside Boston, where they could be closer to their sons.

"I didn't think I would survive the change," Felix said. He'd observed in his patients how difficult the transitions of age could be. Examining his last patient, packing up his home, he felt that he was about to die. "I was taking apart my life as well as the house," he recalled. "It was terrible."

We were sitting in a library off Orchard Cove's main lobby. There was light streaming through a picture window, tasteful art on the walls, white-upholstered Federal-style armchairs. It was like a nice hotel, only with no one under seventy-five walking around. Felix and Bella have a two-bedroom apartment with forest views and plenty of space. In the living room, he has his grand piano and, at his desk, piles of medical journals that he still subscribes to— “for my soul,” he said. Theirs is an independent-living unit. It comes with housekeeping, linen changes, and dinner each evening. When they need to, they can upgrade to assisted living, which provides three prepared meals and up to an hour with a personal-care assistant each day.

This was not the average retirement community, but even in an average one rent runs thirty-two thousand dollars a year. Entry fees are typically sixty thousand to a hundred and twenty thousand dollars on top of that. Meanwhile, the median income of people eighty and older is only about fifteen thousand dollars. More than half of the elderly who live in long-term-care facilities go through their entire savings and have to go on Medicaid—welfare—in order to afford it. And, ultimately, the average American spends a year or more of his old age disabled and living in a nursing home (at twice the cost), which is a destination Felix desperately hopes to avoid.

He tries to note the changes he’s experiencing objectively, like a good geriatrician. He notices that his skin has dried out.

His sense of smell has diminished. His night vision has become poor. He tires easily. He has begun to lose teeth. He takes measures where he can. He uses lotion to avoid skin cracks; he protects himself from the heat; he gets on an exercise bike three times a week; he sees a dentist twice a year.

He's most concerned about the changes in his brain. "I can't think as clearly as I used to," he said. "I used to be able to read the Times in half an hour. Now it takes me an hour and a half." Even then, he's not sure that he has understood as much as he did before, and his memory gives him trouble. "If I go back and look at what I've read, I recognize that I went through it, but sometimes I don't really remember it," he said. "It's a matter of short-term registration. It's hard to get the signal in and have it stay put."

He makes use of methods that he once taught his patients. "I try to deliberately focus on what I'm doing, rather than do it automatically," he told me. "I haven't lost the automaticity of action, but I can't rely on it the way I used to. For example, I can't think about something else and get dressed and be sure I've gotten all the way dressed." He recognizes that the strategy doesn't always work. He sometimes told me the same story twice in a conversation. The lines of thought in his mind would fall into well-worn grooves

and, however hard he tried to put them onto a new path, sometimes they resisted. Felix's knowledge as a geriatrician has forced him to recognize his own decline, but that hasn't made it easier to accept.

"I get blue occasionally," he said. "I think I have recurring episodes of depression. They are not enough to disable me, but they are..." He paused to find the right word. "They are uncomfortable."

What buoys him, despite his limitations, is having a purpose. It's the same purpose, he says, that sustained him in medicine: to be of service, in some way, to those around him. He had been in Orchard Cove for only a few months before he was helping to steer a committee to improve the health-care services there. He tried to form a journal-reading club for retired physicians. He even guided a young geriatrician through her first independent research study—a survey of the residents' attitudes toward Do Not Resuscitate orders.

More important is the responsibility that he feels for his children and grandchildren—and, most of all, for Bella. Her blindness and recent memory troubles have made her deeply dependent. Without him, I suspect, she would probably be in a nursing home. He helps her dress. He administers her medicines. He makes her

breakfast and lunch. He takes her on walks and to doctors' appointments. "She is my purpose now," he said. Bella doesn't always like his way of doing things. "We argue constantly—we're at each other about a lot of things," Felix said. "But we're also very forgiving."

He does not feel this responsibility to be a burden. With the narrowing of his own life, his ability to look after Bella has become his main source of self-worth. "I am exclusively her caregiver," he said. "I am glad to be." And this role has heightened his sense that he must be attentive to the changes in his own capabilities; he is no good to her if he isn't honest with himself about what he can and can't do.

