Volume 36 Number 2 Spring 2021

age in action

Activities in geriatrics and gerontology education and research
Virginia Center on Aging
and
Virginia Department for Aging and Rehabilitative Services

Case Study

Strengthening Capacities to Respond to Dementia with Lifelong Disabilities: Using the Project ECHO Model

By Edward F. Ansello, PhD

Educational Objectives

1. To discuss the need for interprofessional training about aging with lifelong disabilities and dementia.
2. To demonstrate the continuing heterogeneity among adults growing older with these conditions.
3. To report the relevance of the Project ECHO model as a means of collaborative training and practice improvement.

Background

More adults are growing into later life (ages 55+) with lifelong disabilities such as Down syndrome, other intellectual disabilities, and cerebral palsy. They are beneficiaries of the gift of time because of a number of circumstances, including better management of midlife conditions through medications and the extended survival of their family caregivers. However, upon reaching later life, these individuals tend to encounter healthcare providers who are underprepared or great gaps in related expertise and resources across support and services sectors. If dementia accompanies these lifelong disabilities, odds are even worse.

Interventive care for persons with intellectual and developmental disabilities (I/DD) has been pediatrically driven, in the understandable position that early intervention can improve the course of life. There's been remarkable success, e.g., a doubling of life expectancy within the last decades of the 20th century for those with Down syndrome (Yang et al., 2002). However, healthcare providers have little clinical experience with older adults with lifelong I/DD. Parental care has often limited interactions with health systems that themselves have few providers with combined expertise in healthcare, geriatrics, and I/DD; so providers are undertrained to differentially diagnose dementia from multiple conditions that can create similar behaviors and typically have little or no baseline data on the individual with lifelong disabilities.

Project ECHO, an innovation in distance education that emerged to address healthcare shortfalls in rural and isolated areas, has proven to be especially effective in building interprofessional geriatrics training on dementia with lifelong disabilities.

Project ECHO (Extension for Community Healthcare Outcomes)

Project ECHO employs a technique called

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guided-practice credited with reducing health disparities in underserved areas around the world (see https://hsc.unm.edu/echo/ for details). Created by the University of New Mexico School of Medicine, ECHO features "telementoring," with virtual interactions, that is not only well-suited to a COVID-19 reality of restricted in-person meetings but is also fully adaptable to an interprofessional focus on under-recognized issues like aging with lifelong disabilities.

Project ECHO uses a Hub-and-Spoke model where subject matter expertise is gathered at the Hub site and providers seeking guidance on that subject matter are at practice or clinical sites elsewhere. In the strict medical model, knowledge-sharing experts at the Hub site constitute a team that leads virtual clinics, "amplifying the capacity for providers to deliver best-in-practice care to the underserved in their own communities." However, the model, as noted, is fully adaptable to non-clinical sites and matters. The Hub-and-Spoke model relies upon an "all-in, all-share, all-learn" approach. After the Hub team shares a brief didactic lesson on a given topic, the Spoke sites share a de-identified case or cases that relate to the topic at hand. Everyone, both Hub and Spokes, is encouraged to offer insights on any given case, possible alternative diagnoses, potential remedies, interventions, related resources, etc.

Growing Older with Intellectual and Developmental Disabilities: When Dementia Is Suspected or Diagnosed

Our Project ECHO on I/DD for healthcare and other service providers addresses an underserved but growing population, offering these providers an interactive, five-part, case-based series to enhance their knowledge, competence, and performance.

Development

The Virginia Geriatric Education Center (VGEC) conducts the Geriatrics Workforce Enhancement Program (GWEP), funded by the Health Resources and Services Administration of the USDHHS for the period 2019-2024. The VGEC partnered with the University of Rhode Island Geriatric Education Center (RIGEC) GWEP to conceive and implement an interprofessional geriatrics training program on helping older adults with lifelong disabilities who have signs of dementia. Both GWEPs recognized this population as a growing segment within their states and saw, as well, a dearth of extant training for professionals. These two GWEPs reached out to colleagues with known expertise in this content area to build a responsive team.

The VGEC and RIGEC partners created an interprofessional Hub team to complement their own expertise by recruiting clinical experts from the National Task Group on Intellectual Disabilities and Dementia Practices (NTG), YAI, Inc. (a New York–based I/DD services provider), and several other organizations.

The overall team included: Edward Ansello, PhD, (Co-Facilitator) Virginia Center on Aging (VCoA) and Virginia Geriatric Education Center (VGEC), Virginia Commonwealth University; Kathleen M. Bishop, PhD, National Task Group on Intellectual Disabilities and Dementia Practices (NTG); Phillip Clark, ScD, (Co-Facilitator) Rhode Island Geriatric Education Center (RIGEC), University of Rhode Island; Catherine Conway, MS, RDN, CDN, CDCES, YAI, Inc.; Samantha Cotton, PhD, MSW, University of Louisville School of Medicine; Ashara Edwards, MS, YAI, Inc.; Faith Helm, MS, RIGEC; Seth Keller, MD, NTG; Matthew Janicki, PhD, NTG; Kathy Service, RN, MS, CFNP-BC, CDDN, NTG; Jennifer Mathews, BS, VCoA and VGEC; Catherine Taylor, BA, RIGEC; and Leland (Bert) Waters, PhD, VCoA and VGEC.

This team tested the waters, so to speak, by conducting in spring 2020 a three-part webinar series to introduce issues of dementia with lifelong disabilities. This series drew over 1,000 participants in total. The webinar series proved our collaborative capabilities and served as advance promotion of the forthcoming ECHO series.

The full team, in turn, worked to develop a virtual, interactive, case-based Project ECHO experience entitled ***Growing Older with Lifelong Intellectual Disabilities: When Dementia Is Suspected or Diagnosed.*** ECHO emphasizes brief, focused interactions, with a session typically lasting only 60-75 minutes.

As noted, ECHO employs a Hub-and-Spoke model

whereby Hub members share their content expertise didactically, that is, in a brief lecture, and through analyses of a case study submitted by one of the Spoke sites. However, the format is not unidirectional, from experts to learners. Once discussion of the submitted case study begins, all participants at the Hub and Spoke sites may offer their perspectives. Because Spoke sites can include representatives from day programs, residential facilities, healthcare practices, and more, and because the case under consideration may relate to a medication regimen, diet and nutrition, clinical care, social supports or other factors, a true interprofessional geriatrics mentality is required in order to address each case effectively. Using the Zoom platform allows everyone to see each other. The discussion produces recommended interventions and resources.

Implementation

Through extensive collaboration over the months that followed the webinar series, this team identified core content areas and related competencies for four 75-minute ECHO sessions during October through December 2020. Each session began with a brief (15-20 minutes) didactic presented by one of our Hub team: 1) Assessment and Diagnosis of Dementia by Seth Keller; 2) Behavior = Communication by Kathy Service; 3) The Difference Physical and Social Environments Can Make through Understanding Sensory Processing and Sensory Impairment by Kathleen Bishop; and 4) Nutritional Concerns by Catherine Conway.

The ECHO series was promoted this way: "This Project ECHO series is a free, practical, case-based education series for health care and other providers who want to enhance their knowledge, competence, and performance related to improving care for people with intellectual and developmental disabilities affected by dementia. Each virtual meeting will include a short presentation by a content expert followed by a case study (submitted in advance by participants), and open discussion to teach and learn from one another."

