

Case Study

Care Transitions: Empowering Older Adults with Post-Hospital Interventions

by Karen Moeller, MS in Gerontology
Care Transitions Manager
Senior Connections, The Capital Area
Agency on Aging



Educational Objectives

1. Understand how Care Transitions Interventions® (CTI®) can decrease hospital readmission rates among older adults, ages 60 and over.
2. Recognize how CTI® services assist older adults to stay in their homes after hospitalization for 30 days or more without unnecessary readmissions.
3. Appreciate examples of ways Senior Connections, The Capital Area Agency on Aging, collaborates with community partners.
4. Identify how Senior Connections refers older adults and caregivers to community resources for effective utilization and outcomes.

Background

Older adults may have necessary hospital stays due to chronic conditions and look forward to returning home. Yet, many end up going back to the hospital because of complications, confusion, or because they or their caregivers were not prepared to manage their care. The Centers for Medicare and Medicaid Services estimates that nearly one in five Medicare beneficiaries readmits to the hospital within 30 days of discharge. (Centers for Medicare and Medicaid Services, 2019) It is crucial for those recovering to have adequate and safe housing, good nutrition, available transportation for medical appointments, and, especially, an understanding of what to do to after hospitalization.

When patients are about to be discharged from the hospital, a medical provider reviews specific instructions with them and any caregivers present. All may be focused on leaving the hospital itself rather than absorbing this important information. There are several other reasons why there may be unsuccessful information sharing at the time of discharge, including changes in care settings; providers who fail to communicate well; confusion over which medications to take upon returning home, resulting in errors and complications; and discharge instructions that are confusing or that conflict with information received from other providers.

Older adults discharging from the hospital can experience successful recoveries when empowered with knowledge on how to manage their health. Knowing

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what to expect and having a plan on what to do in the event of health setbacks can help prevent unnecessary hospital readmissions. The ability to visualize a desired lifestyle after recovery is equally important.

Coleman Care Transitions Intervention®

Eric Coleman, MD, MPH, a nationally recognized expert on hospital-to-home care transitions, has developed an evidence-based model to reduce high readmissions rates. To address the problems of uncoordinated and fragmented care during the period of hospitalization and transition back to home, the John A. Hartford Foundation awarded the University of Colorado Health Sciences Center, Denver, a five-year grant in 2000 to develop the Care Transitions Intervention® focusing on the critical first 30 days after discharge. Dr. Coleman, a Robert Wood Johnson Clinical Scholar and a Beeson Scholar, served as principal investigator of this project.

During the 30-day Care Transitions program, patients with complex care needs and family caregivers work with a Care Transitions Health Coach and learn self-management skills that will assist in easing their transition from hospital to home.

The 30-day Care Transitions Intervention® (CTI®) begins with a visit by the Health Coach to the patient in the hospital, at which time the Health Coach introduces the CTI® program to the patient and/or caregiver at the bedside. The Health Coach gives the patient a Personal Health Record, a pamphlet to be used as a tool to record his or her individualized health information and instructions following discharge. Subsequently, this tool is reviewed in detail during the Health Coach's home visit with the patient, which is ideally scheduled to take place within the first three days following the patient's discharge from the hospital. After the home visit, the Health Coach makes three weekly phone calls to follow up with the patient's progress. After the third phone call, at 30 days following discharge, the case is closed.

The Coleman Care Transitions Intervention® Model focuses on The Four Pillars®:

1. Medication self-management
2. The Personal Health Record

3. Timely primary care/specialty care follow up
4. Knowledge of red flags that indicate a worsening in their condition and how to respond

At the CTI® home visit, the Health Coach coordinates with the patient to have him/her reconcile medications, comparing the previous medicines taken by the patient to those ordered at discharge. Many hospital readmissions are caused by mistakes or confusion regarding which medications to take following discharge, and in what dosages. The Health Coach makes certain that the patient or caregiver knows the name of each medication, its purpose, and the proper dosage. The Health Coach assists the patient with calling the pharmacist or primary care physician, if any clarification is needed.

The CTI® Personal Health Record previously given to the patient at the hospital visit is brought out at the home visit, and the Health Coach assists in guiding the patient in recording individual information in the pamphlet. The patient lists medications being taken and any questions to ask of the primary care physician and/or pharmacist. The Health Coach also asks the patient to visualize and record details of an activity that he or she might reasonably resume 30 days from the time of the home visit. Some patients look forward to attending an important social or family event, while others may simply desire to return to gardening in their yard.

Every patient discharged from the hospital is instructed to have a follow-up appointment with his or her primary care physician within a week of discharge. Often, this appointment is scheduled for the patient prior to discharge, and the information is included in the discharge documents. The Health Coach can remind the patient of the appointment and assist in arranging for transportation to and from the appointment. This primary care physician appointment is essential for transferring the first point of contact from the hospital to the primary care physician.

Recovery from a hospital stay often has its setbacks. The Health Coach discusses the patient's condition and reviews potential symptoms that may require additional medical attention. These "red flags" are addressed individually and the Health Coach assists the patient in devising a plan of action to adopt in the

event they should occur. When at all possible, the Health Coach encourages the patient to notify the primary care physician or specialist, rather than making the hospital emergency department the first resource.

After the home visit, the Health Coach makes three weekly phone calls to the patient or caregiver. They discuss the outcome of the follow-up appointment with the primary care physician, whether the patient has experienced any red flag symptoms, and how the patient is progressing toward personal goals.

Senior Connections' Care Transitions Program
To address repeat hospitalizations among older adults with chronic illnesses, and to improve quality of care by reducing unnecessary readmissions, Virginia's Area Agencies on Aging have individually and collectively joined with community partners to provide patients with successful care transitions from hospital to home. Senior Connections, The Capital Area Agency on Aging, began its Care Transitions Program in 2014 as part of the Community-based Care Transitions Program (CCTP). Created by Section 3026 of the Affordable Care Act, the CCTP tested models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.

Three full-time and one part-time Health Coaches completed the Care Transitions Intervention Coach Training Program® in multi-day sessions in Richmond, Virginia and Denver, Colorado. Training consisted of lectures by Dr. Coleman and staff, observation and discussion of video CTI® examples, and role playing. Each Coach was certified in CTI® before Senior Connections began its program.

Senior Connections established partnerships with area hospitals in working to reduce hospital readmissions among older adults, under the CCTP, starting in 2014. Hospital case managers forwarded referrals for patients meeting the following criteria: 60 years old, or older; a primary diagnosis of: COPD, pneumonia, sepsis, congestive heart failure (CHF), acute myocardial infarction (AMI), diabetes, stroke, renal failure, or atrial fibrillation; and residing in Senior Connections' Planning District of the counties Hanover, Henrico, Charles City, Chesterfield, Goochland, New Kent, Powhatan, or Richmond City.

