

## Case Study

# The Health Empowerment Program: A Primary Care – Area Agency on Aging Partnership

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### Educational Objectives

1. Appreciate the benefits of a primary care-area agency on aging collaboration.
2. Identify strategies for enhancing this cross-organizational partnership.

### Background

Family Practices and other primary care organizations are challenged to optimize care of high-risk/high-need older adults. These are patients for whom a mix of unregulated chronic illnesses, cognitive impairment, and/or poor functional status predispose to repeated hospitalizations and poor outcomes. Care is further complicated by low confidence for self-management and need for linkages to community-based services and supports (Byhoff, Freund, & Garg, 2018).

To better illustrate high-risk/high-need attributes, we introduce the cases of Mr. Andrews and Ms. Baker. Later we will see how our Health Empowerment Program (HEP) helped both of these patients.

*Case 1: Mr. Andrews is a 92-year-old male with mild dementia, a prior stroke, and osteoarthritis. His daughter, a Hampton Roads resident, moved Mr. Andrews to live with her following the death of Mr. Andrews' wife, his prior caregiver. She has established him with her own doctor and relates a high level of caregiver burden as well as concerns about injury; Mr. Andrews has had several falls since the move. The physician recommends a Medicare Wellness Visit with one of the practice's nurse care managers as a means of further assessment.*

*Case 2: Ms. Baker, a 78-year-old female, has poorly controlled diabetes and hypertension. She has flagged on quality metrics surveillance as being at high risk from preventable morbidity. She has also had multiple emergency room visits related to high sugars and hypertensive urgencies. She lives alone and has a fourth grade education. Given these concerns, Ms. Baker is assigned a nurse care manager who suggests a Medicare Wellness Visit as a means of both getting to know Ms. Baker and deciding about further assessment.*

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Partnering with Area Agencies on Aging (AAAs) can potentially address these and other challenges posed by patients such as Mr. Andrews and Ms. Baker. This approach was introduced in a 2014 *Family Practice Management* article (Coleman, Whitelaw, & Schreiber, 2014) which described the range of services AAAs provide and offered general suggestions on how to engage in collaboration. More recently, the American Academy of Family Physicians EveryONE project (AAFP, 2018) offers a toolkit for developing partnerships with community programs, again in general terms. There is a place for specific examples of how a primary care-AAA partnership can work and what one might expect as a result.

Accordingly, we are reporting our experiences partnering with our local AAA, Senior Services of Southeastern Virginia (SSSEVA). We first describe our intervention and its benefits. We then delineate next steps and conclude with suggestions on how other practices can adopt our approach.

## Who We Are

In our settings (Eastern Virginia Medical School's two family practice residencies, Sentara Healthcare's primary care practices), we prioritize Medicare Annual Wellness Visits (AWVs) as a means of improving care for older adults (Blustein, et al., 2017). The importance of the wellness visit in this regard was further highlighted in a 2017 *Age in Action* article (Blustein & Diduk-Smith, 2017) which also stressed the need for active follow-up to ensure wellness visit recommendations are enacted. The work presented here illustrates one such approach to wellness visit aftercare of high-risk/high-need patients who would benefit from linkage with resources and supports, health education, and reinforcement of self-management skills.

We saw collaboration with SSSEVA as a means of achieving these ends. However, communication with the social sector had heretofore been indirect and we sought to build bridges. SSSEVA's mission is "to provide seniors and their caregivers with access to programs and services so they may live with choice and dignity in their communities." (See Figure 1) SSSEVA has participated in multiple partnerships to enact this mission. Collaborating with primary care

was thus in keeping with this strategy and a means of furthering organizational impact and effectiveness.

## Our Intervention

Our initiative, the Health Empowerment Program (HEP), was designated a quality improvement project by the Eastern Virginia Medical School Institutional Review Board. Funding for the HEP was provided by a Hartford Foundation Practice Change Leader project enhancement award to Dr. Blustein. In 2019, the HEP received a 2019 National Association of Area Agencies on Aging Innovations Award (naa.org, 2019) and a Health Quality Innovators for Virginia runner-up award (HQI Solutions, 2019).