Each session listed in advance the session's synopsis, objectives, and didactic speaker's qualifications. Typical is the description for the first session:

Assessment and Diagnosis of Dementia
Presented October 19, 2020:
This session includes a discussion of the challenge of assessing a decline in function and making an accurate and appropriate diagnosis of Alzheimer's disease/dementia.

Learning Objectives:
After completing this webinar, participants will be able to:
1. Describe the possible reasons why decline may occur in someone aging with an I/DD
2. Describe what tools may be helpful in determining if dementia is occurring
3. Explain how a family member/caregiver is helpful in providing input to a healthcare provider with dementia care

Presenter(s)/Panelist(s):
Seth M. Keller, MD, Neurologist, Neurology Associates of South Jersey and National Task Group on ID and Dementia Practices.

Dr. Keller in his brief didactic shared observations on how to determine if behavior is attributable to dementia and not to some other condition. The expectation that Down syndrome leads to dementia can lead to "diagnostic overshadowing," that is, the tendency to see what one expects to see. He asked participants to ask, when changes occur: Is the change normative or a sign of disease? Are there co-morbidities that might cause the changes? Could depression be an issue? Further, he recommended assessing functional decline by categories: cognitive, sensory, neuromotor, etc. He cited the NTG's EDSD (Early Detection Screen for Dementia) as an especially helpful first step tool, and, as a neurologist, discussed the benefits of testing for Alzheimer's disease biomarkers like amyloid imaging and cerebral spinal fluid.

This series presented five, real life, de-identified cases in the Project ECHO format of individuals with lifelong disabilities who were diagnosed with or suspected of having dementia. The cases ranged in impairment from mild to severe; not all individuals were ultimately deemed to have dementia, as Down syndrome regression can mimic dementia. The group process helped to create a person-centered, 4Ms

(What Matters to the person, Medications, Mobility, Mentation), interprofessional approach to healthcare and produced practice change recommendations.

After launching the four-part ECHO series, the team added a fifth session to focus on the case of misdiagnosed "dementia" in a young man with I/DD and to revisit cases and group recommendations presented earlier. The overall team partnered with the Special Interest Group on Lifelong Disabilities within the national Geriatrics Workforce Enhancement Program, the Virginia Center on Aging, NTG, the Academy for Gerontology in Higher Education, and others to promote this ECHO series, recruiting for each session 30 or more participants at 13 or more Spoke sites, including those in CA, CO, MA, NJ, NY, OH, OR, RI, and VA.

Follow up in the fifth session revealed that implementation of group recommendations regarding two of the earlier presented cases had already resulted in some improvements within the individuals in the intervening period. While focus was on practice change, participant evaluations, although limited, were very positive and the interprofessional team is implementing another five-session series in spring 2021 based on participants' feedback. Evaluation questions common to the first four sessions included 5-point Likert scales (5 most positive) on the featured didactic, the case study presentation, and the case study discussion by Hub and by Spokes; scores in the four sessions ranged from 3.94 to 4.13; 4.40 to 4.62; 4.57 to 4.86; and 4.81 to 4.94. Intention to train their staffs on session content ranged from 62% to 81% overall. Knowledge gain questions showed consistent positive directionality.

Case Study #1

Ronald is a 48-year old man with Down syndrome who has been diagnosed with early onset Alzheimer's disease. Ronald has been living for the past three years in a mid-size residential facility in the memory care unit. His behavior changed dramatically over a short period of time. He has been having seizures and reports episodes of intense pain. He had transferred here from a small group home when he could no longer keep up with the day program tasks. He began spitting on the floor and running out of the house. This behavior changed, and there is no aggressive behavior or wandering but his irritability, confusion, and disorientation have increased. Ronald's medications include clonazepam (Klonopin), an anti-anxiety tranquilizer, levetiracetam (Keppra) for seizures, and Haldol (2 mg/twice a day) for mood disorders. His history incudes seizures, frequent infections, suspected depression, and myoclonic jerks (involuntary muscle contractions), mostly in the morning.

The Hub and Spokes participants determined that the goal was to promote a better quality of life for Ronald at this stage of his dementia. Participants asked about the composition of his healthcare team (there had not been a neurologist or a pharmacist consultation); if the staff had been creating a behavior log tracking his behaviors (when and where did the seizures and the upsetting behaviors occur, time of day, environmental conditions, presence of people, stimuli, etc.).

A Hub team member noted that myoclonic jerks are common with Down syndrome with Alzheimer's disease, that a frequent side effect of levetiracetam (Keppra) is headaches, that the combination of Haldol and clonazepam could trigger a stroke, and that Keppra could cause irritability; he added that Haldol is a very strong medicine and recommended a consultation with a neurologist to assess his regimen's dosages and appropriateness.

Participants asked if Ronald could be easily distracted when upset; staff answered yes and noted that giving him a mirror calmed things. A Hub team member inquired about sensory processing, as persons with Alzheimer's disease are lost in space and time and are "meaning deaf," unable to understand their surroundings as before; and about sensory impairments, noting the frequency of ear infections among persons with Down syndrome because of their narrowed ear canals; infected ear passages could cause hearing difficulties that trigger inappropriate responses and could also be painful. As well, a heightened sensory sensitivity might mean that Ronald's clothing is irritating him and staff might explore offering more loose fitting clothing. Participants agreed that we need to help Ronald find his place in space; they suggested, among other things, strong contrasting colors along halls and walkways to help guide him.

A participant recommended Music & Memory as an alternative to medications to calm Ronald. As Ronald frequently visits with his family, this music is something that they can enjoy together. A Hub member noted that beating a drum quietly at a pace desired for Ronald might achieve a calm slow down, and reported anecdotes from individuals taking Haldol that they were just as agitated inside, even as externally they were slowed down. One of this session's concluding remarks was that diagnosis is a continuous process.

Case Study #2

Theresa is a 61-year old woman with moderate intellectual disability and severe arthritis who lives with her unmarried sister is an apartment complex. There is very little regular involvement by other members of her family. She loved participating in a supervised day program. She has always been social and warm with peers and staff. A few years ago, the program staff noted changes in her behavior: she stopped one of her favorite activities, writing in her notebooks, and had a period of crying, pouting, and yelling. She became disoriented when walking in familiar places. Her sister took her on vacation to family out of state but she didn't recognize her brother and each night stood in a corner of the room and would not go to bed without coaxing. She had six eye surgeries in 2017 and gall bladder surgery in 2018. In 2018, there were rapid changes in her behavior that included confusion regarding bathroom routine and onset of incontinence (no UTI) that resulted in her leaving the day program. She is now completely bedridden, sleeps during the day, and sleeps little at night, sometimes screaming. She is currently non-verbal.

Theresa has an extensive drug regimen that includes Omeprazole DR (Prilosec) for acid reflux; thyroxine for digestion, etc.; levetiracetam (Keppra) 100mg, twice a day; Tramadol for pain, four times/day; simethicone, an anti-gas, three times/day; diphenhydramine (children's Benadryl) as needed for sleep; quetiapine (Seroquel), anti-psychotic, three times/day; and Tylenol, PRN (as needed). Theresa had been taking lorazepam (Ativan), a sedative, 1 mg, three times/day and again in the evening, 2 mg, for sleep. However, her primary care physician has just discontinued these and has prescribed Haldol, 0.5 mg, three times/day.

