

Case Study

A Multifaceted Approach to Address Food Insecurity in Urban Dwelling Older Adults

By Ana Diallo, PhD, MPH, RN, and Katherine Falls, MSN, RN

Educational Objectives

1. Identify and discuss concepts of food insecurity as a social determinant of health in older adults.
2. Explain the health benefits of participation in a nutrition initiative, Healthy Meals Program, to address food insecurity among low-income older adults living in an urban food desert.
3. Describe the use of motivational interviewing and goal setting techniques for nutrition-related behavior in the management of chronic disease.
4. Summarize the lessons learned and implications for clinical practice.

Background

The World Health Organization defines social determinants of health as factors that impact one's health based on the person's age, where the person was born, raised, or lives (WHO, 2018). Food insecurity, the inability to access enough food to maintain an active and healthy life, affects almost 5.5 million individuals aged 60 and older (Ziliak & Gundersen, 2019). Older adults who are food insecure are at greater risk of chronic diseases including diabetes, cardiovascular diseases, dementia, and depression (Leigh-Hunt et al., 2017; Jackson, Branscum, Tang, & Smit, 2019). For these reasons, food insecurity is considered a social determinant of health. Functional

impairment in older adults also compromises their ability to access, prepare, and consume adequate amounts of nutritious food, which in turn increases the inability to maintain activities of daily living (Jackson, Branscum, Tang, & Smit, 2019). However, older adults in the U.S. wish to live independently in their homes for as long as possible, a phenomenon known as aging in place (Federal Interagency Forum on Aging-Related Statistics, 2016).

While aging in place promotes overall health benefits, disparities in the welfare of older adults based on race, ethnicity, and socio-economic status negatively affect the ability to maintain a safe and healthy life. Low income older adults living in an urban setting face the high burden of social vulnerability due to limited public transportation, uneven sidewalks, increased vehicle traffic, greater numbers of fast food restaurants, and limited access to grocery stores selling nutritious food, the latter called living in food desert areas (Vaccaro & Huffman, 2017). In order to optimize health outcomes, and support older adults aging in place, a number of academic and clinical faculty partnered with community agencies to create the Richmond Health and Wellness Program (RHWP), an interprofessional health and wellness program that provides onsite health promotion, prevention services, and coordination of care. Parsons, Slattum & Bleich (2019) have published a detailed

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description of RHWP.

RHWP currently operates in five low-income, HUD rental assistance buildings in Richmond. An estimated 20% of Richmond residents live in food desert neighborhoods due to socio-economic and health disparities, coupled with geographical and transportation barriers to accessing nutritious food (Food Policy Task Force., 2013). Urban food deserts in Richmond are characterized by limited retail stores selling nutritious food, including high-priced cornerstone markets and convenience stores. Additionally, changes to the bus system routes and schedules have exacerbated the difficulty that older adults have in accessing affordable, nutritious food.

During RHWP clinics and home visits, residents reported having not enough money available to buy food, especially near the end of the month. During home visits, some residents had empty refrigerators; this was mainly the case of individuals with limited physical abilities to prepare their own meals due to functional impairment. In response, RHWP faculty created a partnership with a local health insurance company, United Healthcare, and the region's food-bank, FeedMore, to establish the Healthy Meal program (HMP). The initial pilot phase of this partnership resulted in 1,682 meals served to 339 residents at three low-income housing buildings serving older adults and individuals with disabilities. Outcome measures for the initial pilot included number of individuals assessed for food insecurity, referrals to food assistance programs, social isolation, changes in dietary intake, and satisfaction.

The Healthy Meal Program



Going in its fifth year, HMP has become a multifaceted program that measures the prevalence of food insecurity among the older adults served by RHWP and intervenes where needed. The HMP has four main components: 1) weekly congregate meals provided by FeedMore; 2) screening and referrals to community and federally funded resources; 3) Shalom Farms' mobile market, and 4) kitchen clinic. The congregate

meals, which were the first part of the HMP program, provide a healthy, hot meal to participants once a week during RHWP clinic hours. FeedMore prepares and delivers these to the RHWP sites. The congregate meals are intended to address food insecurity and social isolation by offering a free meal to residents and encouraging them to discuss healthy food choices through group education sessions, as well as by being an opportunity to screen for food insecurity.

Screening for food insecurity is accomplished by evidence-based surveys, including the USDA Six-Item Short Form (United States Department of Agriculture and Service, 2012). Food insecure participants or individuals at-risk of food insecurity are referred to resources such as the Supplemental Nutrition Assistance Program (SNAP), USDA Commodity Supplemental Food Program, and Meals on Wheels. Participants needing emergency food access are referred to FeedMore and local food pantries.

In addition, the HMP partners with Shalom Farms, a local non-profit whose mission is to work with communities to provide access to healthy vegetables grown at their farms. Shalom Farms brings their mobile market filled with vegetables to three of the five buildings where RHWP conducts weekly clinics. The mobile market has enabled residents to purchase fresh vegetables on a weekly basis at affordable prices. Partnership with Shalom Farms also includes the "Kitchen Clinic," an eight-week program that offers HMP's participants "hands on" experience cooking fresh vegetables. The weekly classes enable participants to learn new recipes that focus on low salt, sugar, and fat. The goal of the Kitchen Clinic is to increase consumption of fresh produce, while offering an opportunity for older adults to engage with one another, sharing similar needs and experiences. Each cooking session ends with participants enjoying what they have made together. Participants also receive a bag of fresh produce, at no cost, to encourage them to prepare the same recipe during the week.

HMP Participants

HMP participants are low-income older adults residing in four of five RHWP sites. They are older adults or individuals with disabilities, ranging in age from 45-94 years old. A majority of the participants (81%)

is African American, 60% are female, and about 33% did not complete high school. Most live below the poverty level, and 42% live on less than \$1,000 a month. The most prevalent chronic diseases include hypertension, diabetes, obesity, cardiovascular disease, and chronic obstructive pulmonary diseases.

HMP Outcomes

As of December 2019, the HMP has delivered 7,122 meals weekly and has referred 230 food insecure older adults to different local community-based social services (Diallo et al., 2020). Participants have stated that the improved access to fresh vegetables has helped increase their weekly consumption of vegetables and enhanced their quality of life. Participants have also said that the Kitchen Clinics have both provided opportunities for social interaction and supported their efforts to consume more vegetables.