The HEP leveraged SSSEVA's experience in implementing the Coleman Care Transition Intervention (CTI), aimed at reducing 30-day hospital readmissions (Coleman et al., 2006). We adapted elements of the CTI model to improve care for high-risk patients identified in AWVs. These included use of a health coach who works directly with clients to complete a Personal Health Record (PHR), a patient activation tool that promotes: medication understanding and adherence, ability to recognize and respond to "red flag" symptoms of decompensation, formulation of self-management goals, and advance care planning review ([Caretransitions.org](http://Caretransitions.org), 2015). The coach also assessed client eligibility for SSSEVA services and programs.

Participants were recruited by practice nursing staff (RNs, care managers, LPNs, Nurse Practitioners) who described the program, obtained written agreement to exchange information with SSSEVA, and had enrollees complete a four-item survey of patient or caregiver level of confidence using a scale of 1-10 (1-not at all confident to 10-completely confident). Nurses communicated with the SSSEVA health coach by phone and through exchange of documents by a HIPAA-compliant, secure file exchange software (ShareFile). The health coach conducted a home visit with the patient/caregiver during which she facilitated completion of the PHR. The coach also identified eligibility for SSSEVA services and initiated referrals. The coach shared findings with nurses who contacted patients with updated care plans as necessary. The coach conducted follow-up phone

calls at 30 and 60 days to assess progress and help problem-solve any issues identified during the home visit and implementation of any updated care plan. The coach re-administered the four-item confidence survey and assessed patient/family satisfaction with the program at 60 days.

Our outcome metrics thus included change in health confidence in medication understanding and adherence, ability to recognize and respond to “red flags”, and making lifestyle changes. We also assessed satisfaction with the program, advance care planning completion, and service linkages. These measures were chosen because increased confidence (Wasson & Coleman, 2014) and higher satisfaction (Anhang Price et al., 2014) predict self-management and adherence; advance care planning is a value-based reimbursement quality indicator that may reduce futile, high-cost hospitalizations; and service linkages may improve access to care and quality of life.

## Our Findings

During 2018, we approached 42 patients who completed AWVs and were identified as high-risk due to low health literacy, poor confidence for self-management, unregulated chronic illnesses, frequent hospital and ER visits, unmet social needs, cognitive impairment, poor functional status, caregiver burden, or an admix. Of these, 27 agreed to participate and 20 completed our intervention. Of the seven non-completers, one died, two entered long-term care, and four refused follow-up. Participants’ mean age was 77 years (range 61-93); 69 percent were female; 57 percent were African-American, 38 percent were White, and five percent were Hispanic. Participant characteristics were comparable across all practices.

We measured change in confidence levels using a scale of 1-10, where 1 represented Not Confident and 10 represented Very Confident. We asked four separate questions: “How confident are you that you: Understand your medications? Can take them correctly? Know the “red flags” for which you should call your doctor? Can make lifestyle changes to improve your health?” Data (Figure 2) show increases in confidence for all domains, although not surprisingly, the increase was smallest for lifestyle changes. Patient satisfaction, the extent to which patient expectations

are met (Anhang Price et al., 2014), was measured by a single item assessing the likelihood of recommending a service (Ahmed et al., 2017). Participants uniformly viewed the HEP program positively, using a single item measure, “Would you recommend this program to someone else?” However, the four who did not complete the program were *de facto* dissatisfied. ACP was discussed with nearly all participants. Of these, six (30%) completed ACP documentation as a result of participating in the HEP. All designated power of attorney for health, five of six were “full code”, and one placed some limits on the aggressiveness of end-of-life care. Figure 3 enumerates services and programs for which participants qualified. It should be noted that actual uptake of these services was much lower, less than 50 percent.

## What We Learned

Taken together, these findings indicate that collaboration with an area agency on aging improved health confidence, facilitated advance care planning completion, and provided linkages with services that improve access to care, caregiver support, and better nutrition, safety, and chronic illness management. Participants voiced satisfaction with the program, which is important as higher satisfaction is correlated with better adherence and patient buy-in (Anhang Price et al., 2014). Direct communication between partners proved invaluable in enhancing AWV care plans. Nearly 1/3 of HEP participants completed advance care plans through HEP participation. Although only one of the six ACPs completed under this project limited care, advance care planning is a process and dialogues begun here can be continued.

These benefits are further illustrated by revisiting the cases of Mr. Andrews and Ms. Baker.