The Hub team first addressed Theresa's heavy medication list, saying that some medications don't make sense, particularly taking two different antipsychotics (Haldol and Seroquel). A Hub member stated that Theresa's Keppra dosage was "super low, a pediatric dosage" and she may be having seizures; she should have an EEG to make sure that she isn't. Hub and Spoke participants discussed Theresa's inability to sleep at night and suggested that the timing of the administration of some medications could be affecting sleep. They also questioned whether Theresa may be in more pain at night because of lack of movement all day; obtaining a hospital bed might help with repositioning and prevent pain and bedsores; they noted that giving medications PRN for pain does not work well with someone who is non-communicative. The Hub team asked if anyone was keeping a behavior log to determine when and under what conditions Theresa was evidencing pain.

Participants suggested exploring non-pharmacological interventions for Theresa's sleep and pain. Because Theresa is in bed all day staring at the ceiling, they recommended purchasing a small projector that would project stars or movement on the ceiling. Noting the relative stimulus deprivation she is experiencing, they suggested playing soft Christmas music at bedtime (she loves this music year round), adding a gurgling fountain, and soothing sounds in her room. A participant occupational therapist asked if Theresa has been visited by an OT (she has not) for help with moving and observed that the less one moves, the harder it is to move; others suggested that she might also be moved into other rooms periodically for stimulation but they cautioned that one has to pay attention to her reactions to these added stimuli in case they are too much for her to handle. Because of her taking medications for acid reflux, they asked if Theresa was sitting up when eating and if she lay back down immediately afterward, conditions that could exacerbate reflux and cause pain.

Conclusion

Older adults grow less like each other with increasing age, a process we have long called *individuation* (Janicki & Ansello, 2000). This growing heterogeneity has begun to be recognized formally in healthcare (Ferrucci & Kuchel, 2021). It is critical to understand

that this growing heterogeneity pertains to older adults with I/DD and to care appropriately with interprofessinal responses. The Project ECHO model proved to be an effective means of building interprofessional knowledge and skills about individuals who will increasingly be seen in clinical practices and various supportive services. Participants in this Project ECHO series discussed real-life cases presented by the Hub and Spokes and contributed to diagnoses and treatment recommendations. Cases always engendered more than originally anticipated, so Hub and Spoke participants learned of interventions related to pain management, family caregiving, program eligibility, sensory impairments, drug regimen reviews, screening tools, content resources online and in the community, and more.

The Project ECHO model was productive for interprofessional geriatrics communication. The overall team has developed Series 2 on *Growing Older with Lifelong Intellectual Disabilities: When Dementia Is Suspected or Diagnosed.* It began March 29, 2021 and contains four parts on: Nurturing Brain Health across the Lifespan; Family Dynamics and Communication; Families and Planning for the Future; Medications and ID and ADRD; and may contain a fifth session to introduce a new case and assess the effectiveness of earlier suggested interventions.

Study Questions

1. Why should healthcare providers and supportive services staff receive interprofessional geriatrics training about older adults with lifelong disabilities and dementia?
2. What are some examples of heterogeneity among these older adults?
3. What are the principal features of the Project ECHO model?

Suggested Resources

Down syndrome regression

Ferrucci, L. & Kuchel, G. A. (2021). Editorial: Heterogeneity of aging: Individual risk factors, mechanisms, patient priorities, and outcomes. *Journal of the American Geriatrics Society, 69*, 610-612.

Graham, M.E. (2017). From wandering to wayfaring: Reconsidering movement in people with dementia in long-term care. *Dementia, 16*(6), 732-749.

Janicki, M.P. & Ansello, E.F. (2000). *Community supports for aging adults with lifelong disabilities.* Baltimore, MD: Paul H. Brookes Publishing Co.

National Task Group on Intellectual Disabilities and Dementia Practices

Project ECHO

Virginia Geriatric Education Center

YAI, Inc.

Yang, Q., Rasmussen, S. A., & Friedman, J. M. (2002). Mortality associated with Down's syndrome in the USA from 1983 to 1997: A population-based study. *Lancet, 59,* 1019–1025

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This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant numbers U1QHP28737 (URI) and U1QHP28744 (VCU), Geriatrics Workforce Enhancement Program. Information, content, and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by, HRSA, HHS, or the U.S. Government.

From the Director, Virginia Center on Aging

By Edward F. Ansello, Ph.D.

Metabolic Syndrome and How to Fight It

While Metabolic Syndrome sounds like a great name for a rock band, it's actually a health condition that's causing an increasing amount of attention. It's present in one of three adults in the United States. Fortunately, there's good news to share about fighting this condition.

Metabolic Syndrome involves the presence of five features in our bodies: 1) a larger than preferred waist size (above 35 inches for women, 40 inches for men), 2) high levels of triglycerides (150 or higher), 3) low levels of the good cholesterol HDL (under 50 for women, 40 for men), 4) blood pressure higher than ideal (systolic 130 or higher, diastolic 85 or higher), and 5) too much blood sugar (100 or higher). We have metabolic syndrome, a sign of insulin resistance, if we have three of these five features.

Understanding metabolic syndrome and the ins and outs of relationships among these five conditions or features goes a long way in helping us to understand the fundamental functions of our well-being.

Not surprisingly, our diets contribute to having the metabolic syndrome. One culprit seems to be too many of our calories coming from carbohydrates in refined grains, potatoes, fruit juices, and added sugars rather than from vegetables, whole grains, beans, and whole fruits. Consider a common American lunch: a sandwich, with a small bag of potato chips, with a cookie for dessert. This is carbohydrates, with a side of carbohydrates, with a dessert of carbohydrates. When we eat too many refined carbohydrates, we can develop "carbohydrate-induced high blood triglyceride levels," basically, fat that can overwhelm the liver and cause it to send these fats into the bloodstream, which, in turn, raises the risk for atherosclerosis, a cardiovascular disease.

Higher levels of triglycerides often go hand-in-hand with low levels of the good cholesterol HDL. Together, they signal a greater risk for developing type 2 diabetes, the adult onset condition that is rampant in many developed countries.

Diabetes affects most every part of our bodies from top to toes. Eyes: diabetes can cause spots, blurry vision, and retinopathy. Brain: diabetes is increasingly seen as a risk factor for dementia and stroke. Kidneys: diabetes is the leading cause of kidney failure. Heart: diabetes doubles the risk of heart attack. Extremities (fingers and toes): diabetes increases risks for numbness, pain, and weakness, peripheral artery disease, and the chances of amputations.

Obesity creates an amazing range of health consequences. Fat around the waist is the most dangerous. But we have to differentiate among subcutaneous fat (just below the surface), visceral fat, and liver fat, the latter two causing greater damage. Visceral fat appears to be more closely linked to type 2 diabetes and coronary heart disease, theoretically because visceral fat cells release fat that goes straight to the liver helping to make the body "resistant" to its own insulin and excess fat in the pancreas helps to make the pancreas produce less insulin. With insulin resistance, our insulin cannot keep up with moving blood sugar into cells and type 2 diabetes results. The relationship to diet in this process is fairly direct. Consuming foods made with saturated fat (e.g., palm oil, butter) rather with polyunsaturated fat (e.g., canola, olive, sunflower oils) produces more visceral fat and liver fat. Fructose (and its dozens of variants with other names) and high-fructose syrups, all found abundantly in so many canned and packaged foods, soft drinks, and snacks, are strongly associated with visceral and liver fat.