The Health Coaches followed the Coleman Model in Care Transitions Interventions® for each participating patient. In addition, the Coaches observed the patient's home environment during the home visit, and listened to the patient and/or caregiver for indications of needs.

Connections to Resources

Health Coaches can make direct referrals to resources within Senior Connections which benefit the patient and improve the probability of a good recovery, such as home delivered meals, respite care, and transportation. Patients requiring multiple resources were referred to Senior Connections' Care Coordination Program for individual follow-up and assistance. Patients who are homebound may not have a dependable food resource. Of course, good nutrition is essential for life and for a healing body. If the Senior Connections' Care Transitions (CT) Health Coaches learn of a nutritional need during the home visit, they will refer a patient who qualifies to the Home Delivered Meals Program. Patients qualify if they are unable to leave home unassisted and have no one to help regularly with meal preparation.

Home delivered meals recipients receive hot meals consisting of meat or other protein food, vegetables, fruit, bread, milk or other dairy food, and dessert. Those requiring special diets such as diabetic, renal, and vegetarian receive meals prepared accordingly. Foods may be chopped or pureed, if needed. Daily social contact from the delivering Meals on Wheels volunteer offers a means for regular check-in. Senior Connections provides an annual reassessment with each meals recipient for eligibility and other needs.

Older adults and their families may encounter increasing needs, yet be at a loss to know how to obtain assistance. CT Health Coaches may recognize a need that the discharged patient has for personal services to assist with activities of daily living. They would then make referrals to Senior Connections to apply for respite services. The Senior Connections Care Coordinator would then complete personal assessments during a home visit and may also coordinate additional resources beneficial to the patient. Senior Connections contracts with community-based service agencies to provide services like homemaker or

personal care services.

The follow-up primary care physician appointment, scheduled within seven days after discharge from the hospital, is a key element in proceeding toward a good recovery. The CT Health Coach asked each patient if he or she had transportation arrangements in place for the appointment. If needed, the Coach could make an internal referral for the patient to Senior Connections' Ride Connection resource, a mobility management program, helping older adults and persons with disabilities to access transportation so they might remain safely at home and live a healthy, connected life. For those who meet eligibility requirements, Ride Connection provides a limited number of round-trip rides to medical appointments for persons living in the City of Richmond and surrounding counties. Ride Counselors offer transportation education, travel training, and referrals to local transportation providers, as well as discounted GRTC fixed route bus and CareVan tickets, and Chesterfield Access vouchers on a limited basis.

Social determinants of health can affect not only health care access, but also health care outcomes. Senior Connections provides opportunities throughout the region for older adults to pair socialization with sustenance through its Friendship Cafés. These are neighborhood gathering places for older adults where a nutritious midday meal is served; they are in 20 churches and community centers in Richmond and surrounding counties. Meeting up with good friends and participating in diverse activities helps to assure that participants remain active and connected to the community, while meeting their nutritional needs.

Case Study #1

Mary G. was in the hospital, diagnosed with pneumonia. The hospital Case Manager referred her for Care Transitions services. Mary is 74 years old and lives with her husband, Ed, in North Chesterfield. Her daughter, Cynthia, was at the hospital bedside when the Senior Connections Health Coach introduced the CTI Program. Mary was scheduled to be discharged later that day, and a home visit was scheduled for the following day. At the home visit, the Health Coach met with Mary and Ed. The Health Coach reviewed the Four Pillars of the CTI

and found that the patient's goal was to go back to church. Mary's follow-up appointment with her primary care provider (PCP) was scheduled in five days and her daughter would take her there. Mary had her hospital discharge summary listing her medications and instructions for taking them. The Health Coach reviewed each and made certain that Mary and Ed understood what each was and the purpose for taking the medicine. Together, they reviewed "red flags" associated with Mary's condition and she and her husband agreed they would call the PCP if any occurred, rather than taking a chance on waiting and having a more serious condition develop. When Ed indicated that he and Mary are unable to see friends as much as they used to, the Health Coach gave them information on Senior Connections' Friendship Cafes and found one near their home. Once Mary recovers, she and Ed can participate together in social activities and enjoy lunch there on weekdays. They both expressed gratitude for the attention, support, and confidence gained as Mary recovers.

Case Study #2

A hospital Case Manager introduced a Senior Connections Health Coach to Barbara, a 68 year old woman in the hospital's ICU. She was receiving care for complications due to diabetes. Barbara was to be discharged that day, and a Care Transitions home visit was scheduled for the following day. Barbara lives alone in a small, neat apartment across the street from the hospital. She stated she often goes to the hospital cafeteria for lunch. At the home visit, she and the Health Coach reviewed the Personal Health Record, in which Barbara recorded each of her medications. Some medications were new, prescribed while in the hospital. Barbara had a question regarding the proper dosage for one of them and was unsure about who to call and the right questions to ask. Instead of calling on the patient's behalf, the Health Coach helped Barbara clarify what her question was and role played how the phone call to the pharmacy might go. Barbara made the phone call during the home visit and obtained the answer to her dosage question. The Health Coach also coached Barbara as she rescheduled a follow-up doctor appointment which conflicted with another medical appointment that had already been set. Barbara stated that she receives medical transportation assistance from friends at her church.

Barbara and the Health Coach reviewed potential red flags regarding her condition and what to do in case they occurred. Barbara agreed it would be best to call her primary care physician when symptoms first arise. They also discussed her plans for the upcoming holiday. The Health Coach followed up with Barbara by phone over the following three weeks. Barbara continued to recover and remained out of the hospital during that time.

Case Study #3

A Senior Connections Health Coach was referred by a hospital case manager to make a home visit with a patient who had been discharged earlier that day. Magda is a 79 year-old woman who had been hospitalized with COPD. A former smoker, she is on oxygen and struggles to reach her bedroom on the second floor of her home. She lives with her daughter, Betty, in a townhouse in Richmond's Oregon Hill neighborhood. Betty is her mother's primary caregiver and provides transportation to doctor appointments. Magda reported being alone at home a great deal, as Betty works full-time. She finds moving around her home to be strenuous due to having difficulty breathing. The Health Coach reviewed the Personal Health Record and the other three Pillars of the Coleman CTI Model with Magda and Betty. Betty had many questions about her mother's medications, and the Health Coach reviewed each one in detail. Magda does not get out of the house often, and the Health Coach told her about Senior Connections' TeleBridges telephone reassurance program. Magda could receive phone calls from volunteers who would check in two to five times each week to listen to and encourage her. The Health Coach made three coach calls to Magda over the next three weeks and learned Betty had inquired about TeleBridges on Magda's behalf. Magda reported she had been writing down questions ahead of doctor appointments in her Personal Health Record so that she would be reminded to ask them during the visits. She indicated she is feeling more confident about managing her health, and is optimistic about the future. She did not have a hospital readmission during the following month.