*Case 1 continued: The wellness visit revealed unmet service needs and the nurse care manager recommended enrollment in the HEP. The health coach noted multiple environmental hazards on her home visit and made suggestions for fall prevention. The patient also qualified for companion, respite, and home PT and OT. In coordination with the nurse care manager, a home health referral was placed. Telephone follow-up by the coach indicated that these various services were initially not received. The care*

*manager circled back to the home health agency and services were put in place thereafter. There were no further falls and the caregiver reported significant stress reduction. Advance care planning was initiated and documented. Although Mr. Andrews remained a full code, he and his daughter said that they would revisit this if his status deteriorated.*

*Case 2 continued: The nurse care manager who had conducted the wellness visit noted a low degree of health literacy during the wellness visit and recommended enrollment in the HEP. The health coach documented poor medication understanding and a lack of awareness of red-flag symptoms while completing the personal health record with the patient. The health coach discussed these findings with the nurse care manager and a joint educational effort was launched. As a result, the patient was better able to understand why she was on certain medication, to recognize symptoms of high and low blood sugars, and to adjust her medications accordingly. The patient's diabetic control improved, as did her blood pressure, and she had no further emergency room visits. She stated how much she appreciated the coach and care manager.*

Findings concerning health confidence are especially key in several respects (Wasson & Coleman, 2014). First, health confidence is a single item measure that is easily assessed in busy practices. Second, discussion of confidence ratings can provide entree to dialogue about behavioral change. Third, health confidence is a proxy for patient activation, with scores of seven and above strongly predicting behavioral change leading to better outcomes and reduced costs. It is noteworthy that confidence levels reported here were increased to at or above seven by our intervention. Improved quality metrics for diabetes, hypertension, and other chronic illnesses become more likely as a result. In addition, increased health confidence is associated with reduced hospitalization in a family practice setting (Nunlist et al., 2016).

Nunlist and colleagues' findings can be used to develop a business case for HEP sustainability. In their panel of 32 high-risk family practice patients (akin to those enrolled in our HEP), the reported acute care (hospitalization/emergency room visit) event rate was eight per month from June 2012-December 2014. In

early 2015, their panel received a health educational intervention wherein confidence for self-management rose from 6.6 to 8.3 on a scale of 10, gains similar to what we observed. As a result, acute care events fell to an average four per month over the ensuing 20 months. Data from the Eastern Virginia Care Transitions Partnership (Center for Healthcare strategies, 2017), indicate that approximately \$9,500 can be saved per event prevented. Using Nunlist et al.'s experience, this would translate to \$38,000 cost savings/month (reduction from eight acute events/month to four/month at cost savings of \$9,500 each). Actual results would probably vary by organization, type of patients, and health confidence intervention.

It is also important to know how likely these savings would offset HEP costs. The concept of "Number Needed to Treat (NNT)" (Siwek, 2015) can be used to address this question. NNT is the number of patients Needed to complete the HEP to avert an acute care event and is determined by comparing the rate of an event in the intervention group versus the rate of the event in a care-as-usual group. Statistically, in our case, it's the inverse of risk reduction attributable to the HEP. Based on Nunlist et al.'s findings, the NNT for the HEP is  $1 / (8/32 - 4/32) = 8$ . So, treating eight patients through the HEP would likely save one acute care event. Again, this number is an estimate but can serve as a point of departure for subsequent inquiries.

Estimated costs per HEP enrollee are \$650 (\$400-health coach; \$250-care manager), and for eight enrollees would be \$5200. HEP cost thus would be more than offset by a cost saving of \$9500 per acute episode averted. Efforts to validate this cost-saving model are needed as are efforts to assess the HEP's impact on quality metrics and thus success under value-based reimbursement.

### **A Collaboration Primer**

We also learned a great deal on the workings of our partnership, which we summarize below as guidance for other practices and organizations.

1. Networking is a start. Members of all three organizations had met in other contexts or at least knew of each other. Hence, it was easy to reach out.
2. Shared values. All involved in this project

believed in the model of team-based care for high-risk/high-need patients

3. There was mutual understanding of what all parties sought from the relationship. This made it easier to align interests and promote problem solving.

4. Communication was key to developing personalized working relationships. Use of secure communications software made document sharing easy.

5. There were frequent interactions between other members of all organizations. This continuing dialogue served to maintain momentum and facilitate problem solving.