One evening, Felix invited me to dinner. The formal dining hall was restaurant-like, with reserved seating, table service, and jackets required. I was wearing my white hospital coat and had to borrow a navy blazer from the maître d'. Felix, in a brown suit and a stone-colored oxford shirt, gave his arm to Bella, who wore a blue-flowered knee-length dress that he'd picked out for her, and guided her to the table. She was amiable and chatty and had youthful-seeming eyes. But, once she'd been seated, she couldn't find the plate in front of her, let alone the menu. Felix ordered for her: wild-rice soup, an omelette, mashed potatoes, and mashed cauliflower. "No

salt," he instructed the waiter; she had high blood pressure. He ordered salmon and mashed potatoes for himself. I had the soup and a London broil.

When the food arrived, Felix told Bella where she could find the different items on her plate by the hands of a clock. He put a fork in her hand. Then he turned to his own meal.

Both made a point of chewing slowly. She was the first to choke. It was the omelette. Her eyes watered. She began to cough. Felix guided her water glass to her mouth. She took a drink and managed to get the omelette down.

"As you get older, the lordosis of your spine tips your head forward," he said to me. "So when you look straight ahead it's like looking up at the ceiling for anyone else. Try to swallow while looking up: you'll choke once in a while. The problem is common in the elderly. Listen." I realized that I could hear someone in the dining room choking on his food every minute or so. Felix turned to Bella. "You have to eat looking down, sweetie," he said.

A couple of bites later, though, he himself was choking. It was the salmon. He began coughing. He turned red. Finally, he was able to cough up the bite. It took a minute for him to catch his breath. "Didn't follow my own advice," he said.

Felix Silverstone is, without question, up against the debilities of his years. Once, it would have been remarkable simply to have lived to see eighty-seven. Now what’s remarkable is that he has the control over his life that he does. When he started in geriatric practice, it was almost inconceivable that an eighty-seven-year-old with his history of health problems could live independently, care for his disabled wife, and continue to contribute to research. Even today, most people his age cannot live as he does.

Partly, he has been lucky. His memory, for example, has not deteriorated significantly. But he has also managed his old age well. His goal has been modest: to have as decent a life as medical knowledge and the limits of his body will allow. So he saved and did not retire early, and therefore is not in financial straits. He kept his social contacts, and avoided isolation. He monitored his bones and teeth and weight. And he has made sure to find a doctor who had the geriatric skills to help him hold on to an independent life.

I asked Chad Boult, the geriatrics professor now at Johns Hopkins, what can be done to ensure that there are enough geriatricians for our country’s surging elderly population. “Nothing,” he said. “It’s too late.” Creating geriatricians takes years, and we already have far

too few. This year, just three hundred doctors will complete geriatrics training, not nearly enough to replace the geriatricians going into retirement, let alone meet the needs of the next decade.

Yet Boult believes that we still have time for another strategy: he would direct geriatricians toward training all primary-care doctors in caring for the very old, instead of providing the care themselves. Even this is a tall order-ninety-seven percent of medical students take no course in geriatrics, and the strategy requires that the nation pay geriatricians to teach rather than to provide patient care. But, if the will is there, Boult estimates that it would be possible to establish courses in every medical school and internal-medicine training program within a decade. “We’ve got to do something,” he said. “Life for older people can be better than it is today.”

Boult and his colleagues have yet another strategy, just in case—a strategy that they have called Guided Care, and that doesn’t depend on doctors at all. They’re recruiting local nurses for a highly compressed, three-week course in how to recognize specific problems in the elderly, such as depression, malnutrition, isolation, and danger of falling; how to formulate a plan to remedy those problems; and how to work with patients, families, and doctors to follow through on the

plan. In a test of the strategy, the researchers are putting the nurses to work in primary-care practices around Baltimore and Washington, D.C., and studying the results. It is a meagre solution for a huge problem, but it is cheap, which insurers demand, and, if it provides even a fraction of the benefit geriatricians have, it could nudge medical care in the right direction.

"I can still drive, you know," Felix Silverstone said to me. "I'm a very good driver."

After our dinner together, he had to go on an errand to refill Bella's prescriptions in Stoughton, a few miles away, and I asked if I could go along. He had a gold 1998 Toyota Camry with automatic transmission and thirty-nine thousand miles on the odometer. It was pristine, inside and out. He backed out of a narrow parking space and zipped out of the garage. His hands did not shake. Taking the streets of Canton at dusk on a new-moon night, he brought the car to an even stop at the red lights, signaled when he was supposed to, took turns without a hitch.