Building Trust through Motivational Interviewing

HMP faculty use a collaboration approach to engage participants in addressing and establishing nutrition related behavior. This collaboration can last several weeks to months as the faculty and participant build a trusting relationship. Motivational interviewing and goal setting techniques are used to ensure a relationship based on collaboration, mutual trust, and respect. Motivational interviewing is a psychotherapeutic approach that helps individuals identify and work through their ambivalence about behavior change. Based on a person-centered principle, motivational interviewing allows the health professional to support the individual by tailoring the encounter to match the individual's level of readiness to change, the identified pros and cons of change, and level of efficacy to change behavior (Miller & Rollnick, 1996). The encounter between the individual and health professional is marked by a positive, encouraging, empathetic, and non-confrontational tone that promotes individual introspection, awareness of internal and external factors associated with a behavior, and building self-efficacy. Techniques used by HMP faculty include reflective communication and eliciting self-motivational statements (Miller & Rollnick, 1996).

Research suggests that using motivational interviewing and goal setting to manage diet significantly

increases fruit and vegetable intake (Resnicow et al., 2001). Participants meet with a health professional faculty member (nurse, nurse practitioner, or nutritionist) to discuss nutrition behaviors. This allows HMP faculty to tailor nutrition education through motivational interviewing (MI) wherein participant and interviewer discuss perceived barriers and motivators related to nutritional behaviors. Each encounter concludes with the participant establishing SMART (Specific, Measurable, Achievable, Realistic/Relevant, and Timed) goals related to his/her dietary intake and nutritional behaviors.

Using motivational interviewing also helps uncover underlying clinical and non-clinical factors that mitigate the access, preparation, and consumption of adequate nutritious food. The most frequent clinical factors have been found to be polypharmacy, decline in cognitive function such as memory loss, poor oral health, impaired swallowing, and frailty. Non-clinical factors are mainly associated with the environmental setting and socio-economic status, such as limited money, easier access to stores selling low-quality diets, lack of transportation, and social isolation. Supporting the participant to address and manage these factors is critical for breaking the cycle of food insecurity that leads to worse clinical outcomes. Accordingly, interventions are tailored to the individual's needs and could vary. These might be creating a daily food log, helping participants make healthy choices given what is available and realistic for them, and making referrals to community-based food resources or legal services. Participants are rescreened every year or more frequently if there is a change in health status such as significant weight loss, multiple falls, or a new diagnosis.

Sustainability of the Program through a Strong Academic-Community Partnership

Sustainable behavioral change and optimal self-management are vital tenets of care management of complex diseases (Napoles et al., 2017). As noted, food insecurity and healthy diet are environmentally and socio-economically driven conditions. Therefore, management of the diet-related chronic diseases must require social and behavioral interventions beyond the clinical settings. Integrating partnerships with local agencies and organizations reinforces the idea

that change must occur at a grassroots level and emphasizes the importance of community collaboration to address health issues.

Identifying and establishing collaborations with local organizations around a common interest to serve vulnerable residents creates a safe network for older adults. Collaboration with local organizations such as United HealthCare, FeedMore, and Shalom Farms has given participants in HMP access to local agencies addressing food insecurity, wellness, and access to fresh produce at low costs. The Kitchen Clinic supplies hands-on experiences that increase nutrition-related knowledge and self-efficacy to prepare and consume fresh vegetables. With individuals residing in food deserts, it is fundamental to provide not only access to resources, but also education on how to incorporate healthy foods, such as fresh vegetables, in their daily diet. Participants were able to learn about healthy foods and gain an understanding of the significance of healthy food in managing their health and wellness. HMP faculty and Shalom Farms representatives also learned from the participants. Their feedback helped tailored cooking sessions and recipes as well as the nutrition education sessions.

Case Study #1

Mr. RH is a 71-year-old male with multiple chronic diseases, including atrial fibrillation, coronary artery diseases, congestive heart failure, chronic obstructive pulmonary disease, chronic pain, type 2 diabetes mellitus, hepatitis C, cataracts, and obesity. He has had stints placed three times. After losing his wife to cancer, Mr. RH lives alone in a federally subsidized, senior apartment building in an urban setting that is considered a food desert. There is a 7-11 convenience store next door and a Kroger Grocery one mile away. Getting to Kroger requires crossing two major streets with significant traffic. Mr. RH mainly eats in fast food restaurants within walking distance.

When we first started seeing Mr. RH, his breakfast would consist of a sausage roll and soda from 7-11. At that time, he cooked very little and did not understand the correlation between his food choices and the self-management of his chronic diseases. His weight was 235 pounds, fasting blood sugar was 160-220, and post prandial blood glucose was 200-300.

When he came to have his blood sugar checked in the morning, he began to see that his nighttime snacks of cookies and cupcakes were negatively affecting his morning sugars. We realized that most of his food was being purchased at 7-11, and he was eating high sugar foods in the evening because he was afraid of his sugar decreasing during the night. He shared that after his wife died, it is hard for him to sleep alone. Dying alone in his apartment is one of his biggest worries and concerns. After understanding this as a motivating factor affecting his behavior, we went to 7-11 with him and found snacks that would satisfy his desire to have a bedtime snack, without adversely affecting his blood sugar.

Mr. RH lives in a food desert where the availability of fast and convenient foods has been an easy option when making choices for daily living. As he learned to live independently, he originally chose the food that was most easily accessible to him. Unfortunately, these foods increased his blood sugar, and his weight, negatively impacted his cardiac disease, exacerbated his liver disease, and has made it more difficult to manage his chronic pain caused by osteoarthritis. Over time, using motivational interviewing, we have ascertained his capacity to make change, the foods that he is willing to eat based on his life experience, and his ability to prepare his own food. Living on a limited income means that managing his finances is extremely important so that he can afford the food necessary to make meaningful change in his health outcomes. Using nutrition education, understanding the resources available in his community, and meeting Mr. RH where he was, we are helping him make changes to his diet. As a result, he has lost 30 pounds, his hemoglobin A1C is between 6-7, and he is better able to manage his chronic pain.

Case Study #2

Mr. JB is a 76-year-old male with a past medical history of pancreatitis, chronic obstructive pulmonary disease, hypertension, type 2 diabetes mellitus, neuropathy, and coronary artery diseases. He lives independently in a low-income, federally subsidized apartment building in an urban area designated as a food desert. Mr. JB uses a walker and reportedly is able to manage all of his activities of daily life independently. He is clean and neatly dressed. He came

to clinic during the middle of the month and shared with his provider that he was out of food. He said he literally had nothing in his apartment to eat. He said he was out of money and would not have money to go grocery shopping again for two weeks. We helped him call the hunger help line and found a food pantry that was open that day. Luckily, they delivered it to him that afternoon, for he had no money for bus fare to get to them to pick it up.