Measure your waist size. Place a tape measure around your middle, just above the hipbones. Pull the tape snug, then breathe out, and measure. Just like the advice to stand on scales daily, regularly measuring our waists will help avoid unwanted gains. At least we are less likely to say, "Where did these 10 pounds or two inches come from?"

Carbohydrates account for about half of the calories in a typical American diet, with about two-thirds of these coming from refined grains, added sugars, fruit

juice, and potatoes. Researchers working to lower triglycerides are testing diets where carbohydrates account for only 40% of the diet. The OmniCarb studies with overweight and obese adults have shown that when carbohydrate intake was cut to only 40% of calories, triglycerides fell sharply and HDL rose (https://pubmed.ncbi.nlm.nih.gov/27933186/ and https://www.ahajournals.org/doi/10.1161/circ.127.suppl_12.A016). This reduction to 40% also lowered levels of fructosamine, a marker of blood sugar levels and predictor of type 2 diabetes.

High blood pressure or hypertension affects some 70 million Americans, and is a risk factor for stroke, and heart and kidney disease, if is not controlled. About one of three American adults has high blood pressure, defined as 130/80 or more.

The DASH (Dietary Approaches to Stop Hypertension) Diet was designed to combat high blood pressure, but, because it is a lifestyle change, it can produce positive results in fighting all five features of the metabolic syndrome. Daily recommended consumption is: Grains: 6-8 servings. Vegetables: 4-5 servings. Fruits: 4-5 servings. Nuts, seeds, legumes: 4-5 servings. Dairy 2-3 servings. Lean meat, poultry or fish: less than 6 one-ounce servings. See this NIH link for an extensive analysis of DASH; https://www.nhlbi.nih.gov/health-topics/dash-eating-plan.

The Mediterranean Diet has become almost a generic term for a way of eating healthy foods. It is a plant-based diet rather than meat-based. Its components have been endorsed by the World Health Organization. We have all heard of its benefits and each of us has some concept of what it entails: daily consumption of vegetables, fruits, whole grains, and healthy fats (especially olive oil), with weekly rather than daily consumption of fish, eggs, beans, and poultry. The Mayo Clinic offers a good overview: https://www.mayoclinic.org/healthy-lifestyle/nutrition-and-healthy-eating/in-depth/mediterranean-diet/art-20047801.

Movement and exercise. As soon as someone recommends more "exercise," many of us tune out. Maybe we should discuss Exercise Resistance as well as insulin resistance. What exercise recommenders are basically encouraging is movement. This has become more difficult, admittedly, during COVID-19 induced isolation. Many of us stay in our homes, some before a television or a laptop, not moving for hours. But breaking this sedative habit is essentially important to countering metabolic syndrome.

Movement prompts digestion, circulation, and metabolism, strengthens joints and muscles, and changes stimulation. What I found in visiting Sardinia, a famed Blue Zone for healthy longevity, was not crowds of older adults exercising in public squares but rather older adults enmeshed in activity and movement. They walk to shop, to visit with family and neighbors, and are engaged as part of their communities. Whether up in mountain villages near Nuoro or the Western flatlands around Oristano, older adults were moving. Perhaps as importantly, when they weren't moving, they were often socially engaged having coffee with friends at small shops or visiting with each other in streets or on benches. I was not struck by images of an idyllic paradise, for there's widespread unemployment and youth exodus; but I was impressed by the integration of movement in the daily lives of these older adults.

Movement, as well as seeing a healthcare provider and the aforementioned dietary improvements, are the basics we need to combat metabolic syndrome.

How to Support VCoA

By partnering with VCoA through a financial gift, you increase our capacity to improve the lives of older Virginians. Help us bring our experts into the fields of health care, research, law enforcement, aging services, and more. **Join us today with your gift, large or small.**

Thanks for being a part of our team!

From the Commissioner, Virginia Department for Aging and Rehabilitative Services

By Kelly Wright, RDN, Nutrition Program Coordinator, DARS, Division for Community Living, Office for Aging Services

The Senior Farmers' Market Nutrition Program: Creating a Path to the Governor's Roadmap to End Hunger

What is the Senior Farmers' Market Nutrition Program (SFMNP)? The SFMNP addresses food insecurity by providing low-income seniors with coupons that can be exchanged for fruits, vegetables, and fresh cut herbs at farmers' markets and roadside stands, where authorized farmers sell their goods.

The purposes of the program are to:

- Provide produce to eligible older adults.
- Disseminate nutrition education for older adults.
- Promote and use farmers' markets as a direct marketing outlet for farmers.
- Encourage locally grown, unprocessed, plant-based food.

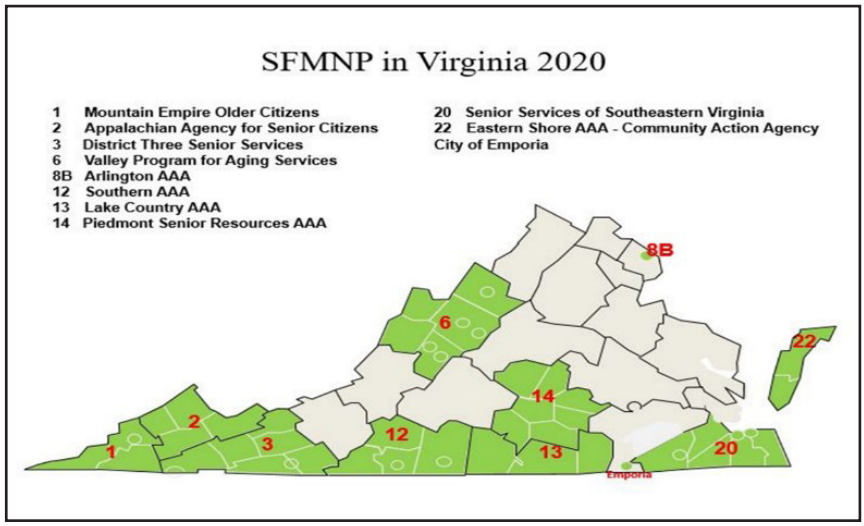
In Virginia, we call this program *Farm Market Fresh*. Virginia's SFMNP began in 2006 as a pilot program, which was offered in select areas of the state with the greatest economic need and a robust farmer's market presence.

Who is eligible? The *Farm Market Fresh* program is for Virginia residents who are 60 years of age or older and are a resident of a locality that participates in the program. Residents must certify that their household income is no more than 150% of the Federal poverty level.

How is a farmer certified? A farmer must meet the following four criteria:

- A person who is authorized under the rules of the SFMNP in Virginia and has a signed Farmer Agreement.
- A resident of Virginia who grows and harvests on land within the Commonwealth of Virginia.
- Annually sells at least $1,000 worth of self-grown "eligible" foods under the *Farm Market Fresh* program.
- A bona fide producer of unprocessed produce offered for sale or exchange for SFMNP checks.