I was, I admit, braced for disaster. The risk of a fatal car crash with a driver who's eighty-five or older is more than three times higher than it is with a driver between sixteen and twenty. The very old are the highest-risk drivers on the road. This past fall, in Los Angeles,

George Weller was convicted of manslaughter after he confused the accelerator with the brake pedal and plowed his Buick into a crowd of shoppers at the Santa Monica Farmers' Market. Ten people were killed, and more than sixty were injured. He was eighty-six.

But Felix showed no difficulties. At one point during our drive, poorly marked road construction at an intersection channeled our line of cars almost directly into oncoming traffic. Felix corrected course swiftly, pulling over into the proper lane. There is no saying how much longer he will be able to count on his driving ability. The day may well come when he will have to give up his keys.

At the moment, though, he wasn't concerned; he was glad simply to be on the road. The evening traffic was thin as he turned onto Route 138. He brought the Camry to a tick over the forty-five-mile-per-hour speed limit. He had his window rolled down and his elbow on the sash. The air was clear and cool, and we listened to the sound of the wheels on the pavement.

"The night is lovely, isn't it?" he said.

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CCB Board Meeting Minutes

By Linda Porelle

California Council of the Blind

Open Board Meeting

Thursday, May 13, 2021

President Gabe Griffith called the meeting to order at 7:34 PM.

Roll Call

Present:

President, Gabe Griffith.

1st Vice President, Sarah Harris.

2nd Vice President, Rob Turner.

Secretary, Linda Porelle.

Treasurer, Lisa Thomas.

Directors: Steve Bauer, Christy Crespin, Nelly Emerson, Larry Gassman, Pam Metz, Guillermo Robles, Jeff Thom, Penny Valdovinos, Frank Welte.

Absent:

Immediate Past President, Judy Wilkinson

Meeting Agenda

Call to order, Gabe Griffith.

Roll call and introduction of guests, Linda Porelle.

Additions to and adoption of agenda, Gabe Griffith.

Minutes March 11, 2021, Linda Porelle.

Treasurer’s report, Lisa Thomas.

President’s report, Gabe Griffith.

Board announcements, any announcements board members may have that are of interest to our members.

ACB summer auction donation.

Member sound off.

Sarah moved and Linda seconded the motion to adopt the meeting agenda with one addition. The motion passed unanimously.

Guillermo moved and Christy seconded the motion to accept the April 8 meeting minutes as submitted. The motion passed unanimously.

Nelly moved and Rob seconded the motion to accept the treasurer's report. The motion passed unanimously. Christy asked about donations for scholarship and Ellen Murphy Fund. Lisa responded with the requested information.

Convention Wrap-up - Lisa

Lisa provided some initial financial information on revenue and expenses. The information below doesn't include individual chapter or affiliate donations, which are not technically part of convention revenue.

Convention Revenue 2021 - $20,750.00

Convention Revenue 2020 - $5,692.00

Difference: Increase of $15,058.00

Convention Expenses 2021 - $3,600.00

Convention Expenses 2020 - $4,350.00

Difference: Decrease of $750.00

We had a lively debriefing meeting with good ideas presented for our future conventions. The committee is hard at work on plans for 2022 and will have information for us in the near future. Sarah especially thanked Rob, Guillermo, and Phill for all of their work on recording segments during the event.

Sarah moved and Christy seconded the motion to provide 6 $25 Starbucks gift cards to the 6 Delta Gamma convention volunteers. The motion passed unanimously.

Jeff moved and Guillermo seconded the motion to donate $150 to ACB radio in appreciation for their generous assistance with the broadcast of our recent convention. The motion passed unanimously.

President's Report - Gabe Griffith

The CCB officers are recommending that, going forward, a full convention treasurer's report will be read at convention but a shorter summary will be included in the convention minutes. No account numbers will be included in the full treasurer's report.

Gabe and Sarah are recommending a series of enrichment meetings for board members only to identify individual member strengths to make better use of the talent represented on our board.

Board Announcements

Sarah noted that there will be a Blind Advisory Council (BAC) meeting on Wednesday, May 19. This is a day-long meeting.

Jeff encouraged members to complete the AAVL aging survey. CAAVL will meet on June 19.