One month later, he returned to clinic reporting being out of money and had no food since the middle of the month. At this point, we noticed that he had lost weight and we became worried. Though we inquired about why he was running out of money, he was not forthcoming with what was happening. We helped him find food resources such as the food commodity boxes that the building gets from FeedMore and educated him about the food pantries in the area. The question remained, “Why is he running out of money?” The next time we saw him he had lost more weight and reported that he had fallen while walking to the grocery store a mile away. He went to the ER and denied any broken bones but was experiencing increased back pain. He began taking opioids for the pain and his substance use disorder began to spiral out of control.

Using motivational interviewing, we learned that his Social Security check was being garnished because of an erroneous veterans benefit that he had been given five years ago. We connected him with a *pro bono* attorney who helped him work out his legal obligation to repay the VA over a longer period of time so that he would have more money each month to pay for necessities like food. This negative trajectory of unintentional weight loss, increased frailty, a fall, and subsequently rebounding into an old opioid addiction, was a result of food insecurity in a person who did not have the means to navigate his financial and legal issues. This difficult situation was complicated by his physical limitations, and his living in a food desert that made his access to healthy food even more difficult.

Conclusion

Participants continue to express gratitude and share the significant effect of the HMP nutrition program

on their overall health. The faculty-participant encounters are tailored to the socio-economic and environmental constructs that define the individual’s life and health. Employing motivational interviewing and goal setting techniques helps RHWP faculty support participants while they develop knowledge and skills to navigate an environment that is not conducive to healthy eating as they age in place.

Over the last decade, the growing recognition of the role of social determinants of health, such as food insecurity, on the individual’s health has led healthcare systems and providers to integrate care coordination approaches to connect low-income older adults at risk for food insecurity to social services. As providers and health systems are recognizing the role of social determinants of health in healthcare management, it is important to develop communication techniques to identify individual’s needs that reflect the social and environmental factors that define the person’s life and health. While we are capturing promising qualitative and quantitative data on the benefits of the different HMP interventions on the participants’ health and wellbeing, more evidence is needed to demonstrate the value of such programs in a sustainable way. We believe the HMP provides important insights into how to integrate community-based social services to address food insecurity for vulnerable older adults.

Study Questions

1. Identify and explain at least two health-related benefits of participating in the HMP.
2. Describe the approach used to help participants uncover the underlying issues that increase their risk for being food insecure.
3. How does motivational interviewing and goal-setting contribute to addressing food insecurity in older adults?
4. What implications for clinical practice does awareness of food deserts offer?

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From the Director, Virginia Center on Aging

By Edward F. Ansello, Ph.D.

Ageism in the Age of COVID-19

If ageism includes the less preferential or more harmful treatment of individuals because of their older age, the COVID-19 pandemic has brought it into sharper focus. If one cares to look.

At present, about three quarters of the deaths attributable to COVID-19 are among older adults, according to the CDC. Their greater vulnerability because of intrinsic causes such as the presence of existing illnesses, co-morbidities, and frailty are major causes. But so, too, are other extrinsic causes, conditions outside of the disease's victims. These include social determinants of health like where one lives, access to transportation and health care, economic stability, educational opportunities, and racial segregation. (See Healthy People 2020 for a fuller exploration: www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources)

Other extrinsic contributors include a too-common cultural underlayment of bias against growing older and, in effect, against older adults. The COVID-19 pandemic has released, for some people, the politically correct restraints customarily imposed on overt ageism. The worst of social media contains references to this deadly virus as a Boomer Remover.

The Decline Narrative of aging refers broadly to the assumption that individuals grow less important, contribute less to societal functioning, and deteriorate to decay with advancing age, say 65 or 70 years old. The Narrative is older than Shakespeare's *Seven Ages of Man* soliloquy that ends with "Last scene of all, that ends this strange eventful history, is second childishness and mere oblivion, sans teeth, sans eyes, sans taste, sans everything."

Practical implications of this biased assumption during this pandemic translate to triaging our focus, resources, and treatments to make older adults last in priority. It's no coincidence that older adults, especially residents of long-term care facilities, account for such a huge percent of deaths related to COVID-19.

The *New York Times* reported on May 11, 2020 (lifetimes ago in COVID-19 calculus) that, while only 10 percent of the country's cases have occurred in long-term care facilities, deaths related to COVID-19 in these facilities account for more than a third of the country's pandemic fatalities. "In 10 states, the number of residents and workers who have died accounts for half or more than half of all deaths from the virus." Long-term care facilities were often at the back of the line in receiving Personal Protective Equipment (PPEs) from government sources. Very scarce resources were prioritized for acute care. Inadequate numbers of PPEs, close confinement, and concentrations of already vulnerable residents made for a deadly mix. Tragically, the Decline Narrative can affect not only older adults but also those of us who care for them.

Louise Aronson, geriatrician at UCSF, asks us in a thoughtful essay in *The Atlantic* (March 28, 2020) to imagine how much different the political and medical responses to COVID-19 would be if the pandemic were killing mostly young people, for instance, middle schoolers, rather than older adults.

Ageism is baked into our health care system, she notes.

American medicine lumps elders in with adults, despite plentiful evidence that drugs and diseases behave differently in older bodies. "Atypical presentations" of illnesses and of responses to medicine are common in older adults, wherein the traditional core features of an illness are missing, for example having a fever without having a high temperature, or having adverse drug reactions to a medicine or greater sensitivity to its intended effects that are not seen when the person taking the medicine is younger.

Aronson anticipated the more deadly impact of COVID-19 on older adults, and ascribes contributing factors. "Medical schools devote months to teaching students about child physiology and disease, and years to adults, but just weeks to elders; geriatrics

doesn't even appear on the menu of required training. The National Institutes of Health mandated the inclusion of women and people of color in medical research in 1986, but it didn't issue a similar mandate for elders until 33 years later, in 2019."

I spent six years traveling with Remington Award winning professor of pharmacy Dr. Peter Lamy in our rural geropharmacy training projects; I heard him lament repeatedly that older adults were rarely, if ever, included in the clinical trials of would-be prescription drugs, even though older adults account for the greatest use of so many of them. Instead, assumed effectiveness and dosage efficacy were "extrapolated" statistically from data on younger adults. Companies opted not to spend time or money securing older adults for these tests.