No Wrong Door and Care Transitions

Senior Connections is part of Virginia's No Wrong

Door Network (NWD), enabling CT Health Coaches to enter data on hospital and home visits along with the weekly coach calls. NWD also allows Coaches to make electronic referrals to resources both within Senior Connections and outside to other agencies that use the system. As the NWD website explains:

"The No Wrong Door System allows providers, who are serving the same individual, to securely share personal-level data between partners, eliminating the need to collect the same information over and over again. The cornerstone of No Wrong Door is an electronic tool called CRIA (pronounced "cree-yah," which stands for Communication, Referral, Information and Assistance). Using CRIA, NWD partners can make electronic referrals to each other with the click of a button. With consent, the referral includes all the information needed for the "receiving partner" to begin working with the individual immediately. Just imagine how much time it could save if the information that you normally collect during intake or enrollment, is already at your fingertips. Imagine how much more personal your first meeting could be if you have access to an individual's background and situation, prior to meeting them. Imagine if you could see a snapshot of the status of all of your referrals at any given time. All of this is possible within No Wrong Door."

Outcomes

Senior Connections' Care Transitions Program using the Coleman CTI® Model dramatically reduced 30-day hospital readmissions among older adults in the Richmond region.

Senior Connections is a member of the RVA Care Transitions Coalition (RVACTC), a group that works with Health Quality Innovators (HQI), the Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Virginia and Maryland. As a participant in the Care Transitions Project, the RVACTC received quarterly, aggregate, community data reports from HQI reflecting hospital readmissions among Medicare Fee-For-Service beneficiaries. In the third quarter (June-September) of 2015, 18.38% of Richmond-area Medicare beneficiaries were readmitted to the hospital within 30 days of discharge. The most recent available data

(January-March 2019) shows a readmission rate of 17.18%.

Senior Connections began tracking its CTI® program's data in the fall of 2015. Between then and May 2019, 1216 people completed the CTI. The first year (October 2015-September 2016) showed an overall 30-day readmission rate of 12.0% for patients completing the CTI® Program. During the following year, (October 2016-September 2017) the 30-day readmission rate was 5.4% for patients completing the 30-day CTI® Program. Subsequent years showed continuation of these reduced rates: 7.9% for October 2017 to September 2018 and currently 6.9% (October 2018 through May 2019).

Conclusion

Senior Connections' Care Transitions interventions have resulted in greatly reduced 30-day readmissions rates for those older adults served. The CTI® model provides a short-term period of support to educate and empower older adults and their caregivers in managing health outcomes. Through successful Care Transitions Interventions®, older adults learn about their illnesses, what to expect during recovery, and how to be proactive regarding their own care.

Senior Connections has been able to arrange for additional services such as home delivered meals, transportation, and socialization opportunities to those needing assistance to remain in their own homes during recovery and beyond. Our success has resulted in our being recognized with a 2019 Best Practice Award from the Commonwealth Council on Aging. The program's success, funding partners, and recognition combine to establish Senior Connections' Care Transitions program as consistent with the agency mission: *Empowering seniors to live with dignity and choice.*

Study Questions

1. What advantages do caregivers have in applying care transitions skills to support older adult patients in their recoveries?
2. Hospitals and senior services providers have established partnerships in encouraging successful recoveries for older adult patients. What other partnerships

might be beneficial in this effort?

3. How can Care Transitions practices be expanded in the community?

Resources

Centers for Medicare and Medicaid Services, Community Based Care Transitions Program. Retrieved August 16, 2019 from <https://innovation.cms.gov/initiatives/CCTP/>

Care Transitions Program, <https://caretransitions.org/> (for more information on Care Transitions Intervention, Dr. Eric Coleman)

John A. Hartford Foundation, Care Transitions Model www.johnahartford.org/ar2007/pdf/Hart07_CARE_TRANSITIONS_MODEL.pdf

Medicare Part A Claims, April 2013 through January 2019. Data provided to HQI as Medicare QIN-QIO.

No Wrong Door Virginia, www.nowrongdoorvirginia.org/providers.htm

Pooler, J., Srinivasan, M. (2018). Issue Brief: Social Determinants of Health and the Aging Population www.impaqint.com/sites/default/files/issue-briefs/Issue%20Brief_SDOHandAgingPopulation_0.pdf

Ride Connection, <https://seniorconnections-va.org/services/support-to-stay-home/ride-connections/>

Senior Connections, The Capital Area Agency on Aging, <https://seniorconnections-va.org/>

About the Author



Karen Moeller is Care Transitions Manager at Senior Connections, The Capital Area Agency on Aging. She holds a Master Degree in Gerontology from VCU. She serves on the RVA Care Transitions Coalition and Advisory Board for Accountable Health Communities – RVA Community Cares representing Senior Connections. She can be reached at kmoeller2@youraaa.org.

Editorials

From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

Dementia-Friendly Resources

Caring for someone with dementia can be exhausting and confusing. We sometimes feel alone, facing challenges we've never encountered before, and facing a person we've never seen before. Who is this man or woman behaving this way? Certainly not the mother or father or spouse I've known most of my life.

There are resources we can access without leaving home. There are like-minded groups intent on making communities more supportive. Here are two helpful resources.

Alzpossible.org is a primarily a workforce development website, dedicated to "person-centered ethical dementia care." But it is also a trove of resources that can help caregivers to cope. In its Mission statement, it speaks of leveraging resources already in place in Virginia. But healthcare professionals, direct care workers, and family caregivers almost anywhere can benefit from its many resources.

There are a number of new and older webinars posted on the site under sub-headings. These can offer an understanding of various matters, such as:

About Alzheimer's and Related Diseases (Parkinson's Disease Dementia; Dementia with Lewy Bodies; etc.);

Concrete challenges and solutions for professionals working with individuals with AD (Best practices for medication management; The use of technology to engage persons with dementia; Personality disorders and aging; etc.);

Role and influence of the family (Compassion fatigue; Caring for a spouse with Mild Cognitive Impairment; Family quality of life in dementia; etc.);

Person-centered principles (Cultural competence in dementia care; etc.);

Communication tools, challenges, opportunities (Strategies for communication and sensitivity; Environment & communication assessment toolkit for dementia care; etc.);

Caregiving recipes (Oral health and dementia; Respite; etc.);

Heart disease, stroke, nutrition, exercise (Heart disease and stroke prevention: Nutritional needs and the ABCs approach; etc.);

High Tech (High tech at home; etc.);

and a catch-all category called What you always wanted to know but were afraid to ask that includes such subjects as Compassion fatigue; Elder abuse, neglect, and exploitation; and Geriatric psychiatry.

Each webinar includes statements about the intended audience, webinar objectives, and the presenters. There are other helpful sections as well.