Linda reported that our CCB auction will be held on Sunday, September 19 at 3 PM. We are seeking prize donations from chapters, affiliates and individual members. Board members are being encouraged to make donations as well.

Steve noted that we've received our first $1,000 from sales of our treadmills from OnTheMuV.

Sarah moved and Christy seconded the motion to donate $100 for 4 door prizes at the ACB convention. The motion passed unanimously.

Christy asked about advertising on ACB radio. Larry says they're working on a structure for that to happen, so stay tuned.

Jeff had added a discussion of membership retention of scholarship winners to tonight's agenda. The four scholarship committee members on the CCB board all agreed that the discussion should be postponed and feature more prominently at our June board meeting.

Member Sound Off

Niki asked about cancellation fee for convention hotel. The recent cancellation fee of $2,500 was explained. We

will be seeking a stronger cancellation clause for future contracts.

Livvie said she ran for DKM and Morgan Chase and wants to run for an officer position with ACB diabetics.

Jeff reviewed plans for this year's Virtual Capitol Day. He also reported that AB 371 passed the Senate today.

Virtual Capitol Day priorities include:

Increased home and community MediCal services,

electronic ballot return options,

Guide dog bill about sales of emotional support dog certificates and paraphernalia.

Planning meetings will happen on May 25, and June 1.

Chris asked about updating committees on the web site. This is an ongoing effort and needs everyone to send in needed changes whenever they occur.

The meeting adjourned at 9:07 PM.

California Council of the Blind

Open Board Meeting

June 10, 2021

President Gabe Griffith called the meeting to order at 7:32 PM.

Roll Call

Present:

President, Gabe Griffith.

1st Vice President, Sarah Harris.

2nd Vice President, Rob Turner.

Secretary, Linda Porelle.

Treasurer, Lisa Thomas.

Immediate Past President, Judy Wilkinson

Directors: Steve Bauer, Christy Crespin, Larry Gassman, Pam Metz, Guillermo Robles, Jeff Thom, Penny Valdovinos, Frank Welte.

Absent:

Nelly Emerson

Agenda

Call to order. Gabe Griffith.

Roll call and introduction of guests. Linda Porelle.

Additions to and adoption of agenda. Gabe Griffith.

Minutes May 13, 2021. Linda Porelle.

Treasurer's report. Lisa Thomas.

President's report. Gabe Griffith.

Board announcements, any announcements board members may have that are of interest to our members.

Advertising CCB on ACB Radio.

CCB Scholarship winners membership retention.

Member Sound Off.

Adjourn.

Guillermo moved and Rob seconded the motion to adopt the meeting agenda with the following additions:

*** Convention update**

*** Email move to groups.io.**

The motion passed unanimously.

Jeff moved and Penny seconded the motion to approve the May board meeting minutes. The motion passed unanimously.

Treasurer's Report - Lisa Thomas

Linda moved and Guillermo seconded the motion to accept the treasurer's report. The motion passed unanimously.

Summary:

Bank of America Accounts:

1. General Account

Beginning Balance as of June 10, 2021: $119,894.27

(Estimated) Ending Balance at June 30. 2021: $107,482.92

2. On The Muv

Balance as of 6/10/2021: $4,000.15

3. CEA Loan Fund

Balance as of 6/10/2021: $520.80

4. Fogarty Scholarship

Balance as of 6/10/2021: $200.33

5. Crisis Committee Fund

Balance as of 6/10/2021: $845.06

6. Lopez Scholarship

Balance as of 6/10/2021: $139.97

7. Fixed Term CD - Life Membership

Balance as of 6/10/2021: $2,886.18

Chase Bank Scholarship Accounts:

1. Checking Account

Balance as of 6/10/2021: $1,243.76

2. Savings Account

Balance as of 6/10/2021: $9,982.06

Christy asked about the donation amount for the Ellen Murphy Fund. Lisa will get that figure for her. Jeff asked about getting cyber security insurance. Lisa is already working on that with our insurance agent.

President's Report - Gabe Griffith

Gabe began by thanking Pam Metz for her service on the board. He reported that our website redesign project is underway. The work will address content, design, and accessibility.

We will be keeping the Zoom webinar option. James can use it and EUC can pay for it. We will send an invitation in August for training on using Zoom webinar.

The Lily Perry Fund bank accounts have been moved and the investments are being moved as well. Gabe will appoint a committee for overseeing these assets.