People age 65 and older are at higher risk for COVID-19, declares a June 29, 2020 report from AARP. As are people with chronic medical conditions like heart and kidney diseases, diabetes, and respiratory illness. As AARP notes, "Both groups are heavily represented among the nation's 1.3 million nursing home residents. That concentration is a key reason why 2 in 5 U.S. deaths from COVID-19 have occurred in nursing homes and other long-term care facilities, according to tracking by the Kaiser Family Foundation, but it's not the only one." Other conditions at nursing homes can worsen the spread of the disease, like shortages of coronavirus tests, shortages of or lack of access to personal protective equipment (PPE) such as masks and gowns, understaffing, and employees who work in multiple facilities, often because of low wages for aging-related care, thereby increasing chances for exposure.

COVID-19 has empowered those who exploit or mistreat older adults, as well.

AARP has reported a significant increase so far this year in frauds and scams perpetrated against older adults, preying on their isolation and health concerns. These include fake vaccines and COVID-19 tests, and stimulus check scams that ask for call backs to verify personal information.

Recently, in the *Journal of Applied Gerontology* (May 8, 2020), Alyssa Elman and 15 co-authors have

contributed "Effects of the COVID-19 Outbreak on Elder Mistreatment." They note that COVID-19's social distancing requirements have increased social isolation for many older adults, and closures of group venues like senior centers and communities of faith have, among other things, taken away traditional safety checks that participation in these activities might normally provide older adults. Those receiving care at home from visiting home health aides have found visits cut or eliminated, at the choice of the aide or the aide's agency or the older adult's family, in order to decrease risk of exposure to the COVID-19 virus. In any event, the informal caregivers end up shouldering greater responsibility, perhaps perceived as burden, for chronic care and there are fewer outside parties to witness or mitigate stressful encounters. As a result, potentially neglectful or abusive scenarios are neither prevented nor detected.

Stay-at-home orders have correlated with significant increases in reported cases of domestic violence and calls to hotlines in countries that have experienced the pandemic earlier, such as France and Spain, according to a recent *New York Times* report by Amanda Taub (April 14, 2020).

Elman and colleagues report on challenges and responses to preventing and treating elder mistreatment in New York City. There, such hospital- and emergency department-based elder abuse intervention programs as the Vulnerable Elder Protection Team at New York Presbyterian/Weill Cornell Medical Center have had to reduce the services they provide and reassign health care providers who work within the program in order to provide care for COVID-19 patients

In NYC, Adult Protective Services workers shifted to virtual visits but these can be compromised if a victim of elder mistreatment is on a tele-visit while the perpetrator is in the same room, or even more basically, if the older adult simply lacks the technological equipment to have the tele-visit.

Ombudsman programs are not allowed to enter long term care facilities during the crisis because the Center for Medicare and Medicaid Services (CMS) has banned these visits. They must, instead, rely on phone calls or teleconferencing to connect with

residents. And, if the residents don't know how to contact the Ombudsman for help, they are left vulnerable.

Elman et al. do share some promising initiatives: an emergency food program to ensure that basic needs are met during COVID-19, with taxis delivering food to older adults, free of charge; senior centers calling their participants regularly to make sure that they are receiving meals; public benefits, such as food stamps, now being accessible online and by phone, with agency staff providing assistance to those needing help managing their case or applying by phone.

The authors encourage regular, interdisciplinary meetings among those seeking to prevent or respond to elder mistreatment and vigilance by Adult Protective Services through virtual and in-person visits with at-risk older adults. Of course, this vision can be hampered when Adult Protective Services receive just pennies for each dollar allocated Child Protective Services, which is the norm across the country.

Greater awareness of biases in health care and protective services is needed. The pandemic is worsening across the United States. Ageism is not going away but at least COVID-19 has unveiled some of its manifestations. If we care to look.

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Life As a Verb

William DeWitt Hyde, a renowned theologian, philosopher, and author of at least 16 books related to guiding one's life, was president of Bowdoin College about a century ago. While president, he drew on his vast scholarship to advise his students. That advice was incorporated into an orientation booklet for new students that Bowdoin distributed for over 60 years. His advice remains timeless:

"Get your grammar right and all other needful things will fall to you.

Live in the active voice, not the passive. Think more about what you make happen than about what happens to you.

Live in the indicative mood, rather than the subjunctive. Be concerned with things as they are, rather than as they might be.



Live in the present tense, facing the duty at hand without regret for the past or worry over the future.

Live in the first person, criticizing yourself rather than finding fault with others.

Live in the singular number, caring more for the approval of your own conscience than the applause of the crowd.

And if you want a verb to conjugate, you cannot do better than to take the verb 'to love'."

From the Commissioner, Virginia Department for Aging and Rehabilitative Services

By Kathy Miller, Director of Aging Programs and Services, and Sara Link, Director, No Wrong Door; Division for Community Living

COVID-19: Creative and Promising Practices from the Aging Services Network

With the onset of the coronavirus (COVID-19) pandemic, the Department for Aging and Rehabilitative Services (DARS) responded swiftly to remove restrictions and increase flexibility, allowing automatic eligibility for home delivered meals for adults age 60 and over who are practicing “social distancing” at home. The Department also worked quickly to distribute \$23.5 million made available from the federal Administration for Community Living through the Families First Coronavirus Response Act and the CARES Act. These funds are helping to support pandemic relief activities provided by the local area agencies on aging (AAAs) in response to the emergency declaration.

Throughout the coronavirus (COVID-19) crisis, Virginia’s 25 AAAs are supporting, assisting and engaging with the Commonwealth’s older adults as they stay safe at home. With the pandemic, every AAA has been challenged to shift resources and services to comply with the stay at home order and find ways to reach across the social distance to provide meals, groceries, online activities, well-being checks and in-home services. They are following Centers for Disease Control guidelines on cleaning, disinfecting and social distancing, while instituting additional safety measures to protect staff and clients. Promising practices are being compiled from interviews, conversations and statewide surveys of the AAAs conducted by the DARS Division for Community Living’s Office for Aging Services.