Dementia Friendly America (dfamerica.org) is a nationwide movement that began after the 2015 White House Conference on Aging aiming to ensure that communities are equipped to support people with dementia and their caregivers. It defines a dementia-friendly community as one "that is informed, safe and respectful of individuals with the disease, their families and caregivers and provides supportive options that foster quality of life."

The website includes the report *Better Together: A comparative analysis of age-friendly and dementia-friendly communities* (2016) that compares and contrasts these two movements. While there are some overlaps in values, age-friendly initiatives tend to be more generic, necessarily encompassing the great heterogeneity of the aging experience, while dementia-friendly initiatives focus on the specific sub-set of adults who have dementia conditions and their needs to be recognized.

A brief introductory video on the website expresses the hope that in a dementia-friendly community "people will walk toward people with dementia" to see how they might help.

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There are dozens of communities, from villages to metropolitan cities, that have joined this movement. Common to all is an emphasis on the social dimensions of dementia over the medical.

Alzheimer's Disease International states that dementia friendly communities, "not only seek to preserve the safety and wellbeing of those living with dementia, [but] also empower all members of the community to celebrate the capabilities of persons with dementia, and view them as valuable and vital members of the towns, cities, villages and countries in which they reside."

Dementia Friendly America identifies "Ten Sectors" where the above-mentioned aspirations need to be realized. These and their respective goals are:

- 1) Transportation, Housing and Public Spaces (Local Government). Infrastructure that makes communities more livable for people with dementia and their caregivers.
- 2) Businesses. Dementia-supportive customer service and environments and policies that support employee caregivers.
- 3) Legal and Advance Planning Services. Legal services that help vulnerable clients express their wishes early and avoid problems such as unpaid expenses.
- 4) Banks and Financial Services. Dementia friendly practices that help maintain clients' independence while protecting them from problems
- 5) Neighbors and Community Members. Raising awareness to help neighbors and community members understand and support people living with dementia.
- 6) Independent Living. Home-based services available to maximize independence and promote autonomy and a high quality of life.
- 7) Communities of Faith. Faith communities use dementia friendly practices to provide a welcoming, compassionate environment and spiritual connection.
- 8) Care Throughout the Continuum. Early diagnosis of dementia and ongoing medical care; patient education; and connecting patients and their caregivers with community resources that promote quality of life.
- 9) Memory Loss Supports and Services. A spectrum of settings and services needed by people with dementia, from long term care facilities and assisted

and independent living residences, to home care, adult day services, and hospice.

10) Emergency Planning and First Response. Community planning and family preparation considers safety, security, and needs of people with dementia in disaster planning and emergency response

Dementia Friendly America lists hundreds of resources that can help any community to become more dementia-friendly. These can be accessed by clicking any of the 27 subject areas, such as Arts and Cultural Activities, Clinical Tools, Local Government, Memory Cafes, and Youth and Education/University Partners.

While caregiving challenges continue for individual caregivers and communities, these two resources can offer immediate support and a hopeful vision.

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www.vadars.org

Editorials

From the Commissioner, Virginia Department for Aging and Rehabilitative Services

Virginia No Wrong Door

Virginia No Wrong Door: Transforming the Way People Access Services

No matter our age or ability, life's transitions are smoother when we have supports and resources to weather change. Virginia No Wrong Door (NWD) is a statewide network of community partners and shared resources linked through a virtual system, designed to streamline access to long term services and supports (LTSS), connecting individuals, providers, and communities across the Commonwealth.

As a growing statewide network of 220 partners using a person-centered approach to serving older adults, caregivers, individuals with disabilities, veterans, and families, NWD supports Virginians in leading lives they desire and imagine. Each year NWD connects over 50,000 people to services and resources, supporting individual choice with options available for living and thriving in their communities.

In 2018, Virginia was selected by the federal Administration for Community Living (ACL) as one of ten state grantees to participate in the NWD Business Case Development learning collaborative for innovating "single point of entry" Systems and marketing to statewide leaders and their networks. This learning collaborative of state grantees, facilitated by ACL and the Lewin Group, serves as a data-informed national incubator for measuring the impact of No Wrong Door as an intervention that improves health outcomes, increases length of community living, and is cost effective.

The goals of Virginia's Business Case Development project include: 1) enhancing Virginia's LTSS workforce capacity through person-centered training, 2) linking NWD to Social Determinants of Health (SDoH) and 3) developing a Return on Investment (ROI) calculator.

Virginia has been implementing the following into our statewide NWD System.

Person-Centered Training

Person-centered thinking recognizes that people reside at the center of decision-making regarding their own lives. NWD's person-centered philosophy of working to understand the goals and needs of each individual, combined with a robust technology that connects a community-based provider network, delivers efficiencies that better serve individuals across Virginia. Through the Business Case Development project, NWD is improving the person-centered practice capacity of the statewide workforce through:

- Training 100 providers across Virginia in person-centered thinking and practices,
- Recruiting, training, and mentoring six new person-centered thinking trainer candidates from the NWD network to become trainers in person-centered planning, and
- Developing in-person and online training opportunities for the statewide LTSS workforce with an emphasis on disrupting ageism and trauma-informed approaches to service.

Social Determinants of Health

Quality of life is often dictated by social determinants of health (SDoH). No Wrong Door effectively connects people to resources and referrals related to social determinants such as education, employment, housing, social supports, and health care access. Powered by Virginia Navigator's information database of 27,000+ services and supports, spanning every city and county in Virginia, NWD gives its partners real-time access to knowledge about service availability for their clients. We often hear, "No Wrong Door connects me with other services I hadn't even thought about." With NWD, LTSS staff can quickly understand what exists and what is possible locally or anywhere in Virginia.

Earlier this year, the Department of Gerontology at Virginia Commonwealth University partnered with NWD, inviting graduate students to participate in a service-learning project to assist in developing a strategy to monitor and measure social determinants

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of health in Virginia's NWD System. Focused on three domains (Physical Environment, Social Support, and Health Care), students conducted literature reviews to examine how SDoH are being tracked and measured within health care settings, with particular emphasis on LTSS and home and community-based services. Based on their findings, students then compared SDoH assessment elements against NWD data elements and recommended approaches for connecting NWD to SDoH. This June, students presented their recommendations to the No Wrong Door Virginia Resource Advisory Council.

Return on Investment Calculator

Virginia NWD's efforts for developing a Return on Investment (ROI) calculator and business case are ongoing and include core measures for demonstrating NWD's impact on the lives of individuals, families, and the LTSS delivery system. NWD's prior work on making the case for impact has included monitoring network expansion and growth, measuring consumer satisfaction, and tracking individual community tenure (community living vs institutional living). Logic models and outcome frameworks have guided NWD evaluation in the areas of Options Counseling, Care Transitions, and Person-Centered Practices.