Gabe will serve as California delegate and Sarah as alternate for the ACB convention in July. The voting task force will hold an instruction session on June 21 to prepare attendees for electronic voting.

Gabe reminded everyone that 50% of the donations we make to the Brenda Dillon Walk come back to California.

Sarah reported that Vanda will hold a

presentation on June 26 at 11 am to make up for their missed opportunity at our April convention.

Vita Zavoli reviewed option for moving our email lists to groups.in. This change should resolve current problems with some ISP's blacklisting our email. ACB speaks positively about it. The pricing is $20 a month for 500 emails. Our domain will change to groups.io. Keeping our own domain would cost about $200 a month. Everyone would be resubscribed.

Judy moved and Rob seconded the motion to authorize the transfer to groups.io including the cost for $20 per month. The motion passed unanimously.

Convention Report - Sarah Harris

Sarah began by thanking the hard-working convention committee. They are now busy exploring in-person, hybrid and virtual options for both 2022 and 2023. The quotes they are seeing right now for food and beverage costs are very high with one being as much as $15,000. The committee is looking at a time frame of April and May. They are also considering some regional one day options. Or, we could go with all virtual again. One thing for certain is that our pre-convention affiliate meeting structure is here to stay.

Board Announcements

Judy and Steve gave an update about On-the-MUV. They reported On-the-MUV sales of 34 units, 17 mini-treads and 16 sit mills. They spent $225 for 2 10-minute ads at the ACB convention.

Sarah reported on the recent BAC meeting and task forces, where they discussed the real potential for conflict of interest involving technology training providers.

Larry announced that our auction will be on ACB radio.

Christy announced that scholarship applications are now welcome. She also has bags for sale.

Our diabetic group will be starting up again.

CAAVL will conduct a workshop on June 19.

Guillermo announced that next gen is planning to hold an employment event.

Guillermo moved and Christy seconded the motion to purchase an advertisement on ACB Radio. The motion passed unanimously. Larry reported the cost at $75 per quarter for a 30-second recorded spot.

A general discussion followed on scholarship winners, their retention as members, and ideas for building the blind students affiliate. Suggestions for recruiting more students included:

Creating a brochure and using staff times to send it out,

Increasing contact with DSPS and TVI folks,

Facilitating stronger student connections with chapters and affiliates,

Getting our members that work with students more involved,

Doing more on facebook,

Encouraging students to apply for different scholarships locally.

Sarah suggested setting up a task force. Sarah moved and Christy seconded the motion to set up a student outreach and retention (SOAR) task force with representation from student, scholarship, and membership committees with recommendations due in December. The motion passed unanimously.

Several board members expressed appreciation for Pam's time and service on the board. She noted that she only missed one meeting and thanked the board for the new plan to focus on increasing student participation

Members Sound Off

There will be a CDA (California Diabetics in action) meeting on June 26.

Livvie noted her upcoming 50th high school graduation anniversary.

The meeting was adjourned at 9:42 PM.

California Council of the Blind

Open Board Meeting

Thursday, September 9, 2021

President Gabe Griffith called the meeting to order at 7:33 PM.

Agenda

Call to order, Gabe Griffith.

Roll call and introduction of guests, Linda Porelle.

Additions to and adoption of agenda, Gabe Griffith.

Minutes June 10, 2021, Linda Porelle.

Treasurer’s report, Lisa Thomas.

CCB nonprofit status update, Gabe Griffith.

Board announcements, any announcements board members may have that are of interest to our members.

2022 CCB convention, Sarah Harris.

Member Sound Off.

Adjourn.

Roll Call

Present:

President, Gabe Griffith.

1st Vice President, Sarah Harris.

2nd Vice President, Rob Turner.

Secretary, Linda Porelle.

Treasurer, Lisa Thomas.

Immediate Past President, Judy Wilkinson

Directors: Steve Bauer, Christy Crespin, Nelly Emerson, Larry Gassman, Jeff Thom, Penny Valdovinos, Stephanie Watts, Frank Welte.

Absent:

Guillermo Robles

Sarah moved and Penny seconded the motion to adopt the meeting agenda.

The motion passed unanimously.

Nelly moved and Steve seconded the motion to accept the June 10 meeting minutes with two corrections. The motion passed unanimously.