What is provided? Once the local Area Agency on Aging (AAA) approves the one-page application, participants receive a booklet of nine $5.00 checks, ($45.00 worth), per eligible senior for that growing season. The checks may only be used to purchase fresh, locally grown fruit, vegetables, and cut herbs from participating certified retail farmers' market vendors. *Farm Market Fresh* checks must be spent during the months of June through November, depending on availability of produce. The varieties, volume, and quality of available produce may vary depending on the weather and other factors. Nutrition education, provided by the AAAs, is required and includes how to select, store and prepare the foods that participants typically buy at a farmers' market.



The Virginia Department for Aging and Rehabilitative Services - Office for Aging Services (DARS-OAS) partners with the Virginia Department of Agriculture and Consumer

Services (VDACS), ten local AAAs, and one city government (Emporia) to operate the program which is now funded by the US Department of Agriculture, Food and Nutrition Service. DARS also administers the SFMNP's sister program, WIC Farmers' Market Nutrition Program (FMNP), which is offered to Nutrition Program for Women, Infants, and Children (WIC) families with infants four months old to children age five.

Success of the program is measured by coupon redemption rates. In 2020, even amidst the pandemic, the SFMNP utilized 87% of the available food funds, which was a 2% increase from the previous year.

The outcomes included:

- $359,690 infused into the local communities
- 10,282 eligible older adults received checks
- 207 farmers authorized
- 26 new growers
- 62 farmers' markets
- 31 roadside stands

In addition to these measurable successes, there are immeasurable successes, too, such as the creation of new relationships and hubs for community contacts and gatherings. This program supports behavior change among a targeted constituency by offering the value of a product and an opportunity to build relationships with their local farmers.

In 2020, Governor Northam released the Roadmap to End Hunger (RTEH), which is a unified set of goals and strategies to prioritize food security during the current public health emergency and beyond. The RTEH illuminates a pathway to improve food access for all Virginians through programmatic and policy solutions.

Overarching goals and strategies of the RTEH related to SFMNP and the aging population include:

- Increase nutrition support for seniors.
- Grow access to local food for schools and families.
- Encourage food and agriculture investments in food deserts and marginalized communities.
- Support community organizing to combat food insecurity and hunger.

The RTEH's Top Ten by 2025 list related to SFMNP and the aging population includes:

- Virginia Fresh Match and the WIC and Senior Farmers' Market Nutrition Programs will be available at all highly accessible, high-need farmers' markets.
- A framework for incentivizing investment in food deserts and marginalized communities will be established.
- Evidence-based nutrition education programming will be made available to food insecure families in all regions of the Commonwealth.

Virginia has 25 Area Agencies on Aging; however, only 10 agencies participate in the SFMNP due to limited Federal funding. Every year, DARS hears from countless numbers of constituents in underserved areas that want to participate. With State funding support for this program, SFMNP could provide access, equity, and inclusion for all eligible senior Virginians at farmers' markets. SFMNP is well established and has a proven track record of success with its consistently high redemption rates, while providing an integral hub for the community to gather and support each other. To find more information about the program, visit https://vda.virginia.gov/sfmnp.htm.

DARS 2021 Meeting Calendar

The DARS advisory boards meet quarterly and are open to the public. For information, call (804) 662-9333 or visit vda.virginia.gov/boardsandcouncils.htm.

Commonwealth Council on Aging
April 28, July 28, September 22

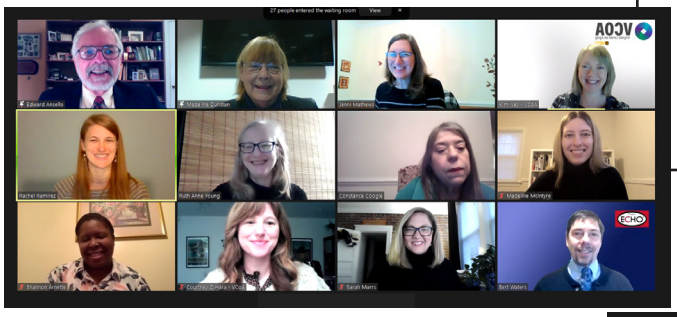
Alzheimer's Disease and Related Disorders Commission
June 8, September 14, December 14

Virginia Public Guardian and Conservator Advisory Board
June 22, September 21, November 9

The Virginia Center on Aging's 35th Annual Legislative Breakfast

VCoA hosted its 35th annual breakfast on January 27, 2021. While we had to meet virtually this year, we were still able to welcome members of the General Assembly, their staffs, the Executive Branch, state departments, Councils, and colleagues in agencies and organizations across Virginia. We had multiple virtual breakout rooms for attendees to discuss our several program areas and research.

VCoA hosts this annual breakfast to inform the General Assembly, which created it in 1978, of progress in meeting our three fundamental mandates: interdisciplinary studies, research, and information and resource sharing. We take this opportunity each January to review our activities in the calendar year just concluded. As has been the case for so long, partnerships with many others enabled us to achieve success in helping older Virginians and their families. VCoA trained, consulted, researched, or collaborated in every region of the Commonwealth in calendar year 2020.



Commonwealth of Virginia

Alzheimer's and Related Diseases Research Award Fund

2019-2020 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 2019-2020 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).

Carilion Clinic — **Azizza Bankole, PhD, Martha Anderson, DNP, and John Lach, PhD**

Implementing a Caregiver-Personalized Automated Non-Pharmacological Intervention System for Dementia-Associated Agitation (CANIS)

These investigators previously demonstrated the ability of the Behavioral and Environmental Sensing and Intervention (BESI) system to detect early-stage agitation and provide automated notifications to dementia caregivers, who could then intervene in a timely manner. Expanding work on individualized interventions tailored to each caregiver's unique set of issues, the current study developed a higher level process of agitation classifications and assessments to train the next computer-generated intervention model, called the Caregiver-Personalized Automated Non-Pharmacological Intervention System (CANIS). Interviews with caregivers revealed that functionality issues included timeliness in notification of approaching agitation and simplicity in selecting descriptive words on the tablet interface. Case study analyses revealed well received intervention suggestions and a decreased number of agitations, confirming that BESI has good value and acceptability. Helpfulness and usefulness of the invested caregivers were discerned thematically. Results support the use of caregiver knowledge and experience to inform further development of a potentially helpful technology. *(Dr. Bankole may be contacted at 540/981-7653, aobankole@carilionclinic.org; Dr. Anderson may be contacted at 540/520-2761, msaconsulting@mail.com; Dr. Lach may be contacted at 434/924-6086, jlach@virginia.edu)*

UVA — **Christopher Deppmann, PhD, and John Lukens, PhD**

Receptor Mediated Death Pathways in Alzheimer's Pathogenesis

Neuronal death is a hallmark of Alzheimer's disease (AD). AD pathology spreads from one brain region to another over the course of decades, yet the mechanism underlying this spreading remains unknown. Necroptosis and extrinsic apoptosis are two cell death pathways that have been implicated; however, their precise contributions to AD pathogenesis and spread have not been elucidated. The investigators delineated the role of these signaling receptors in the AD inflammatory response and the promotion of pathology. They confirmed that caspase-8 is a key regulator of the pro-inflammatory cytokine IL-1β, which induces apoptosis, and a negative regulator of Receptor Interacting Protein Kinase 3 (RIPK3), a key regulator of necroptosis. They also found that loss of caspase-8 led to reductions in neurotoxic amyloid deposition and inflammation via glial cells in AD mouse models. Interestingly, blocking RIPK3 had no comparable influence on AD pathogenesis, suggesting that it is likely affecting AD pathogenesis through pathways that do not involve necroptosis. Overall findings suggest that caspase-8 inhibition may offer a therapeutic strategy to limit neurodegeneration and neuroinflammation in AD. *(Dr. Deppmann may be contacted at deppmann@virginia.edu; Dr.Lukens may be contacted at 434/924-7782, john.lukens@virginia.edu)*