Joining the ACL's Business Case Development cohort takes this work to a national level. Developing a valid, reliable ROI calculator for NWD projects across the nation, begins with this formula:

$$\frac{\text{savings associated with intervention} - \text{cost of intervention}}{\text{cost of intervention}}$$

While the ROI formula has a clear definition, operationalizing the associated savings and costs is dependent upon multiple factors, such as data availability, data reliability, and data definitions. Throughout 2019, Virginia NWD and nine other state NWD initiatives continue to collaborate on development of the nationwide NWD ROI Calculator Version 1.0. All 10 states have brought their teams together to determine data elements and data collection strategies for the national calculator, which will initially be comprised of five ROI formulas for:

- Person-centered options counseling,
- Care transitions interventions,
- Caregiver support,
- Veteran-directed care program, and
- Medicaid administrative claiming.

Data collected through NWD tells a powerful story about Virginia's residents and their preferences for where and how they live. Over the course of this two-year project, Virginia No Wrong Door and key statewide partners will work to maintain, expand, and innovate the Commonwealth's coordinated statewide system and network for individuals, families, and community-based organizations to access long term services and supports. By expanding person-centered training, integrating social determinants of health, and connecting NWD outcomes to a sound Return on Investment Calculator, older adults, individuals with disabilities, veterans, caregivers, and families will have more options and gain access to home- and community-based supports.

For More Information about Virginia No Wrong Door, please visit: www.nowrongdoorvirginia.org.

DARS Meeting Calendar

The DARS advisory boards meet quarterly and are open to the public. All meetings will be held from 10:00 a.m. - 2:00 p.m. at the Virginia Division for Aging Office, 1610 Forest Avenue, Suite 100, Henrico. For information, call (804) 662-9333.

Commonwealth Council on Aging
December 18, 2019

Alzheimer's Disease and Related Disorders Commission
December 4, 2019
March 10, June 9, September 8, December 8, 2020

Public Guardian and Conservator Advisory Board
November 21, 2019

Road Scholars Go Hiking

by Alexa Van Aartrijk,
Hike Leader, Gerontologist



VCU Road Scholar, a program for lifelong learners over the age of 50 offered by the Virginia Center on Aging, hosted a group of 24 older adults in the Shenandoah Valley this September. The majority of participants were over the age of 70, the oldest being 86 years old. The assembled group came from all around the country, including Mississippi, Washington State, Oregon, Maryland, and West Virginia. Many were nature-enthusiasts who have spent their lives hiking. Those who had never visited the park before had heard about the beauty of the Shenandoah National Park, and were eager not only to visit the trails of the famous Appalachian Trail (AT), but also to learn about its history and creation. Each day for four days the group walked between four and 10 miles, with most mileage being spent on the AT. Although these were strenuous hikes, some participants energetically opted to extend their hikes even longer after the hikes were completed. The deeply-ingrained ageism in our society likes to tell us that older adults don't have the physicality and energy to complete activities such as this, but these Road Scholars defied those cultural stereotypes.

All of the hikers who joined us on the trip had impressive resumes. One gentleman in the group had been gently nudged out of his leadership position in the Air Force because of his age. He decided that he was not ready to retire just yet, so after a 30-year career with the military, he earned his law degree. Because, why not?

A couple who came on the trip together still spends time on Capitol Hill lobbying for various causes,

such as those in support of women's rights, accessible transportation, and clean water for all.



One member of our group was a retired emergency medical doctor who now volunteers part-time at a rural hospital in its emergency wing.

No matter what their background, everyone found community and connection on the trails. Whether it was seeking solitude and change or looking to hike with a group of people with similar activity interests, all 24 individuals had one thing in common: they enthusiastically wanted to continue growing, learning, and experiencing.



For more information on VCU Road Scholar, contact Jeffrey Ruggles at (804) 828-1623 or jruggles@vcu.edu.

New Geriatrics Workforce Enhancement Program (GWEP II): Overview of Our Five Objectives

by Edward F. Ansello, PhD

I am pleased to share more information about our new five-year federal award to strengthen interprofessional geriatrics. We are part of the Virginia Geriatric Education Center (VGEC).

The VGEC is a consortium of VCU, Eastern Virginia Medical School, UVA, and George Mason University. An all-in interprofessional Plenary oversees all initiatives of the VGEC; the Plenary is composed of representatives from dentistry, medicine, nursing, OT, patient counseling, pharmacy, PT, speech pathology, and social work. The federal Health Resources and Services Administration (HRSA) has just awarded the Virginia Center on Aging, which administers the VGEC, a five-year (2019-2024) \$3.75M cooperative agreement. The VGEC will address the following objectives:

GWEP OBJECTIVE ONE: Develop partnerships between academia, primary care delivery sites or systems, and community-based organizations to educate and train a workforce to provide value-based care that improves health outcomes for older adults. This VGEC GWEP project will conduct four activities for geriatrics workforce development:

1.1 Institute Creating Interprofessional Readiness for Complex and Aging Adults (CIRCAA), a faculty and clinicians development program, of 100 hours, 9 months, face-to-face with technology, emphasizing MIPS processes, to improve patient care in a measurable manner through team work.

1.2 Conduct Senior Mentoring with VCU Professional students at local community-based organizations (CBOs).

1.3 Partner with Rappahannock Emergency Medical Service (EMS) to provide training on advanced care planning and on recognition of dementia, and disseminate to other locations.

1.4 Engage dental and dental hygiene students in rotation at Lucy Corr Nursing Home dental clinic to educate low income older adults referred by Senior Connections (CBO) on oral health

GWEP OBJECTIVE TWO: Train geriatrics specialists, primary care providers, and health professions students, residents, fellows, and faculty to assess and address the primary care needs of older adults. This VGEC GWEP project will conduct three activities on primary care needs of older adults:

2.1 The VGEC will enhance a pre-clinical, web-based, virtual case study course (IPEC 561 at VCU) of a complex, unfolding geriatrics case, with a new software platform to enhance student interactions and preceptor feedback.

2.2 The Excellence in Primary Integrated Care-Geriatric Practice program at Eastern Virginia Medical School will establish the SeniorStrong Program (SSP) focusing on Social Determinants of Health, with partnerships with community-based organizations, including VirginiaNavigator, as resources.

2.3 The Richmond Health and Wellness Program (RHWP) will expand its care coordination program, with new sites, and a beta-tested “RHWP Opioid Risk Reduction” training for IP faculty and staff.

GWEP OBJECTIVE THREE: Transform clinical training environments into integrated geriatrics and primary care systems to become age-friendly health systems: What Matters to patient, Medication, Mentation, Mobility (the 4Ms). This VGEC GWEP project will conduct two activities to help transform primary care:

3.1 The VGEC will partner with a VCUHS primary care out-patient practice in Northern Virginia to train 24 medical residents (1st, 2nd, 3rd year residents) on advance care planning, dementia care, and community resources; and will develop educational content for the practice’s patient portal and measure clinical impact.