Corrections:

CCB will use Groups.io for 20 months at $20 per month.

Judy and Steve reported that 34 On-the-Muv were sold.

Treasurer's Report - Lisa Thomas

Stephanie moved and Jeff seconded the motion to accept the treasurer's report. The motion passed unanimously.

Summary: Notes From Lisa

General Account Beginning Balance: $122,190.84

AP Checks Still Outstanding: $10,850.14

General Account Estimated Ending Balance: $111,340.70

Scholarship Checking Balance as of 9/9/2021: $1,108.76. Christy asked about a scholarship payment that she hasn't seen. Lisa will look into it.

Non Profit Status Update - Gabe and Lisa

Lisa reported that our 2020 tax return is almost complete. She still has some questions for the IRS about allocating some income and expenses connected with our tax status. She noted that the Franchise Tax Board (FTB) non-profit status

reinstatement form has been submitted, along with a required overdue payment of $275. These were sent by certified mail a few days ago.

As required, Lisa will be sending the following material to the IRS:

* The last four years of returns

* The non-profit tax status reinstatement application.

Rob moved and Nelly seconded the motion authorizing $3000 for consultation with legal counsel on which financial activities CCB can conduct legally while our tax exempt status remains suspended. After discussion, the motion passed unanimously.

Discussion:

Christy asked who we will consult for legal advice and why we didn’t seek legal consultation earlier.

We will consult the law firm of Calvo and Fisher. This is the same law firm we are using to settle the Mel Kahn Trust. Jeff noted that we worked with them on transferring the Lily Perry Trust funds as well. Margie asked if we should be consulting with tax attorneys, not trust attorneys. Jeff and Steve M. both responded that non-profit attorneys would be more qualified to give advice on the tax exempt status issues we are facing right now. Chris was concerned that the motion is too broad. Donna asked about identifying a possible second legal firm for

consideration. She also asked to include the name of the firm or firms to be consulted in the meeting notes. One possibility might be a firm that previously helped GSGDHI. Alice could be asked about this option. Christy wants the names of both firms. (As noted above, we will consult with Calvo and Fisher, a firm we have recently dealt with successfully). Christy asked for confirmation that all tax materials have been sent. Lisa will send notice to the board when all tax return documents have been delivered. Regina wondered if seeking lawyers will delay resolving the tax issue. Lisa and Jeff reassured her that this will not be a problem.

Board Announcements

There will be a California Diabetics in Action (CDA) meeting on September 11.

Sarah reported that a task force of the Blind Advisory Committee (BAC) made recommendations about consumer safety and conflict of interest. CalATS was the conflict of interest policy for AT assessments and vendors. She also attended the State Rehabilitation Committee (SRC) meeting as well. This meeting dealt with the Independent Service Provider (ISP) issue. There will be public hearings for stakeholders. ISP’s have been extended through January because of a resolution passed by the BAC.

Report On Convention for 2022, Sarah

The committee conducted some hotel outreach with few, or too high responses.

Sarah moved and Christy seconded the motion to hold a virtual convention in 2022. The motion passed unanimously. Stephanie asked about dates. The committee is still planning. We just don’t have the person power for a hybrid convention yet. However, we might consider a regional one-day meeting to practice for a hybrid convention. Aaron asked about the registration fee and would prefer that we not have a fee for attending a virtual convention. Chris said everyone is going virtual. Larry said ACB radio is creating docs for hybrid conventions and meetings.

Sarah moved and Jeff seconded the motion to have the president appoint a taskforce to make recommendations to the Convention Committee and the board of directors on the feasibility of holding a hybrid convention model for the 2023 CCB Conference and Convention, with appointees to reflect expertise in those areas necessary for consideration in the planning of such a convention model. The motion passed unanimously. Linda asked if we should get outside experts to help. Frank suggested we look at event planning over the long term.

Members Sound Off

Chris said it’s healthy to ask questions.

Donna expressed concerns about our unresolved tax status and urged the board to be more transparent in sharing important information with the membership in a timely way.

Livvie asked for clarification about getting a business license.

Sarah mentioned the upcoming employment workshop in October. Joe Xavier will be the keynote speaker.

The meeting was adjourned at 9:24 PM.

California Council of the Blind

Public Board Meeting

Thursday, October 21, 2021

President Gabe Griffith called the meeting to order at 7:35 PM.