Across the Commonwealth, requests for groceries, meals and pet food are increasing from older adults and people with disabilities, and the AAAs are innovating, collaborating and going above and beyond to respond to these needs. For example, Appalachian Agency for Senior Citizens (AASC) in Cedar Bluff has re-routed the food supply chain to better serve older adults by contracting with a local grocery

store to deliver food boxes. The agency has added an intergenerational flair by including art and notes from children enrolled in their day care program with the boxes. In addition to delivering fresh vegetables, shelf stable meals, cleaning supplies and paper products, New River Valley Agency on Aging (NRV) in Fairlawn is offering a pet meals program called “Fido’s Pantry,” recognizing that food security is also important for family pets that provide social contact and comfort. Valley Program for Aging Services (VPAS) in Waynesboro has teamed with farmers and August Health to provide food boxes to 100 food-insecure households. Bay Aging in Urbanna launched its Helping Neighbors Initiative, partnering with 17 local restaurants to provide nearly 1,400 meals weekly to area residents. Volunteers also deliver groceries and prescription medications. The Local Office on Aging (LOA) in Roanoke is working with Feeding America to deliver COVID-19 food boxes.

Despite the stay at home order, the AAAs are finding ways to convey heartwarming and heartfelt expressions of love for older adults. Shenandoah Area Agency on Aging transformed Mother’s Day into a town parade, with the Front Royal Police Department and Warren County Sheriff’s Office joining in to deliver meals and Mothers’ Day gifts, while AAA staff dressed in 50’s-themed costumes. Rappahannock-Rapidan Community Services staff and volunteers in Culpeper, along with a miniature horse, held a drive-through parade for members of the Fauquier Senior Center. Fairfax County launched its “Virtual Senior Center for Active Adults” through partnerships with many county agencies. Its twice weekly “Lunch Bunch,” facilitated by ServiceSource, allows participants to eat together virtually. Mountain Empire Older Citizens (MEOC) in Big Stone Gap partnered with Mountain Empire Community College to have RN nursing students provide “well-check” calls to older individuals. While providing social con-

nection and health education, the students are able to complete their course requirements. Piedmont Senior Resources in Farmville and the Jefferson Area Board for Aging in Charlottesville are playing conference call and Facebook Bingo with senior center and home delivered meal participants. The Longevity Project, led by Senior Connections, the Capital Area Agency on Aging in Richmond and Virginia Commonwealth University, has partnered with Henrico County's Advocate for the Aging Office to launch a phone-based lifelong learning program called EngAge. Several AAAs are also finding ways to conduct exercise classes and musical events via Zoom and Facebook Live. Many AAAs also are sending games, puzzles, art projects and even seed packets with food boxes to keep older adults active while they stay at home.

Through community partnerships and collaborations and innovative thinking, the AAAs have created new best practices to meet the unprecedented demands for services that have emerged as the pandemic continues to impact our daily lives. A recent survey of the AAAs was conducted by DARS. With a 92% response rate, the survey revealed that 82% of AAA main offices are closed to the public; however, they continue to answer calls, connect individuals with resources, provide transportation for dialysis and cancer treatments, and deliver groceries, medications, and other consumable supplies. They are providing 37% more home delivered meals than they did before the pandemic began. Although most have closed their adult day centers, 63% continue to provide necessary homemaker services, and 76% are providing personal care for individuals who need assistance with activities of daily living to remain safely in their homes. Many of the AAAs are transitioning/repurposing staff, hiring additional staff and recruiting volunteers to meet the increased demand for services. Through their tireless and valiant efforts, older Virginians recognize that AAA staff and volunteers are there for them during this public health crisis, and it's very rewarding for AAA staff and volunteers to hear thanks from all those they serve.

Visit Our Websites

VCoA: vcoa.chp.vcu.edu

DARS: www.vadars.org

DARS 2020 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 or visit vda.virginia.gov/boardsandcouncils.htm.

Commonwealth Council on Aging
September 16, December 9

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

Virginia Public Guardian and Conservator Advisory Board
September 3, November 19

Timeless Ethical Advice

In times of social upheavals, words by W.L. Sheldon, a lecturer of the Ethical Society of St. Louis in the 1890s, seem to be without an expiration date:

"Remember that in the struggle of life it is always possible to turn one kind of defeat into another kind of victory."

"Remember that there is nothing noble in being superior to some other man. The true nobility is in being superior to your previous self."

"What to Believe: An Ethical Creed" (1897) by W. L. Sheldon.

CIRCAA Scholars 2019-2020

The Virginia Geriatric Education Center (VGEC), a consortium of Eastern Virginia Medical School, George Mason University, the University of Virginia, and VCU, launched a new faculty and clinician development program last September called CIRCAA: Creating Interprofessional Readiness for Complex and Aging Adults. This is one of many initiatives within the Geriatrics Workforce Enhancement Award from the federal Health Resources and Services Administration that VCoA received.



Mary Rubino, EVMS Medicine, leads a discussion on geriatric assessments at the January retreat.

CIRCAA offers a broad and comprehensive program of monthly sessions from September through June. The CIRCAA interprofessional geriatrics curriculum covers a range of topics, including: interprofessional geriatrics care; falls; dementia, delirium, depression, and lifelong disabilities; care transitions; medication management; complex patients; team-based learning; health promotion; geriatric assessment; caregiving and caregiving resources; health-related public policy; and curriculum design, implementation, and evaluation. Participants, called CIRCAA Scholars, invest their time and talents in a true team-learning experience that culminates with the Scholars developing self-chosen capstone projects to implement in their home institution or work setting. This “passes the torch” of learning.

The 2019-2020 CIRCAA year was affected, of course, by the COVID-19 pandemic three quarters of the way through the curriculum. CIRCAA adapted

with videoconferencing technology and Scholars presented and discussed their capstone projects virtually. Most Scholars completed the program but the work-lives of some were interrupted by the pandemic; we look forward to their completing in the forthcoming program.

CIRCAA 2019-2020 Scholars could not assemble for the traditional graduation photo in June but we recognize this year’s cohort: Linda Brown, PhD, RN-BC, Nurse Educator, Hampton University; Theresa Farley, RN, Nurse Educator, Riverside Health System, Lifelong Health Division; Emily Hawkins, DPT, Physical Therapy, Old Dominion University; Marion Kyner, MSN, RN, CMC, CDP, Nursing, Psychiatric Mental Health, The Woodland, Inc.; Mira Mariano, PT, PhD, OCS, Physical Therapy, Old Dominion University; Michelle McGregor, MEd, RDH, Oral Health, Virginia Commonwealth University; Zakia McManus, PharmD, Pharmacy, In-Clinic Rx; Judy Simmons, RN, DON, Nursing Administrator, Riverside Health System; Diane Simons, PhD, OTR/L, Occupational Therapy, Virginia Commonwealth University; Tina Thomas, MSHP, CDP, CADDCT, Health Policy and Management, Alzheimer’s Association; and Whitney Zentgraf, PharmD, BCGP, Pharmacy, Shenandoah University.