6. It was important to look continuously at results. Frequent reviews helped us to realize we were “getting somewhere,” which was reinforcing. These frequent data reviews also served to identify and address incipient problems.

7. Participant recruitment relied on nurse “champions” who were able to describe the benefits of participation from the client perspective.

8. There was a minimum of “red tape” for participants, who were asked only to sign an interagency agreement to share information.

9. While confidence increased, this is a dynamic, process measure. It is important that physicians, nurses, and other practice staff continue to foster confidence to improve outcomes.

10. While many participants qualified for services, acceptance was variable and can be reinforced by a practice team that advocates for use.

11. Be patient. Change takes time.

12. Be persistent. There will be challenges.

## Conclusion

We have described a quality improvement project involving collaboration between family practices and an area agency on aging that led to enhanced patient self-confidence, patient satisfaction, linkage with services, and promotion of advance care planning. These are important patient-centered outcomes in their own right that can, potentially, improve quality metrics, prevent hospitalization, and advance practice performance under value-based reimbursement. There was further professional satisfaction as our work pragmatically impacted several social determinants of health factors that have major deleterious effects yet are challenging to address in the clinical realm.

Limitations should be noted. Measurement of actual quality outcomes and impact on financial performance lay beyond our scope and should be the subject of subsequent Plan, Do, Study, Act (PDSA) cycles. Over half of patients who might have benefited refused enrollment or withdrew. Many that did not participate chose not to accept services for which they were eligible. Better understanding of patient motivations is needed to improve program effectiveness and efficiency. In addition, we report on a small number of patients drawn from a few practices. Although generalizability of our approach is unknown, it is reasonable to hope that others can learn from our experience.

## Study Questions

1. Increased Health Confidence is associated with
  - a) Increased costs
  - b) Higher emergency room use
  - c) Uncontrolled Hypertension
  - d) Better diabetic control
  - e) Dissatisfaction with care

Answer “d”

2. Primary Care-Area Agency on Aging cooperation is facilitated by all except:

- a) Shared values
- b) Alignment of interests
- c) Impatience
- d) Frequent interactions
- e) Persistence

Answer “c”

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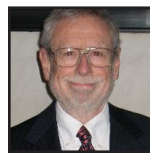
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**Figure 1: SSSEVA Services and Programs (services vary by AAA)**

<b>Medicare Benefits Counseling</b>	Assists with education and enrollment counseling for Medicare Part D and other plans, Medicaid, long-term care insurances, and other programs.
<b>Options Counseling</b>	Links individuals to resource options for physical, medical, financial, or emotional needs; coordinates with other agencies as necessary; and provides caregiver support.
<b>I-Ride Transit</b>	Provides medical transportation to medical appointments and senior center wellness and nutrition sites.
<b>Nutrition Services</b>	<u>Congregate meals</u> combined with socialization opportunities at senior wellness centers; <u>Meals on Wheels</u> - for homebound seniors who cannot prepare meals on their own.
<b>Wellness Programs</b>	A Matter of Balance, Chronic Disease Self-Management (Lorig).
<b>Senior Companion Program</b>	Partners senior volunteers with adults living in the community in need of companionship and a helping hand.
<b>Senior Advocate Ombudsman</b>	Investigates complaints, mediates issues, and provides counseling and education about nursing homes, assisted living facilities, and community-based care services.
<b>Personal Care/Homemaker Programs</b>	ADL assistance/housekeeping after an illness or hospital stay, or short-term service until long-term care is in place.
<b>Senior Cool Program</b>	Provides fans or air conditioners to eligible seniors who need help cooling their homes.
<b>Coordinate linkages to other, external services and supports</b>	Medicaid, Supplemental Nutrition Assistance Program (SNAP), Veterans Services, Alzheimer’s Association, etc.

**Figure 2: Change in Confidence**

<b>Understand medications</b>		
Pre	Post	Change
5.5	7.0	1.5
<b>Knows red flags</b>		
Pre	Post	Change
6.1	8.4	1.3
<b>Takes medications correctly</b>		
Pre	Post	Change
5.9	7.4	1.5
<b>Can make lifestyle changes</b>		
Pre	Post	Change
6.1	7.0	0.9

**Figure 3: Service Linkages**

<b>Program</b>	<b>Number of linkages*</b>
Benefits counseling	10
Legal aide	3
Transport	19
Home companion	8
Nutritional services	8
Respite care	12
Durable equipment	4
Chronic illness and wellness program	3

\* There was less than 50 percent uptake of services for which participants were eligible

# From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

## Benefits of Physical Activity on Depression

Depression saps one's energy and enjoyment of things. It's too common in later life. We may feel persistently sad, useless or empty. We may curtail our daily activities.