VCU Shenandoah Valley Family Residency Practice — **J. William Kerns, MD, and Jonathan Winter, MD**

Evaluation of the Impact of Race, Payer, and Other Factors on the Changing Management of Dementia Symptoms: High and Low Performing Virginia Nursing Homes Compared

Although use of risky antipsychotic drugs is declining in Virginia long-term-care facilities (LTCFs), prescribing of unreported alternative drugs, such as mood-stabilizers, has increased precipitously. The

investigators compared LTCFs in the highest and lowest quintiles of antipsychotic use and found that higher antipsychotic use was found more predominantly in African American males, rural areas, locales with poorer social determinants of health (SDH), and predominantly publicly owned facilities. An examination of payers in the three highest antipsychotic use quintiles showed that most were in good SDH locales with greater than 95% Caucasian residents, selective admissions, and enhanced nursing, physician, and psychiatric staffing. Qualitatively, the perspectives of facility managers, key clinical personnel, and medical directors revealed that drug use focused on safety and quality of life in patients with dementia. Yet all LTCFs in these quintiles reported more than 20% antipsychotic use. Successful strategies to positive change included individualized non-pharmacologic management of behaviors and the employment of multiple behavioral modalities. *(Dr. Kerns may be contacted at 540/636-2028, bkerns@valleyhealthlink.com and Dr. Winter may be contacted at 540/631-3700, jwinter@valleyhealthlink.com.)*

UVA **Amanda M. Kleiman, MD, and colleagues**

Post-operative Electroencephalographic Changes and Effects on the Incidence of Delirium Following Cardiac Surgery

Sleep impairment, defined as problems falling asleep, staying asleep, reduced rapid eye-movement (REM) sleep and slow wave sleep, and increased non-REM sleep, is prevalent in the post-operative period. It has been implicated in the development of post-operative cognitive dysfunction and delirium, as well as dementia. This study aimed to determine the prevalence and severity of sleep disturbance following cardiac surgery using a single-lead electroencephalograph (EEG) device and sleep questionnaires. Self-reported questionnaire data suggest the post-operative period is associated with a reduction in the perceived amount of sleep. This was associated with post-operative EEG findings of a reduction in sleep quality (reduced deep and REM sleep), as opposed to actual time spent sleeping (light sleep and total sleep) which was increased in the post-operative period. Due to a low sample size and the non-standardized nature of the delirium assessment, poorer self-assessments and lower quality sleep EEG results were only weakly associated with delirium in the intensive care unit. More formalized assessments will be conducted moving forward. This cohort of subjects will ultimately be followed for five years to evaluate the association between EEG changes following surgery and the development of dementia. Results show that sleep is altered post-operatively following cardiac surgery and that this sleep alteration is likely associated with post-operative delirium. They also highlight the potential importance of interventions aimed at reinstating restorative sleep in the post-operative period for cardiac and other surgeries. *(Dr. Kleimann may be contacted at 434/924-2283, ak8zg@virginia.edu)*

VCU **Faika Zanjani, PhD, Jennifer Inker, PhD, and Joann Richardson, PhD**

Health Coaching to Prevent Alzheimer's Disease

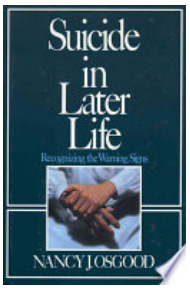
Behavior change health coaching is an underutilized strategy for AD prevention. Targeting AD prevention factors (e.g., alcohol, depression, physical inactivity, smoking, isolation, medication management) is extremely challenging for multiple reasons, including the failure in making the connection between AD and health behaviors, and due to motivational, self-efficacy, and knowledge barriers. Connecting health behaviors to AD can be psychologically beneficial, motivating, and programmatically supportive. To improve AD risk factors, the investigators recruited 20 diverse older adults (aged 60+) with incomes below $12,000/year who were managing diabetes and/or cardiovascular disease as part of the iCubed Health and Wellness in Aging Population Core. A patient preference behavior change health coaching strategy was used, where the person decides on health goals, and is offered health coaching education, motivation, self-efficacy, and referral support targeting AD risk factors. Ninety-five percent of those recruited participated in the health coaching. They all rated their health coaching experience as positive, and reported improvement in health and healthy behaviors. There were also improvements in AD lifestyle risk, AD knowledge, and cognitive function. These findings demonstrate that telephone-based health coaching is feasible (based on participant engagement) and beneficial (based on positive trends in reducing AD risk factors). *(Dr. Zanjani may be contacted at 804/828-0670, fzanjani@vcu.edu; Dr. Inker may be contact at 804/828-0670, inkerjl@vcu.edu; Dr. Richardson may be contacted at 804/828-1948, jtrichar@vcu.edu)*

In Memoriam: Nancy Jean Osgood, PhD

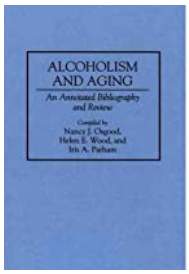
By Constance L. Coogle, PhD, VCoA

The aging community lost one of its brightest scholars February 11, 2021.

Nancy Jean Osgood, PhD, cultivated a stellar international reputation for her ground-breaking work in suicidology. Our paths crossed in the late '80s when she asked me to analyze some data she had obtained from the Commonwealth's Violent Death Reporting System. Our results confirmed the growing body of knowledge that older men have significantly higher suicide rates than any other demographic group.



In the span of six short years, Nancy established herself as the go-to authority on late-life suicide; first through an annotated bibliography and review, then with the first large-scale study of suicide by institutionalized older adults, and culminating in her landmark book, *Suicide in Later Life: Recognizing the Warning Signs*. Some of Nancy's work focused particularly on abuse and suicidal issues in older women, but her passions were broad and included dance movement therapy, successful retirement, and pet therapy.



Most of my partnerships with her concerned alcohol abuse disorders. I learned of a grant she had received from the US Administration on Aging (now the Administration on Community Living) and offered to help her with the first statewide detection and prevention program on geriatric alcoholism. My master's thesis explored the neurophysiology of addiction, so it was a good match and "the beginning of a beautiful friendship." I rapidly digested her book, *Alcoholism and Aging: An Annotated Bibliography and Review* until I felt a mastery of the topic. She and I represented the Gerontological Society of America in helping to develop the *Get Connected Toolkit* from the Older Americans Substance Abuse and Mental Health Technical Assistance Center, which is still available from the Substance Abuse and Mental Health Services Administration. Nancy inspired me. I later went on to train Virginia's aging and psychological service providers to establish linkages that would better help older adults in need of medication, alcohol, and mental health resources. But it all began with Nancy!