Kristin Zimmerman, VCU Pharmacy, discusses medication management during the December session.

If you are interested in applying to the CIRCAA Program, please visit go.vcu.edu/circaa.

Pathways to Permanent Supportive Housing: Arlington County's Effective Approach to Alleviating Homelessness in the Aged Population

By Patricia Nance, Arlington County Department of Human Services

Homelessness is a great concern across the United States. The number of older adults who are homeless is alarming.



In 2011, Arlington County joined a statewide initiative entitled 1000 Homes for 1000 Homeless Virginians. This was a part of a national 100,000 Homes

Campaign created to aid communities throughout the U.S. in placing chronically homeless individuals in permanent and supportive housing. The Arlington County component of the Commonwealth of Virginia's initiative, 100 Homes, was a collaborative effort by Arlington County and their nonprofit partners to identify and house the most vulnerable homeless population within the county.

An unexpected and significant outcome of this campaign was the identification of a number of elderly and disabled individuals who were homeless and had a high vulnerability based on their age and health conditions. This article will focus on this specific homeless population and the positive impact of the County's housing effort over the past nine years. Highlighting this success will demonstrate the ongoing need for this program that supports the unique needs of homeless individuals who are elderly and disabled and empowers them to live more stably.

The 100 Homes initiative was fueled by the Arlington Continuum of Care (CoC), a network of initiatives across the County committed to improving services for the homeless by identifying and housing those living on the streets. Participants included Arlington County Department of Human Services (DHS), Arlington Street People's Assistance Network (AS-PAN), Volunteers of America, various programs one street outreach engagement, homelessness preven-

tion, and housing, as well as many other community organizations.

Identification and Assessment of the Homeless Population

A Vulnerability Index specific to the homeless population was used to determine a homeless individual's health and social status as well as other factors contributing to a high mortality risk. This tool was administered by teams of volunteers visiting homeless individuals for several days during the late night and early morning hours. During the initial 100 Homes campaign, it was determined that 10% of Arlington's homeless population were 60 years old or had disabilities. Subsequent annual campaigns have continued to monitor and identify elderly homeless individuals.

An Adult Services (AS) social worker was designated by DHS to provide outreach to the 100 Homes program. Although Adult Services staff traditionally visit clients in their homes, contact instead consisted of meeting individuals in unconventional locations. This required the worker to "meet the client where they were," both emotionally and physically. Clients often changed locations, lacked contact sources (e.g., phone, mailing address, or email), and had inconsistent and unpredictable routines. Individuals slept under bridges, at the airport, outside of Metro or bus stops, on park benches, near the libraries, outside the Pentagon, by railroad tracks, or in the woods. Some individuals carried or pushed many items and suitcases, while others had little or no personal items and simply slept where they spent their day. Several of these persons had elaborate, fortified campgrounds, some resembling communities.

Challenges of Housing Elderly Homeless Clients

Although DHS Adult Services had previously engaged with, and housed, homeless individuals, the

100 Homes program's expanded scope encompassed homeless persons who had never received County services. Many elderly individuals were either not aware of the services available to them or reluctant to interact with the DHS system.

Arlington County follows the "housing first" approach, which prioritizes finding permanent housing for the homeless before addressing other issues and underlying causes of homelessness. While housing is the priority, finding permanent housing was not always an easy process. Most of these individuals desired housing but were unable to navigate the complicated systems and services on their own. Among other issues, they lacked any basic form of identification such as DMV IDs, passports, birth certificates, or Social Security cards. Lack of bank accounts, health insurance, or benefits further complicated the housing process.

So, a pathway for re-establishing their basic identification had to be initiated. Most were not only eager to be housed but were also agreeable to obtaining some form of ID, which had often been lost, stolen, or expired and never replaced. This was frequently a long and tedious process compounded by the fact that none of the individuals had a listed address, a DMV requirement to issue an ID. Similarly, Social Security required an address or a DMV ID before mailing a Social Security card. The DMV and the Social Security offices also required a birth certificate or passport, and some states required a legitimate ID even before sending a birth certificate copy.

Once necessary documents were obtained, referrals could be made to appropriate housing programs. These included DHS Permanent Supportive Housing (PSH), Arlington Street People's Assistance Network (ASPAN) housing programs, New Hope Housing, and Veteran Affairs Supportive Housing voucher (VASH voucher). Although these programs were experienced with difficult-to-place clients, many additional factors created barriers. Extensive criminal records, lack of, or poor credit history, as well as untreated physical or mental health conditions often delayed or prevented actual housing of this fragile population.

Factors Identified Among Elderly and Disabled Homeless Clients

The aging homeless are often more vulnerable and susceptible to their environment. "Homeless persons aged 50-65 frequently fall between the cracks of governmental safety nets: while not technically old enough to qualify for Medicare, their physical health, assaulted by poor nutrition and severe living conditions, may resemble that of a 70-year-old" (National Coalition for the Homeless, 2009, p. 1). Years of untreated alcohol or drug abuse, deficient medical treatment, or unsafe environments often contribute to their rapid decline. Inclement weather, refusal to enter a shelter, and inadequate areas to perform basic needs also affect an individual's physical and mental health and emotional condition.

Older homeless adults are often medically compromised or have untreated mental health or substance abuse issues. Many have limited mobility and lack basic mobility assistive devices such as canes and walkers. Some have experienced violent episodes which left them physically impaired. The National Coalition for the Homeless (2009) explained that elderly homeless are more at risk for violence and less likely to be protected by police. For example, three clients identified and currently housed were left visually impaired by physical assaults. The National Coalition for the Homeless also found that, "in addition to the worsening of physical health caused by homelessness, the homeless elderly are also more likely to suffer from depression or dementia" (2009, p. 3). DHS observed similar trends, as several clients had undiagnosed dementia, and many admitted to ongoing depression, often self-medicating with drugs or alcohol. Undiagnosed or unacknowledged mental health issues and refusal to accept treatment offered often made it difficult to serve these individuals.

Intervention

After experiencing years of chronic homelessness, many of the individuals were initially suspicious, guarded, and uncertain about how to work with DHS. With referrals, encouragement, and vetting from ASPAN workers, police officers, and other agencies, clients began to engage in a relationship with their DHS worker. At first, some clients presented with

alternative names while others provided inaccurate information. With time, consistent follow-through, communication, and reliability in providing needed resources (e.g., health insurance, medical treatment, and transportation), a relationship of trust between the client and worker was established. The worker also set clear expectations and realistic limitations with the client, which further deepened the level of trust. Most importantly, the process was successful due to the clients' own commitment to their housing and beliefs in their responsibility to participate in obtaining and sustaining it.