3.2 As stated in section 2.3, RHWP will add a new, non-housing-based site in Richmond’s East End at the new VCU Hub on 25th Street, where clients

will engage in similar care coordination as in the housing-based RHWP. In addition, all RHWP locations (now 5, soon 6) will improve integration with primary care using Virginia's Health Information Exchange, Connect Virginia. RHWP will also enhance workflows specific to the age-friendly health systems initiative in the domains of advanced care planning (Matters), falls prevention (Mobility) and high-risk medication use (Medications). Additional domains, such as cognition, may be developed based on community need and opportunities.

GWEP OBJECTIVE FOUR: The VGEC will deliver community-based programs that provide patients, families, caregivers, and direct care workers the knowledge and skills to improve health outcomes for older adults. This VGEC GWEP project will conduct three community-based training and education programs for patients, families, caregivers, and direct care workers:

4.1 The VGEC will partner with the Virginia Association of Area Agencies on Aging (V4A) to identify, deliver, and evaluate three training events each year on opioids proper use, misuse and abuse; behavioral health; dementia care; and/or abuse in later life at sites and times identified by various AAA members of the V4A, according to their needs analyses.

4.2 Virginia Navigator/Senior Navigator, a CBO partner, will apply a Virtual Learning Community that will house microlearning modules and lessons as resources for healthcare providers, older adults, family caregivers, and direct care workers.

4.3 The VGEC will partner with Health Quality Innovators (HQI, our QIO) to provide each year: 1) older adult patient opioid training programs addressing safe use and proper disposal of opioid medications; and 2) Harm Reduction PowerPoint training on opioids for pharmacists to enhance their role as community resources for older adults.

GWEP OBJECTIVE FIVE: Provide training to patients, families, caregivers, direct care workers, healthcare providers, and health professions students on Alzheimer's Disease and Related Dementias (ADRD). This GWEP project will conduct four community-based programs on ADRD:

5.1 UVA Memory and Aging Care Clinic will conduct dementia care training at 30 primary care clinics over the five years, with data tracking; some of these practices are in Medically Underserved Areas.

5.2 The VGEC will work with partner CBOs to conduct three on-going community-based training events. 1) Hampton University conference, Years 1, 3, and 5; 2) Greater Richmond Alzheimer's Chapter conferences, workshops, and staff development for family caregivers, direct care workers, and Alzheimer Association staffs, each year; and 3) Dementia and lifelong disabilities conferences in Southside Virginia and on the Eastern Shore, Years 2 and 4.

5.3 The VGEC will partner with CBOs to conduct four technology-based ADRD trainings.

5.3.1 Riverside Center for Excellence in Aging & Lifelong Health (CEALH) will provide access to training with microlearning modules for primary care providers (PCPs) on delivering the diagnosis of dementia: CEALH will work jointly with Virginia Navigator which will develop an educational platform. CEALH will contribute to the evaluation design and beta-test it with primary care providers.

5.3.2 George Mason University (GMU) will develop two initiatives: Music and Memory web-based microlearning for direct care staff in LTCs in rural underserved areas (MUAs), and Timeslips training of health professional students and faculty who will implement group interventions at facilities having individuals with moderate to severe dementia; both initiatives will gather MDS data on psychiatric medication use and behavioral problems.

5.3.3 CEALH will develop five microlearning modules on lifelong disabilities and dementia, partnering with the VGEC and other resources.

5.3.4 This GWEP will work in joint development with Rhode Island GEC on ECHO training for primary care providers on ADRD with ID/DD.

5.4 The VGEC and Virginia Geriatrics Society (VGS) will together develop, implement, and evaluate five one-hour presentations on ADRD at VGS annual meetings.

LLI Groundbreaking

The Lifelong Learning Institute in Chesterfield (LLI) has outgrown its (parking) space. So, it is “paving” a new future.

LLI is a member-supported nonprofit organization designed to meet the educational and social enrichment needs of adults age 50 and “better.” It benefits from on-going support from the Virginia Center on Aging at VCU, Chesterfield County Public Schools, and Chesterfield County, who co-founded the institute in 2003. The building where all the courses are held is owned by Chesterfield County.

LLI is a learning community of peers committed to education and their own intellectual development. The institute develops and offers daytime courses, lectures, and special events across 14 different categories taught by members and volunteer instructors from the community, and across spring, summer, and fall terms.

Current enrollment includes more than 1,100 members from Chesterfield and the surrounding localities. LLI brings immense value to its members by offering supportive learning opportunities, a life-enriching community, and access to a vast range of resources.

However, the growth experienced by LLI over the years has taxed available parking to the extreme. Fortunately, a nearby church generously welcomes LLI members to use its lot. But continuing growth in membership brings greater diversity in many ways, one of which is mobility. The church’s gravel lot across the street can be a challenge for LLI members with mobility issues.

So, LLI has purchased a house next door to build more parking spaces, hired an engineering firm to move the project ahead, and the county has helped with each step along the way to secure code and construction approvals. The house has been razed, and work officially began in September with a collaborative ground breaking.

As Executive Director Rachel Ramirez noted, “We will know we have been successful when every member can arrive at LLI, park safely, and attend their courses comfortably. When our members no longer have to arrive three hours early for their class just to find a parking spot, we will have accomplished our goal.”

Photographer Ash Daniel of the *Chesterfield Observer* captured the ceremony below:



From left: Dr. Joseph Casey, Chesterfield County Administrator; Dr. Mervin Dougherty, Chesterfield County Public Schools Superintendent; The Honorable Leslie Haley, Chesterfield County Board of Supervisors, Midlothian District; Mitchell Bowser, Timmons Group; Rachel Ramirez, Executive Director, LLI; Dr. John Lemza, President, LLI; Dr. Edward Ansello, Director VCoA and LLI Board; Gerry Ferguson, LLI Member; Bob Ferguson, LLI Board; Toni Kumery LLI Member; Bud Martindale, LLI Board.

COMMONWEALTH OF VIRGINIA

Alzheimer's and Related Diseases Research Award Fund

2018-2019 FINAL PROJECT REPORT SUMMARIES

The Alzheimer's and Related Diseases Research Award Fund (ARDRAF) was established by the Virginia General Assembly in 1982 and is administered by the Virginia Center on Aging at Virginia Commonwealth University. Summaries of the final project reports submitted by investigators funded during the 2018-2019 round of competition are given below. To receive the full reports, please contact the investigators or the ARDRAF administrator, Dr. Constance Coogle (ccoogle@vcu.edu).