A growing body of research, however, is showing that physical activity may protect against depression. The irony, of course, is that depression may encourage inertia and discourage activity. The adage that the greatest challenge in any race is taking the first step may well apply.

If one can motivate to initiate physical activity, the potential benefits seem to be substantial.

Two recent separate studies by teams at Harvard University and elsewhere have examined whether physical activity can affect depression and vice versa, and whether physical activity can modify the risk for depression even among those with genetic risk factors for depression.

The first study, "Assessment of bidirectional relationships between physical activity and depression among adults," conducted by a team of researchers led by Karmel Choi and Jordan Smoller, appears in *JAMA Psychiatry* (2019). The researchers asked the question, "Does physical activity have a potential causal role in reducing risk for depression?"

Depression is a prevalent condition, one with troubling consequences for the individual and the society at large. While major depression is less frequent among older adults than younger counterparts, late life depression is an important public health problem. So, identifying effective strategies to prevent or reduce depression can ultimately improve population health.

While recent studies suggest that physical activity may protect against the risk for depression, it's not clear if there's a causal relationship between the two and if this causality goes in both directions: physical

exercise causing less depression and more depression causing less physical activity. As the researchers here note, "If the relationship between physical activity and depression is not causal, recommendations to promote physical activity, while beneficial for other health outcomes, would yield limited results for depression."

The research team had access to both de-identified, self-reported exercise data and objectively measured (wrist-worn, accelerometer-based) data on physical activity from adults in the UK Biobank Study (for physical activity data) and to the Psychiatric Genomics Consortium (for data on Major Depressive Disorder-MDD) from adults of European ancestry. Together, they had information on over 611,000 adults.

"We found evidence of a protective causal relationship between accelerometer-based physical activity with MDD. In contrast, we found no statistically significant evidence of a relationship between self-reported activity and MDD...In the other direction, across all methods, we found no evidence of causal relationships of MDD with accelerometer-based activity."

The researchers estimated a moderate but significant reduction of MDD risk for every one SD (Standard Deviation) increase in objectively measured physical activity. They state, "One SD of objectively measured physical activity in the UK Biobank Study has been reported to be approximately 8 milligravities of acceleration in a mean 5-second window of analyzed accelerometer data." Thankfully, the authors translate what this means for everyday life: "roughly what we might observe in a 24-hour period if—for example—a person replaced sedentary behavior with 15 minutes of vigorous activity (e.g., running); just more than one hour of moderate physical activity (e.g., fast walking); or some combination of light activity (e.g., standing, stretching, easy chores) and more vigorous activity."

In sum, they "examined self-reported and objectively



measured (i.e., accelerometer-based) physical activity and discovered that findings on the relationship with depression are specific to objectively measured—but not self-reported—activity. Meta-analytic data have shown that self-report and objective measures can yield discrepant estimates of physical activity. Self-report measures of activity may be affected by mood states and cognitive biases that also affect mental health, making it difficult to ascertain whether observed associations are true or simply artifacts of a common liability. For example, individuals vulnerable to depression may perceive themselves as more inactive and disengaged than their peers or compensate by over-reporting activity. Although this does not invalidate the utility of self-reported measures, verifying their conclusions with objective measures is essential.”

Regarding the inverse relationship between physical activity and depression, the researchers “found evidence of only one direction of this relationship, where physical activity demonstrated a potential causal relationship with depression, while depression does not appear to have such a relationship with physical activity. Other factors may better explain the observed depression-activity relationship rather than depression directly compromising physical activity. For example, underlying conditions such as chronic pain could interfere with activity and lead to depression.”

This study’s findings strongly support the importance of objective measurement of physical activity in epidemiologic studies of mental health, as well as the hypothesis that more physical activity can be an effective prevention strategy for depression.

The second study, “Physical activity offsets genetic risk for incident depression assessed via electronic health records in a biobank cohort study” published online in the *Journal of Depression and Anxiety* (November 5, 2019) examined whether physical activity could reduce the risk of depression even among adults with genetic predispositions for depression.