Between 2011-2020, 71 older adults (60 years or older) or individuals with disabilities were identified and referred to Adult Services (AS). To date, AS has worked directly with 54 individuals to house them. Currently, AS is working with one individual who is about to sign a lease, three who are housed in hotels instead of shelters due to COVID-19, and one who chooses to reside in his car.

Findings

Many homeless individuals sought housing due to the realization that their medical issues were not being addressed and they could no longer successfully maneuver life on the streets. Some found it difficult to maintain the lifestyles they previously had. "Homeless seniors are more likely to experience multiple medical issues at a time and often have chronic illnesses that go untreated" (Sermons & Henry, 2010, p. 5). Navigating the healthcare system and medication management also poses hurdles with which DHS assists. For some, this means weekly nursing case management and for others it means enrollment in Hospice care. Some require daily assistance from an in-home aide, while others manage with less frequent visits. Three clients were eventually determined to lack capacity and were unable to safely reside alone. They required a Legal Guardian and were then housed in assisted living or long-term care facilities.

Daily life tasks are also challenging for those transitioning from a life on the streets. Managing rent payments, grocery shopping, transportation, required paperwork, and finances can be extremely difficult for clients who are not accustomed to these responsibilities. Likewise, because of some clients' previous

involvement with the legal system, they often require guidance and assistance in managing non-legal institutions. Two clients had been institutionalized since the age of 10 and three other clients entered the legal system in their mid-teens. Many had relied upon formal institutions such as prisons and jails to provide structure and stability and respond to their needs.

Outcomes

Adult Services works closely with Arlington County's housing team throughout the housing process. The Arlington County Permanent Supportive Housing (PSH) team locates and identifies apartments for specific populations. AS clients often require accessible apartments located in areas with few physical impediments. The team frequently needs to rule out apartments located on hills, identify units that have elevators, and ensure proximity to public transportation. Although quarterly visits are required through the PSH program, the level of involvement is often much more demanding, and clients require more regular visits. Workers frequently need to adjust client visits to early morning hours to accommodate clients' previous routines of rising early when they were homeless. Although DHS offers services to address both medical and psychiatric issues, many of the housed clients continue to decline these services or acknowledge their impairments. This often presents challenges to the client and the workers. A collaborated effort between PSH staff and AS workers provides a strong support to the clients. With continued encouragement, structure and follow up, their rent obligation is maintained, medical treatment is encouraged, and other responsibilities are addressed.

The Continuum of Care is designed to assist clients with these challenges once they have been housed and can make a successful transition to, and remain in, safe and permanent housing. The retention rate of sustaining housing is remarkable. All but one client who was housed remains housed today. Some of this can be attributed to ongoing case management, a dedicated housing staff, availability of resources, and coordinated teamwork. Commitment to the initiative and to the foundation of the program, as well as the continued ability to "meet the client where they are" are also contributing factors. More importantly, the individual's commitment to recognize personal

responsibilities and obligations and a growing sense of self-worth are cornerstones of success.

The significance and the impact that housing has had in providing a sense of self-worth is immeasurable, however evident. What sometimes began as a request to establish an identity became a request to improve their health and appearance. What had been a request to obtain basic benefits became a request to obtain dental care, for a high percentage required dentures. Throughout the years, there have been frequent requests for appropriate apparel to wear to church, work, or other community events. Some have entered stable relationships, and several have reestablished family contact that had been severed. Four clients are currently employed, while three clients actively volunteer. Many are now active within their communities of faith, with one individual playing weekly in the church's band. Since church services have been moved online due to COVID-19, he has learned to record himself and collaborate digitally with the other band members.

Though these individuals still require assistance and services, they have experienced stability in their lives in a way that would have been impossible without housing. With a combination of continued resources and a strong interdepartmental collaboration of AS and Arlington County Housing Division, our clients are enjoying a successful living environment. More importantly, the individual's own committed determination to personal responsibility in being housed has made their housing possible and sustainable. It is crucial that the safety net of services which evolved through the 100 Homes program be maintained. New Hope Housing, ASPAN, hospital staff, librarians, police officers, EMTs, and other community partners continue to refer, but there has been an increase in self-referrals and even referrals made from other concerned, homeless clients. Sustaining this model will provide future opportunities for care and empowerment, which are key values in Arlington County.

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About the Author



Patricia Nance, LCSW, ACSW, CSW is a Human Service Clinician at Arlington County Department for Human Services. She works in Adult Services with a focus on Aging Homeless.

Patricia earned an MSW from New York University and a Post-Graduate Certificate in Gerontology from Hunter College. She has worked with the homeless and aged population for most of her 38-year career. She can be reached at pnance@arlingtonva.us.

Potassium and Blood Pressure

Managing our blood pressure as older adults can be a challenge. Tufts University Medical Center offers familiar advice, such as maintaining a body weight within the normal range, exercising regularly, and keeping a healthy diet that's high in fruits and vegetables and low in processed foods. But potassium as a help in preventing or treating high blood pressure tends to get overlooked.

The American Heart Association advises that we consume 3,500 to 5,000 mg of potassium a day. Turns out, it's not so hard to do, if we know where to look. There is evidence that getting our potassium from foods rather than from potassium supplements works better in lowering blood pressure. So, what are the potassium-rich foods? The richest go from beet greens (654 mg, 1/2 cup) to canned tomato sauce (364 mg, 1/2 cup). In between in descending order are sweet potatoes, yogurt, prune juice, soybeans, white beans, halibut, winter squash, bananas, and spinach.

The Shepherd's Center of Richmond Adjusts Program; Studies the Future

How do you carry out the mission of your organization in the midst of a pandemic? Not easily, The Shepherd's Center of Richmond (TSCOR) has discovered, especially when the older adults you serve are the ones at greatest risk from COVID-19.

Reluctantly, the Shepherd's Center canceled the spring session of its Open University. Due to have begun on March 23, this lifelong learning program featured 27 courses, 20 lunch talks, and one special offering, with 54 teachers and lecturers. Erin Reibel, the lifelong learning coordinator, began by contacting those 54 individuals to see whether they might still be available in the fall. Most were. Two instructors from the Virginia Museum of Fine Arts would not be, however, and one of the two was even moving out of town for further graduate study. Not wishing to miss out on what these two had to offer, the Shepherd's Center arranged with the instructors to put their two courses online in May via Zoom - free for anyone who wanted to join in.