Agenda

Call to order, Gabe Griffith.

Roll call and introduction of guests, Linda Porelle.

Additions to and adoption of agenda, Gabe Griffith.

Moment of silence for Bernice Kandarian.

Minutes September 9, 2021, Linda Porelle.

Treasurer’s report, Lisa Thomas.

November board meeting date, Gabe Griffith.

Board announcements, any announcements board

members may have that are of interest to our members.

CCB nonprofit status update, Gabe Griffith and Lisa Thomas.

Board enrichment/organizational centered plan, Sarah Harris.

CCB employment mini conference wrap up, Guillermo Robles.

2022 CCB convention, Sarah Harris.

Board liaisons revisited, Gabe Griffith.

Member Sound Off.

Roll Call

Present:

President, Gabe Griffith.

1st Vice President, Sarah Harris.

2nd Vice President, Rob Turner.

Secretary, Linda Porelle.

Treasurer, Lisa Thomas.

Immediate Past President, Judy Wilkinson

Directors: Steve Bauer, Christy Crespin, Nelly Emerson, Larry Gassman, Jeff Thom, Penny Valdovinos, Stephanie Watts, Frank Welte.

Absent:

Guillermo Robles

Agenda

Steve moved and Penny seconded the motion to adopt the proposed meeting agenda. The motion passed unanimously.

President Gabe Griffith invoked a moment of silence in memory of Bernice Kandarian. He also offered to share the recording of a recent CCLVI-sponsored

gathering in remembrance of Bernice. CCLVI will create an annual service award in her name and award the first one posthumously to Bernice. Roger Petersen announced that there will be a gathering on December 5 as well to share memories of Bernice.

Minutes

Linda moved and Stephanie seconded the motion to accept the meeting minutes for September 9. The motion passed unanimously.

Treasurer's Report

Lisa moved and Nelly seconded the motion to accept the treasurer's report. The motion passed unanimously.

Summary:

General Account Beginning Balance: $105,301.14

AP Checks Still Outstanding: $6,480.00

General Account Estimated Ending Balance: $98,821.14

Scholarship Checking Balance as of 10/21/21: $2,591.76

Scholarship Savings Balance as of 10/21/21: $4,532.3

Jeff asked Lisa to compare how we're doing now to when she came on board. Lisa replied that our financial situation is the best she's seen since she started.

November Board Meeting

Gabe asked if we should change the date for the November board meeting from November 11,

Veterans Day. The board chose to keep November 11 as our meeting date.

Board Announcements

Christy announced the next California Diabetics in Action (CDA) meeting for October 30 at 2 PM They will be voting on constitution and by-laws. Members should let Christy know if they wish to attend.

Jeff and Sarah then reviewed state budget issues for next year. There may be some initiatives for older adults. In addition, the expanded core curriculum needs to be moved from recommended to required for all blind and low vision students.

CCB Non-profit Status Update - Gabe and Lisa

Summary:

On October 5, Lisa, Judy, and Gabe met with our attorneys at Calvo and Fisher. They were impressed with Lisa’s diligence in preparing and submitting the required documentation. They strongly recommended that Lisa be the only one designated to call IRS or FTB, since every additional call will get on the record and could raise red flags. They also recommended that On-the-MuV should be rebranded to not be a fund-raiser, which would be fine since it’s taxable income not fund-raising. In addition, they indicated that member dues are not tax deductible donations.

Lisa reported that all required tax return

materials and forms have been sent. Now we must wait 4-6 weeks for IRS confirmation of receipt or request for more information. They might want our articles of incorporation and 501c3 acceptance letter again. Lisa will be calling on a regular basis. She is also staying connected with Calvo and Fisher, who is preparing our RRF1 form for the Attorney General's office. Judy said they're not charging us and we're not fund-raising. Steve will ask about the rebranding of On-the-MuV. Gabe will talk with Steve and Judy about that and go back to On-the-MuV about it. Christy again expressed concern about the awarding of scholarships and the work of the scholarship committee. We do have some funding for that. Can we go ahead with a new round of applications? She also asked about the Ellen Murphy Fund status. The EMF trustees have suspended all financial activity for now. Gabe responded that we should wait for resolution of our tax status because the line between these entities is too blurred. He said we could ask the attorneys about the EMF investments. Gabe will also ask for guidance about how to proceed with scholarships.