We collaborated in writing many grant applications, articles, and even a chapter in a book she edited. Then there were the car trips that we took together, mostly to DC and Maryland, to consult on related projects. Once, we mistakenly went south on I-95 and didn't realize it until we reached Chester, many miles in the wrong direction. All because Nancy was such an engaging conversationalist.

Nancy was pleasantly complex. Most people didn't know that she played the piano and clarinet. She and her husband, Ray, had quite a collection of parakeets and parrots (even a Macaw) that she used in her pet therapy at senior housing sites. Once, Nancy told me one of my favorite anecdotes. You see, one of her parrots used to call for her husband all the time and Nancy would tell him, "Ray's not home"; that was until two of the parrots started conversing, and one would answer the other's call himself with "Ray's not home."

Nancy was quite health conscious. Because we were both proponents of the behavioral substitution approach to addiction, we created the *More Life to Live* training manual, brochure, and video on gambling problems in older adults as resources brimming with information about healthy aging. That was about the time that she started wearing five-pound weighted shoes to strengthen her calves and practicing Zen in Japanese soaking tubs, in Japan no less.

So, we are without her incomparable spirit and the world is a poorer place. But, oh, what a gift to the heavens she is now!

Civil Money Penalty Reinvestment Funds in Virginia Help Protect and Improve Quality of Care for Nursing Facility Residents

By Evelyn Hardwick and Courtney Richter, MSW; CMP Reinvestment Program Analysts, Virginia Department of Medical Assistance Services

The Civil Monetary Penalty (CMP) Reinvestment Fund is a federal fund created by collecting penalties imposed on nursing facilities deemed non-compliant with one or more Medicare or Medicaid participation requirements. States reinvest these funds through special projects to help protect and improve nursing facility residents' quality of care. Utilizing CMP Reinvestment Funds provides a unique opportunity to improve the lives of many residents of nursing facilities across the Commonwealth.

In Virginia, the Reinvestment Funds are appropriated by the General Assembly and administered by the Department of Medical Assistance Services (DMAS). Through an annual application, submission, and review process, DMAS identifies projects that will move forward to the Centers for Medicare & Medicaid Services (CMS) for consideration. If approved by CMS, DMAS oversees project progress by reviewing the quarterly and final program and financial reports. Previous projects and proposals have helped to benefit the staff and service delivery in nursing facilities. They have informed recommendations for improving how the Commonwealth provides services and supports for residents of nursing facilities.

One such project is the **Person-Centered Trauma-Informed Care Training** project that concluded on schedule in November of 2019. For this project, DMAS contracted with the VCU Department of Gerontology. VCU recruited four nursing facilities to design trauma-resilience training for certified nurse aides (CNAs). Fifty-four CNAs participated in nine training sessions on trauma-informed care. Ninety-five interdisciplinary team members from 21 nursing facilities participated in online or in-person training using the trauma-informed training curriculum. Follow up surveys of participants indicated significant increases in knowledge, confidence, and application of concepts. Through testimonials, participants expressed intent to make behavior and service delivery changes that will encourage trauma-informed care within facilities in the Commonwealth.

The **Advanced Nurse Aide Revitalization Project for Rockingham County**, a three-year project, led by LeadingAge Virginia, is creating and delivering a curriculum for advanced certification CNAs. Not only will CNAs learn additional skills to improve the care and well-being of nursing facility residents, but also the certification creates a career path and advancement ladder that will lead to staff retention and decrease burnout among CNAs. The four units of the curriculum include Leadership and Mentoring Skills; Care of the Resident with Cognitive Impairment; Restorative Care; and Wound Care. The Virginia Board of Nursing approved the curriculum, and the Blue Ridge Community College is offering the course. The course start date was delayed due to COVID-19 but is now expected to begin in March of 2021.

DMAS contracted with Riverside Center for Excellence in Aging and Lifelong Health (CEALH) to conduct the **Restorative Sleep Program** over two years. The program focuses on creating a positive nighttime environment by addressing common sleep disturbances. A consultant provides education and training on sleep disturbances, their effects, and methods to manage them. Workshops facilitated by the consultant are open to other nursing facilities, while CMP Reinvestment funds are used to implement changes in two facilities. The project hosted three of the four planned workshops, but COVID-19 prevented the fourth workshop from occurring. And implementation in the facilities was also delayed. Thus, Riverside CEALH signed an amended agreement with DMAS to continue their work through December 31, 2020.

The **Reducing Preventable Rehospitalizations** project from the Virginia Health Care Association (VHCA) provides a series of statewide training

sessions conducted by Pathway Health through which providers receive training on the INTERACT® Quality Improvement Program and Tools. These tools intend to coordinate communication between nursing facilities and hospitals to elevate the overall quality of care for residents within Virginia's nursing facilities by reducing preventable hospital readmissions. In 2020, VHCA planned to invite all licensed nursing facilities and hospitals that participated in the first-year training sessions to attend the second round of training days. These sessions will bring acute and post-acute providers together to use data, and for collaboration between care settings to continue to reduce preventable rehospitalizations. COVID-19 interrupted the project's training schedule, and a signed amendment agreement with DMAS will continue their work through June 30, 2021.

The components of the **Holistic Wellness** project, led by Birmingham Green, involve a two-pronged approach: 1) An education component that offers the person-centered Eden Alternative training to team members, and 2) an engagement component, the Birdsong Initiative: a program for residents utilizing personalized person-centered and user-friendly computer tablets. The Birdsong Initiative began its second phase in January 2020, offering tablets to a new set of residents, but experienced interruptions due to COVID-19. A three-day Eden Alternative Training for staff members occurred as scheduled in early March, but ongoing training is on hold.

DMAS contracted with George Mason University (GMU) for a three year **Music and Memory Initiative** project to implement and sustain a person-centered, non-pharmacological intervention (MUSIC & MEMORY®) for Virginia nursing facility residents with dementia that will positively affect behavior and stimulate emotions. Continuous, web-based, micro-learning modules help staff who closely interact with the residents to understand the value of personalized music and how and when to use it. As facilities have entered the project on a rolling basis, the project has concluded data collection in some facilities and is working to recruit new facilities into the project. In other facilities, the intervention is on hold due to COVID-19 visitor restrictions.

VOHRA Wound Physicians successfully completed their project, **Virginia Wound Care Excellence Program for Certified Nursing Facilities**, on schedule at the end of June 2020. This project focused on wound care, which is a major challenge within nursing facilities, causing significant expense, and decreasing the quality of life of residents. The project curriculum was comprised of eleven courses, downloadable study guides, and a certifying final exam. The project met its goal by virtually educating and certifying 150 nurses in wound care. After completion of the program, the number of long-stay residents with pressure ulcers dropped by 43% in participating facilities.

For the **Peer Mentoring Program at Westminster-Canterbury of Lynchburg**, the facility is working with a consultant, PHI, to develop a curriculum for a Peer Mentoring Program designed to advance a culture of Person Directed Living (PDL). This curriculum will provide peer mentors with the resources needed to train, guide, coach, and assist CNAs within the household utilizing person-directed practices. Implementation of the project consists of program management, an advisory committee, a planning phase, an implementation phase, and a final report. The consultant is continuing to work on curriculum development, but the program team's bi-weekly meetings focusing on implementation are on hold due to COVID-19.