These researchers had access to health data in the on-going Partners Biobank, where thousands of adults in the greater Boston area have provided DNA samples which they made available for research.

These individuals had also filled out a lifestyle questionnaire that included their exercise habits, such as frequencies of activities like walking, biking, using exercise machines, and yoga classes. The researchers examined their DNA data, looking for genetic variations associated with increased risk of depression, and scored the individuals as having low, moderate or high inherited risk.

The researchers accessed the volunteers’ electronic health records (EHR) to identify those with incident episodes of depression, based on two or more diagnostic billing codes for a depressive disorder within two years following their lifestyle survey, and no such codes in the year prior to completing the lifestyle questionnaire.

“We tested main effects of physical activity and polygenic risk scores on incident depression, and effects of physical activity within stratified groups of polygenic risk.

“Using clinical EHR data, we observed that higher levels of physical activity at baseline were linked to significantly reduced chances of appearing in the healthcare system with a depressive disorder over the next two years. Descriptive findings indicated that individuals engaging in three or more hours of activity per week showed reduced prevalence of incident depression. Regression models indicated that individuals experienced a 17% decrease in the odds of incident depression for each one *SD* (standard deviation) increase in reported activity, roughly equivalent to four extra hours of activity per week. Together, this suggests that approximately 45 additional minutes of physical activity each day could translate to meaningful reductions in a person’s risk for depression.”

So, physical activity can be an effective counter-measure against depression. Activity need not be strenuous and it may reduce the risk for depression, even among those with a family history or genetic disposition for depression. And depression in itself may not cause a reduction in physical activity. It could be that we will see health care providers increasingly *prescribing* doses of physical activity for our mental health.

# From the Commissioner, Virginia Department for Aging and Rehabilitative Services

George Worthington, Dementia Services Coordinator

## ***Dementia Friendly Initiatives Take Root in Virginia***

In the Fall 2019 issue of *Age in Action*, Dr. Ansello gave a thorough overview of Dementia Friendly resources, including [AlzPossible.org](https://www.alzpossible.org), the website of the Alzheimer's Disease and Related Disorders Commission, and Dementia Friendly America (DFA, [dfamerica.org](https://www.dfamerica.org)), which supports dementia friendly initiatives in 40 states across the country. Led by the Department for Aging and Rehabilitative Services (DARS) and LeadingAge Virginia, Virginians are also embracing these initiatives to create communities that support and engage residents living with dementia and those caring for people living with dementia. The key goals of these initiatives and of the related Dementia Friends program are to raise awareness of dementia and to reduce the often crippling stigma that surrounds the condition and that can exacerbate its effects (e.g., Swaffer, 2014).

As Dr. Ansello described, DFA provides a comprehensive community toolkit that includes tools and resources to implement the initiative successfully, and provides a sectoral breakdown of the community to focus efforts such as training and outreach to build awareness. But while these resources are available, there is little that is prescriptive about the initiative beyond some foundational requirements, such as the inclusion of people living with dementia and caregivers on action teams. Each community's initiative is organically driven by local people, for local people, and thus reflects the unique identity of that community.

The dementia friendly movement in Virginia took off in April 2018 at a day-long workshop in Henrico County that introduced the concept of dementia friendly communities to nearly 40 attendees from across the state. At that time, only one community in Virginia, Herndon, was a member of the national network of dementia friendly communities. Its leader, Toni Rinehart, provided an overview of her community's efforts to date, and encouraged others in the room to start initiatives where they lived.

Since that workshop, initiatives have taken root across the Commonwealth, with seven communities now members of the national network of dementia friendly communities (Herndon, Lexington, Central Virginia/Charlottesville, Leesburg/Loudoun County, Alexandria, Arlington and Fairfax) and several more initiatives in the planning process. The latest iteration of the Dementia State Plan 2020-2024 ([https://vda.virginia.gov/dementia.htm#dementia\\_plan](https://vda.virginia.gov/dementia.htm#dementia_plan)) also includes support for dementia friendly communities, in recognition of their key role in a fully dementia-capable society.