EVMS **Dianne C. Daniel, PhD, and Edward M. Johnson, PhD***

Cellular Mechanisms of Pur-based Peptides for Frontotemporal Dementia

Frontotemporal Dementia (FTD) is currently an incurable disease. The most common genetic cause of FTD is a DNA sequence repeated many times in the gene *C9orf72* (C9). This expanded sequence is made into RNA repeats and dipeptide repeats (DPRs), which aggregate in neurons in the brains of patients and cause them to degenerate. Pur-alpha protein, discovered in Dr. Johnson's laboratory, binds tightly to the RNA repeats and reduces nerve cell degeneration in animal models. Pur-alpha plays an essential role in RNA transport in neurons, and its sequestration by C9 repeat sequences could affect this step in RNA metabolism. The project investigators have tested TZIP, a Pur-based peptide containing a cell entry signal, as a potential therapy for this form of FTD. They identify TZIP binding to the C9 RNA repeats, including structures formed by the repeats known as G-quadruplexes, as a promising target for FTD therapy. Pur-peptide modulation of C9 repeat RNA through conformational shifts in this structure represents a new mechanism for regulation of RNA-protein binding and potentially of RNA transport. Data indicate that TZIP improves the process for removal from the cell of toxic aggregates, which can include DPRs. The investigators have shown that labeled peptide diffuses into cells of brain regions after injection into a ventricle. They have designed a virus with copies of the C9 repeat to infect mouse fetal cortical neurons as an in vitro study model. This system provides a laboratory model for testing promising peptides, which will provide the basis for a potential FTD therapy. **Dr. Daniel may be contacted at (757) 446-5684, danieldc@evms.edu; Dr. Johnson may be contacted at johnson@emeritus.evms.edu.**

UVA **Heather A. Ferris, MD, PhD***

Mechanisms of Diabetes-Mediated Increases in Alzheimer's Disease and Dementia

Although there are multiple competing theories to explain the cognitive dysfunction seen in diabetes, the investigator's lab had preliminary data establishing that the cholesterol synthetic pathway is also disrupted in the brains of diabetics and that this disruption leads to an increase in the cholesterol oxidation product, 7-ketocholesterol, a molecule also increased in AD. Their studies also demonstrated that mice with impaired astrocyte cholesterol synthesis have disrupted circadian rhythms. In this ARDRAF-funded study, it was found that: 1) 7-ketocholesterol could make the astrocyte cells of the brain, the cells responsible for most brain cholesterol synthesis, have weakened circadian rhythms and that 2) the rhythms were strengthened by the use of the hormone melatonin. These two opposing effects indicate that the site of action is a transcription factor, the retinoic acid receptor (RAR)-related orphan receptor alpha (ROR α). Further, the investigators found that the circadian rhythms of mice fed a high fat diet and mice with AD both have a weakening of circadian rhythms similar to what was seen in vitro. These weakened circadian rhythms in mice coincided with an increase in brain 7-ketocholesterol, suggesting that 7-ketocholesterol is driving circadian disruptions in both AD and obesity/diabetes. With this knowledge, the investigator will use the new tools developed to pursue: 1) further direct evidence of the role of 7-ketocholesterol in the disruption of circadian rhythms in mice and 2) strategies to prevent this disruption. The goal is to eventually develop therapeutics to address circadian disruptions in patients with AD. **Dr. Ferris may be contacted at (412) 605-8541, hf4f@virginia.edu.**

Make Downsizing a Dream

by Amanda Scudder, MSW
Certified Professional Organizer and Senior
Move Manager, Abundance Organizing



Moving is stressful, especially when it involves downsizing from a home you've lived in for years. Yet many of us plan to do just that. According to the Demand Institute, four out of 10 Boomers plan to move and 42% of these expect to move into something smaller. If the decision to downsize is keeping you up at night, you are in good company. However, with the right planning and support, your move can be a dream.

Dream Team

Downsizing takes a great deal of physical, mental, and emotional energy. Those who do it well delegate. Identify friends, family, and qualified professionals to help you. Senior move managers can be essential members of your team. With their specialized training and extensive knowledge of resources, they can help you plan, declutter, pack, manage the logistics of your move, trouble-shoot, make recommendations, unpack, and organize your new space, all of which will ensure that you rest easy in your new home.

Curate Collections

One of the biggest barriers to downsizing is the question of what to do with all the stuff. Over the years, acquisitions accumulate, and the older we get, the less energy we tend to have to deal with them. While it's hard to confront decades, or even generations, worth of possessions, downsizing is a great opportunity to curate a lifetime of collections. A neutral third-party can be invaluable in this process, serving as a sounding board, documenting household inventory, supervising distribution of items to family, and coordinating the sale or donation of things you no longer need.

Sort it Out

Deciding what to keep and what to get rid of is easier if you start by sorting your belongings into categories, then evaluate the items using the following criteria:

- **Function:** Does the item meet a recurring need and does it do its intended job well?
- **Form:** Is it more attractive, suitable, or flattering than another that does the same job?
- **Feeling:** Does it make you happy or is it being kept out of guilt or obligation?
- **Fit:** Does it fit you, your new space, and your new lifestyle?

A floor plan of your new home will be tremendously helpful when making decisions about furniture. Choose furnishings that can serve double or triple-duty, like end tables with drawers and storage ottomans.

While making decisions takes some effort, it will save you time and money later. It is far less expensive to pack and move only what you love, use, feel good about, and have room for.

Have a Plan

There are a lot of moving parts in any moving plan. Work back from your anticipated move date to establish timelines with moving partners such as realtors, movers, cleaning services, residential communities, and others. Be sure you understand the scope of services they will provide, so that you can compare across providers; and always ask for references. The lowest bid is not always the best deal.

Move in Day

On move-in day, there is a lot going on: loading, unloading, placement of furniture, household goods to unpack, beds to make, essentials to stock. To prevent important items like wallets, glasses, medicines, and paperwork from getting lost in the shuffle, gather them up into a brightly colored bag or bin and put them in the vehicle in which you will be traveling to your new home.

Unpacking and organizing your belongings will take a substantial amount of time. Most movers only unload and place furniture and boxes in designated rooms. You will need to have a plan to get the boxes unpacked, the packing materials removed, and everything put away. Prioritize essential areas: bedrooms, bathrooms, and kitchen. You may also want to recruit help with provisioning your new household with supplies and groceries so that your first night will be

as comfortable as possible.

Welcome Home!

Decluttering before the move and setting up organized systems right from the start will make your new, smaller spaces work as efficiently as possible and will get you up and running quickly and with a lot less stress. Now, it is time to relax and enjoy your new home. Sweet dreams!

Amanda Scudder may be reached at (804) 212-2160 or info@abundanceorganizing.com.