William Neer, curatorial assistant for exhibitions, presented in two sessions "Japanese Prints in History, Art and Popular Culture." Dr. Colleen Yarger, assistant

curator for European Art and the Mellon Collection, presented "Modern Masters of Printmaking," also in two parts. "Average attendance for these Zoom courses was forty," said Julie Adams-Buchanan, executive director of TSCOR. "We will be looking into offering more online courses in the near future."

In addition to helping older adults remain active and independent through enrichment programs like travel and the Open University, the Center also provides volunteer help through client transportation services. Adams-Buchanan did not want to place volunteer drivers at risk, nor those whom they took on a regular basis to doctors' appointments and the grocery store. When the driving services were suspended, except

for two or three persons already undergoing rigorous treatment, they were replaced with a Friendly Caller program. This gave drivers a new way to volunteer on a regular basis by keeping in touch by telephone with those on the client list. The new form of outreach has proved greatly successful. As one client remarked, "I really appreciate having someone to talk with about how it feels to go through this pandemic. It helps to know I'm not alone."

TSCOR has not canceled its grocery shopping services for clients but has worked on making them safer. Instead of picking up clients and taking them to their preferred market, volunteers are alerted to grocery needs via an online system. They write down the list, checking with the client about preferred quantities and brands. After they purchase the items, they leave the groceries at a designated place, where the client has also left the reimbursement.

What does the future hold for The Shepherd's Center of Richmond? Can all activities be resumed in the fall? President-elect Bernie Henderson has appointed a COVID-19 Task Force to assess the situation. Headed by Stephanie Churchill, vice president-elect, the task force is charged with monitoring the criteria for safe operations and applying them to the services and activities of TSCOR. It will develop plans for the resumption of those services and activities, including how the organization might provide them in ways that might not have been used or contemplated in the past. As Henderson remarks, "The function of the task force is literally to prepare TSCOR for the immediate future. We know that without a vibrant immediate future, there will be no long-range future, so their job is of utmost importance."

Persons interested in the Shepherd's Center are invited to subscribe at the website [TSCOR.org](https://www.tscor.org) to receive emails about the latest news and events, or they may find information on Facebook at Shepherd's Center of Richmond.

Calendar of Events

Special note: This calendar is up-to-date as of July 13, 2020. Events are subject to change or cancellation due to COVID-19. Please check websites for the most current information.

September 1-3, 2020

Envisioning the Future: 2020 & Beyond. A virtual gathering presented by the Pioneer Network. For information, visit www.pioneernetwork.net.

September 22-24, 2020

Better Senior Living. Together. Argentum Senior Living Executive Virtual Conference. For information, visit <https://conference.argentum.org>.

September 24, 2020

5 Over 50. Aging Together's annual fundraiser and reception. Tuscany Hall, Culpeper. For information, visit www.agingtogether.org.

October 7 - December 4, 2020

Serving Seniors, Veterans and Those with Disabilities through Diverse Adult Day Programs. 2020 Virtual Conference of the National Adult Day Services Association. For information, visit www.nadsa.org.

October 8-31, 2020

71st American Health Care Association/National Center for Assisted Living Virtual Convention and Expo. For information, visit www.ahcancal.org.

October 9, 16, 23, 2020

Alzheimer's Disease Virtual Conference Series: Dementia Care in the Era of Covid-19. Jointly sponsored by Hampton University and the Virginia Geriatric Education Center. Three sessions. Noon - 1:30 p.m. Free; registration required. For information, contact Dr. Travonia Brown-Hughes at Travonia.Brownhughes@hampton.edu or (757) 637-2960 or Dr. Ethlyn McQueen-Gibson at ethlyn.gibson@hampton.edu or (757) 727-5657.

October 12-14, 2020

One Size Does Not Fit All. 2020 Fall Conference of the Virginia Assisted Living Association. Newport News Marriott at City Center, Newport News. For information, visit www.valainfo.org.

October 14, 2020

I Don't Want Any Tubes: Understanding Intubation and Breathing Decisions. Virtual Advance Care Planning Training Series presented by Honoring Choices Virginia. 8:30 a.m.- 10:00 a.m. For information, visit www.honoringchoices-va.org.

October 27-28 and November 5-6, 2020

Aging Well: The Great Disruptor. International Council on Active Aging's Virtual Conference, Leadership Summit and Expo 2020. For information, visit www.icaa.cc.

November 4-6, 2020

Turning 75: Why Age Matters. Gerontological Society of America's 2020 Annual Scientific Meeting Online. For information, visit www.geron.org.

November 10, 2020

Annual Conference, Virtual, of The Virginia Association for Home Care and Hospice. For information, visit www.vahe.org.

November 18, 2020

CPR Is Just Like on TV, Right?: Understanding Cardiopulmonary Resuscitation. Virtual Advance Care Planning Training Series presented by Honoring Choices Virginia. 8:30 a.m.- 10:00 a.m. For information, visit www.honoringchoices-va.org.

Age in Action

Volume 35 Number 3: Summer 2020

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.

**Fall 2020 Issue Deadline for Submissions:
September 15, 2020**



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2020 Walk to End Alzheimer's



Walk to End Alzheimer's is the Alzheimer's Association's signature nationwide fundraising event. Each fall, thousands of people walk together to help make a difference in the lives of people affected by Alzheimer's disease and other dementias. Start a team or walk as an individual to help lead the fight against Alzheimer's disease!

<p>Central and Western Virginia Chapter Register for walks in this area at www.alz.org/cwva.</p>	<p>Blacksburg, September 19 Fishersville, September 19 Danville, September 26 Harrisonburg, October 10</p>	<p>Lynchburg, October 17 Charlottesville, October 24 Roanoke, November 7</p>
<p>Greater Richmond Chapter Register for walks in this area at www.alz.org/grva.</p>	<p>Middle Peninsula/Northern Neck, October 3 Fredericksburg, October 10 Richmond, October 31</p>	
<p>National Capital Area Chapter Register for walks in this area at www.alz.org/nca.</p>	<p>La Plata, MD, September 12 Oxon Hill, MD, September 19 Solomons, MD, September 26 Reston, September 27</p>	<p>Washington, DC, October 10 Manassas, October 17 Winchester, October 24</p>
<p>Southeastern Virginia Chapter Register for walks in this area at www.alz.org/seva.</p>	<p>Chesapeake, September 12 Farmville, September 26 Suffolk, October 3</p>	<p>Melfa, October 10 Newport News, October 17 Williamsburg, October 24</p>

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