In 2020, these ongoing projects, funded in previous cycles, continued to operate on schedule until the onset of COVID-19 when, as highlighted in the project overviews, the majority of projects experienced pandemic-related interruptions to project activities. The regular annual cycle for DMAS to solicit new projects was also postponed mid-process as a result of the pandemic. However, the use of CMP Reinvestment Funds to improve the quality of life of residents in facilities persisted throughout the pandemic through two initiatives launched by CMS and administered by DMAS.

The first initiative permitted facilities to apply for CMP Reinvestment Funds to purchase communicative technology and issued guidance for infection control and prevention of COVID-19. Nursing facilities could request up to $3,000 in CMP funds per

facility to purchase devices such as tablets and related accessories for residents to share. The technology allows residents of nursing facilities to communicate with their families and to attend telehealth visits with outside providers. DMAS used CMP Reinvestment Funds to provide residents of 195 nursing facilities in the Commonwealth with communicative technology. The DMAS CMP-RP team received reports of many positive outcomes. Several staff members of facilities expressed that the communicative technology had positive effects on residents. They shared stories of the excitement felt by residents when they were able to reconnect with family members. In some instances, the technology brought together residents and families that had not been able to visit with each other even before the pandemic.

Then, in the fall of 2020, CMS introduced the In-Person Visitation Aid initiative, allowing states to use CMP Reinvestment Funds to help facilitate in-person visitation between residents and their loved ones. The tents for outdoor visitation and clear dividers (e.g., Plexiglas or similar product) that facilities could now purchase with CMP Reinvestment Funds created a physical barrier to reduce the risk of transmission during in-person visits. This has meant that many residents have been able to safely meet face-to-face with family members they have not seen in the months since the pandemic began. Funding for tents and clear dividers are limited to a maximum of $3,000 per facility. As of this writing, DMAS has approved 122 facilities for In-Person Visitation Aids.

CMS gave authority to DMAS to approve applications for communicative technology and in-person visitation aids in order to expedite the receipt of funds by nursing facilities. Just like any CMP Reinvestment project, the state is responsible for accepting applications, determining eligibility, and issuing funds for these initiatives. DMAS is also responsible for accounting and reporting to CMS at the beginning of the calendar year the use of funds for both the special initiatives and the regularly funded projects.

The CMP Reinvestment Fund application cycle for State Fiscal Year (SFY) 2022 opens in February of 2021. DMAS will return to accepting applications for funding for up to three years for projects that directly benefit individuals residing in nursing facilities in the Commonwealth. Information on previously funded projects can be found under the Civil Money Penalty tab of the Long Term Care section of the DMAS website.

The SFY 2022 cycle will follow the same timeline as previous years, with the required Cover Sheet accepted during the month of February and Formal Applications accepted during the month of March. Projects that obtain DMAS and CMS approval are expected to start July 1, 2021. For the Cover Sheet template, Application template, and Application Guidelines, please refer to the CMP-RP webpage mentioned above. The official Request for Applications (RFA) can be found at https://www.dmas.virginia.gov/#/procurement. Applications and Cover Sheets submitted during the postponed SFY 2021 will be considered alongside all new applications. DMAS will outreach to applicants from the SFY 2021 to offer them the opportunity to modify their requests.

The Division for Aging and Disability Services at the Department of Medical Assistance Services administers the CMP Reinvestment Program. Terry Smith is the Division Director and Tim Catherman is the Program Manager; Courtney Richter and Evelyn Hardwick are the CMP Reinvestment Program Analysts to whom you may direct further questions.

The CMP Reinvestment Team at DMAS is excited to hear from you and welcomes inquiries about previous and prospective projects that help protect and improve the quality of care for Virginia's nursing facility residents. You may reach the CMP Reinvestment Team at cmpfunds@dmas.virginia.gov or (804) 225-4218.

Visit Our Websites

VCoA: vcoa.chp.vcu.edu

DARS: www.vadars.org

Calendar of Events

April 20, 2021
Hope for the Caregiver. Webinar presented by Aging Together in partnership with the Piedmont Dementia Education Committee. 10:30 a.m. - noon.

April 20-23, 2021
Aging Better Together: Building an Inclusive Aging Community. 42nd Annual Meeting and Conference of the Southern Gerontological Society. Virtual event.

April 22, 2021
My Care, My Choice: Tools to Help You Have a Say in Your Care if You Can't Speak for Yourself. Webinar presented by Honoring Choices Virginia. 10:30 a.m. - 12:00 p.m.

April 27, 2021
Dementia Friends Virtual Training. Presented by Aging Together in partnership with the Piedmont Dementia Education Committee, Leading Age, and Dementia Friends Virginia. 10:30 a.m. - 11:30 a.m.

April 27-29, 2021
Virtual Aging Policy and Advocacy Summit. Presented by the National Association of Area Agencies on Aging.

May 6, 2021
4th Annual Older Adult Mental Health Awareness Day Symposium. Presented by the National Council on Aging. 10:00 a.m. - 5:00 p.m. Free, virtual event.

May 7, 2021
Lifelong Learning Institute in Chesterfield's online course calendar available. Summer Session runs from May 10-July 30.

May 13, 20, and 27, 2021
2021 Virginia Association for Home Care and Hospice Leadership Conference: Three Part Virtual Event. Session 1, May 13th: Coaching Skills for Leaders. 10:00 a.m. - 11:00 a.m. Session 2, May 20th: Surviving and Thriving in Chaos and Crisis, 10:00 a.m. - 11:00 a.m. Session 3, May 27th: Creating Drama Free Teams That Get Results, 10:00 a.m. - 11:00 a.m.

May 13-15, 2021
American Geriatrics Society's 2021 Virtual Annual Scientific Meeting. Pre-conference day: May 12th.

May 24, 2021
Virginia Governor's Conference on Aging. Virtual, multi-day event to be held the week of May 24th.

June 7-10, 2021
Age+Action 2021 Virtual Conference. Presented by the National Council on Aging.

June 8-10, 2021
Forward: 2021 Annual Conference Virtual Experience. Presented by LeadingAge Virginia.

June 14-17, 2021
2021 Annual Research Meeting: Leading with Evidence in a Time of Change. Virtual event presented by AcademyHealth.

June 28-30, 2021
Virginia Assisted Living 2021 Summer Conference. The Hotel Roanoke & Conference Center, Roanoke.

July 31 - August 1, 2020
Virtual 139th Annual Convention of the Virginia Pharmacists Association.

Age in Action
Volume 36 Number 2: Spring 2021

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.

Summer 2021 Issue Deadline for Submissions: June 15, 2021

Virginia Center on Aging

at Virginia Commonwealth University, Richmond, Virginia
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Richmond Police Department's TRIAD Program

The goal of TRIAD is to reduce the fear of crime and victimization among older adults by increasing awareness of scams and frauds targeting them, strengthening communication between the law enforcement and senior communities, and educating seniors on local and state resources that are available in their community.

Richmond TRIAD's monthly meetings: 2nd Tuesday of each month, 10:00 a.m. via Zoom
Upcoming Meetings: May 11, June 8, July 13
No cost

Interested older adults may email RPDCares@richmondgov.com for more information and to request the meeting link.

age in action

Thanks for reading our Spring 2021 issue!

VCU

VCOA Virginia Center on Aging VCU

DARS Virginia Department for Aging and Rehabilitative Services