Board Enrichment Organizational-centered Plan - Sarah

The board met in late September and looked at current board strengths. We will meet next

weekend. We will set up discussion meetings for members in the new year to discuss possible goals.

Employment Mini Conference - Sarah

Sarah thanked Guillermo, Richard R., Jessica M., Robert W., and Phill O. for their work on this successful event. CCB partnered with Career Connect, a program now run by the American Printing House for the Blind.

The mini conference was planned in response to requests from younger members. They initially planned for 50 participants and 48 attended. The event was held on Facebook Live. The team collected data and sent post-event surveys to participants. The recording is now on our Facebook page.

Judy suggested we package the event for the future. We could also build a partnership with APH going forward.

2022 Convention Report - Sarah

Sarah reported that the committee will have a convention date by the next board meeting. They will host a members meeting on November 9 to discuss possible presentations and will hold a contest to choose a theme. One possible topic is the history of SB 105.

Board Liaison Review - Gabe

Although only two board members had written reports for Gabe on their liaison activity, it was

decided that the responsibilities and assignments will be reviewed with a plan to resume the work early in the new year. Gabe will appoint a new committee composed of two board members and one president to carry out this task. The committee may also be responsible for reminding board members to meet any deadlines that are adopted going forward.

Members Sound Off

Regina thanked Lisa for all of her hard work on restoring our non-profit status. Regina also announced an ACB national meeting on November 4 to discuss ways of increasing diversity in ACB.

Lorene asked about convention timing. Sarah repeated that we’ll announce that in November.

Nicolette asked for statistics about when to disclose a visual disability and what the impact would be. Stephanie responded that this information is generally more anecdotal.

The meeting was adjourned at 9:20 PM.

* * *

CCB Officers And Directors

As Of July, 2021

Officers

President: Gabe Griffith (2020-2022, 1st term), Concord, 925-222-5762, gabe.griffith@ccbnet.org

1st Vice President: Sarah Harris (2021-2023, 1st term), Fresno, 559-816-1507 C, sarah.harris@ccbnet.org

2nd Vice President: Rob Turner (2020-2022, first term), Sunnyvale, 408-203-9300 C, rob.turner@ccbnet.org

Secretary: Linda Porelle (2021-2023, 2nd term), San Francisco, 415-577-8437 C, linda.porelle@ccbnet.org

Treasurer: Lisa Presley-Thomas (2020-2022, 2nd term), Fresno, 559-250-6760 C, lisa.thomas@ccbnet.org

Immediate Past President: Judy Wilkinson (2020-?), San Leandro, 510-388-5079 C, judy.wilkinson@ccbnet.org

Directors

Steve Bauer (2021-2023, 2nd term), Culver City, 310-738-2853 C, steve.bauer@ccbnet.org

Christy Crespin (2021-2023, 2nd term), Highland, 909-800-7189 C, christy.crespin@ccbnet.org

Nelly Emerson (2021-2023, 2nd term), Santa Maria, 951-237-2960 C, nelly.emerson@ccbnet.org

Larry Gassman (2020-2022, 1st term), Fullerton, 562-706-7710, larry.gassman@ccbnet.org

Stephanie Watts (2021-2023, 1st term), Sacramento, 916-304-7297, swwatts3@gmail.com

Guillermo Robles (2020-2022, 1st term), Culver City, 323-490-5753, Guillermo.robles@ccbnet.org

Jeff Thom (2020-2022, 1st term), Sacramento, 916-995-3967 C, jeff.thom@ccbnet.org

Frank Welte (2020-2022 2nd term), San Leandro, 510-541-1442 C, frank.welte@ccbnet.org

Penny Valdovinos (2021-2023, 2nd term), Bakersfield, 661-378-8282, penny.valdovinos@ccbnet.org

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Sarah Harris

Lynne Nishihara

Andrea DeKlotz

Daveed Mandell

Roger Petersen

***

Donations

If you, a family member, or a friend would like to remember the California Council of the Blind in your Will or estate planning, you can do so by employing the following language:

“I give, devise, and bequeath unto the California Council of the Blind, a nonprofit charitable organization in California, the sum of $____ (or ____) to be used for its worthy purposes on behalf of blind persons.”

If your wishes are more complex, please contact the executive office for additional information. Thank you.