The Shepherd's Center of Richmond Creates a Driver Recruitment Video

Thanks to a grant received from the Pauley Family Foundation, The Shepherd's Center of Richmond (TSCOR) has produced a three-minute video for driver recruitment called "*Do You Have the Drive?*" TSCOR provides transportation to seniors who can no longer drive. Volunteer drivers take them round trip to medical appointments or to purchase groceries. The video describes the need for drivers, the satisfaction the volunteer receives, and the gratitude of clients for a more convenient alternative to public transportation. The video may be viewed at www.TSCOR.org.

According to Hal Costley, president of the organization, driving clients is a flexible volunteer activity. The Center's ride scheduling software, illustrated in the video, gives drivers with computer access an easy way to choose the client, the location to which they are willing to drive, and the day and time that are convenient. Drivers typically drive once a week at their discretion. Because of the growing population of older citizens, the need for additional drivers is great. Says Costley, "Being a driver is a delightful opportunity to be of service, to get to know wonderful new people, and to have fun."

Those interested in becoming a driver, learning more about the Shepherd's Center, or requesting a program presented by TSCOR's speakers bureau, should visit www.TSCOR.org or call (804) 355-7282.

ARDRAF Final Reports, continued

Randolph
College

A. Katrin Schenk, PhD
*Interactive Caregiver Portal for the
Visualization of Activity and
Location Data in an Alzheimer's
Population*

The investigator built an interactive web application that allows Alzheimer's patients and informal caregivers to visualize and interact with data collected by a Functional Monitoring (FM) system. The FM system uses ubiquitous computing devices (e.g., cellphones and smartwatches) to continuously collect patient location and activity data in the home and community. Currently, the FM system has collected 265 patient-months of data. These data are classified into representations that provide caregivers with crucial information about the efficacy of their caregiving and the Negative Behavioral Trends (NBTs) of their loved ones (i.e., lower than normal step counts, declining lifespan, and ragged wake-up times). The website allows caregivers to interact with their loved ones' data, and receive appropriate interventional suggestions. For instance, alerts regarding declining lifespan (a measure of the number of excursions outside the home) can result in a caregiver making more of an effort to take the loved one outside the home to interact with a more enriched environment, which has been shown to enhance functional status. Back end coding allowed the investigator to write updated code that queries the database and processes real-time data for the front end (web interface). Website coding allowed for design work to optimize what the Caregiver Portal looks like, what it shows, and how caregivers interact with the resulting data. Once the NBT algorithms were built, they were tested for false positives and negatives by running them on FM data sets. The false negative rates were under 5% because the NBTs were so dramatic, e.g., the average for the lifespan NBTs was a 45% decline. **Dr. Schenk may be contacted at (434) 947-8489, kschenk@randolphcollege.edu.**

Calendar of Events

November 12, 2019

The Confident Caregiver: A Family Caregiver Conference. Sponsored by Valley Program for Aging Services. James Madison University, Harrisonburg. For information, visit www.vpas.info.

November 12, 2019

The Virginia Association for Home Care and Hospice Annual Conference. The Westin Virginia Beach Town Center, Virginia Beach. For information, visit www.vahc.org.

November 13-17, 2019

Strength in Age: Harnessing the Power of Networks. The Gerontological Society of America's Annual Scientific Meeting. Austin, TX. For information, visit www.geron.org.

November 14, 2019

What's New in Alzheimer's Research: Putting the Pieces Together. Presented by the Alzheimer's Association, Central and Western Virginia Chapter. Holiday Inn Valley View, Roanoke. For information, visit www.alz.org/cwva.

November 17-18, 2019

The Power of I: Imagine, Innovate, Inform. 2019 Conference of the Aging Life Care Association's Mid Atlantic Chapter. Falls Church Marriott Fairview Park, Falls Church. For information, visit www.midatlanticalca.org.

November 19-22, 2019

Protecting Vulnerable Adults Is Everyone's Business: 36th Annual Adult Protective Services Conference. Renaissance Austin Hotel, Austin, TX. For information, visit www.dfps.state.tx.us/Adult_Protection/Adult_Protective_Services_Conference/default.asp.

December 3, 2019

First Steps Advance Care Planning Facilitator Certification. Presented by Honoring Choices Virginia. Richmond Academy of Medicine, Richmond. For information, visit <https://honoringchoices-va.org/learn/events>.

January 22, 2020

Virginia Center on Aging's 34th Annual Legislative Breakfast. St. Paul's Episcopal Church, Richmond. 7:30 a.m. - 9:00 a.m. For information, call (804) 828-1525 or email eansello@vcu.edu.

February 29, 2020

Eighth Annual Emswiller Interprofessional Symposium: Building Team Skills for Collaborative Practice. Presented by VCU's Center for Interprofessional Education and Collaborative Care. Lewis Ginter Botanical Garden, Richmond. For information, visit <https://rampages.us/ipe-symposium/>.

March 24-27, 2020

Aging 2020: Examining the Needs of Today's Diverse Older Adults. Annual Aging in America Conference presented by the American Society on Aging. Atlanta, GA. For information, visit www.asaging.org.

April 14-18, 2020

Aging Better Together: Building an Inclusive Aging Community. 41st Annual Meeting of the Southern Gerontological Society. Hilton Norfolk The Main, Norfolk. For information, visit www.southerngerontologicalsociety.org.

May 7-9, 2020

American Geriatrics Society 2020 Annual Scientific Meeting. Long Beach, CA. For information, visit www.americangeriatrics.org.

May 12, 2020

Connect. Collaborate. Contribute: Communities for the Future. 2020 Virginia Governor's Conference on Aging. Richmond. For information, visit www.vgcoa.com.

Age in Action

Volume 34 Number 4: Fall 2019

Edward F. Ansello, PhD, Director, VCoA
Kathryn Hayfield, Commissioner, DARS
Kimberly Ivey, MS, Editor

Age in Action is published quarterly (January, April, July, October). Submissions and comments are invited, and may be published in a future issue. Send submissions to ksivey@vcu.edu.

**Winter 2020 Issue Deadline for Submissions:
December 15, 2019**



Virginia Center on Aging

at Virginia Commonwealth University, Richmond, Virginia
vcoa.chp.vcu.edu

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Virginia Commonwealth University
Age in Action
Virginia Center on Aging
Box 980229
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Aging Better Together: Building an Inclusive Aging Community

41st Annual Meeting of the Southern Gerontological Society

April 14-18, 2020

Hilton Norfolk The Main, Norfolk

Conference presentations will be based on six Program Domains: Age-related Health and Wellness; Environment and Location: The Power of Place; Diversity Topics in Aging Communities; Caregiving, Care Support, and Care Partnerships; Gerontological Education and Professional Development; and Advocacy for or by Older Adults.

Call for Abstracts

Abstracts accepted until November 1, 2019. Notifications of Abstract acceptance will be made between December 2-6, 2019.

Conference Registration

Registration will open on December 1, 2019. Early registration pricing ends on March 2, 2020. To register, visit <https://southerngerontologicalsociety.org/meeting-registration-info.html>.



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