Recognition of a community as a member of the national network does not mean the community has achieved the full vision of dementia friendliness, but it does mean there exists an action team, a strategic plan that includes short- and long-term goals (typically involving workforce training efforts), support from key stakeholders in the community, and other requirements detailed in DFA's Readiness and Recognition Criteria which is available at <https://www.dfamerica.org/toolkit-getting-started>. Beyond those basic elements, the initiatives take quite different forms.

Dementia Friendly Lexington, which is a pilot and jumping-off point for a broader Dementia Friendly Valley encompassing five counties and five cities, is led by the local Area Agency on Aging (AAA), the Valley Program for Aging Services, and the local Health District, the Central Shenandoah Health District. AAAs are often ideally positioned to take a leading role in dementia friendly initiatives, and many across the country are, indeed, led by the local AAA. Leesburg/Loudoun sees the AAA playing a major part, while nascent initiatives in other parts of the state are also being championed by the local AAA.

But other areas are developing with quite different models. The initiatives in Arlington and Alexandria are both led by Goodwin House, a non-profit continu-

ing care retirement community. In Blacksburg, Warm Hearth Village became the first dementia friendly senior living community in the state and plans to be a driving force in a broader dementia friendly community initiative in the New River Valley region.

In Charlottesville, Dementia Friendly Central Virginia is led by a team of volunteers representing various sectors, supported by the Thomas Jefferson Planning District. Like Dementia Friendly Valley, Dementia Friendly Central Virginia seeks to provide an umbrella for local initiatives in communities across the region that will then have a consistent branding and message. This will enable residents across the region to easily identify dementia friendly businesses and organizations in other localities.

Dementia Friendly Central Virginia is also a member of the Charlottesville Area Alliance, the group driving the AARP's Age-Friendly initiative in the Charlottesville area. A report comparing the two initiatives (Turner & Morken, 2016) concluded that, where feasible, age-friendly and dementia friendly initiatives should integrate as much as possible. This report can help communities new to both initiatives consider how to move forward with one or both. It contains a useful mapping of the AARP/World Health Organization (WHO) domains for age-friendly communities onto the DFA sectors and several case studies providing real-world examples of how the two initiatives can overlap and integrate with each other.

Dementia Friends is another national and international effort to raise awareness and reduce stigma that is being leveraged by many of the community initiatives in their outreach and education. Developed by the Alzheimer's Society in the United Kingdom, the program has been growing in this country since 2015. With just 62,000 Dementia Friends in the US, there is some distance to catch up to the more than two million in the United Kingdom. People become Dementia Friends by attending a 60-minute information session delivered by a Dementia Friends Champion and by committing to a dementia friendly action of their own.

In Virginia, more than 300 people have attended Champion training sessions, and more than 3,000 people have attended Dementia Friends sessions in

the past 18 months. Information about upcoming Champion trainings and Dementia Friends information sessions can be found at [https://leadingagevirginia.org/mpage/DFVA\\_Home](https://leadingagevirginia.org/mpage/DFVA_Home).

Swaffer, K. (2014). Dementia: Stigma, language, and dementia-friendly. *Dementia*, 13, 709-716. <https://doi.org/10.1177/1471301214548143>

Turner, N., & Morken, L., 2016. Better Together: A Comparative Analysis of Age-Friendly and Dementia Friendly Communities. Downloaded from [https://www.dfamerica.org/s/AARP-Report\\_BetterTogether\\_March2016-den9.pdf](https://www.dfamerica.org/s/AARP-Report_BetterTogether_March2016-den9.pdf)

## 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](http://vda.virginia.gov/boardsandcouncils.htm).

### Commonwealth Council on Aging

March 18, June 17, September 16, December 9

### Alzheimer's Disease and Related Disorders Commission

March 10, June 9, September 8, December 8

### Virginia Public Guardian and Conservator Advisory Board

March 5, June 11, September 3, November 19

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# College Students Compete to Develop Tech Solutions for Caregivers

*Teams from Virginia Tech, Virginia Commonwealth University, and the College of William and Mary awarded prizes*



*The winning team from VT*

Virginia Tech's team took top honors in the 5th Annual Caring for the Caregiver Hack, an event in which seven Virginia colleges and universities compete over a 25-hour span to create innovative tech tools to help family caregivers.

The Hack, organized by nonprofit VirginiaNavigator's Lindsay Institute for Innovations in Caregiving, seeks to address the growing crisis of caregiver health. Right now, according to the AARP, 40 million Americans are providing unpaid care for aging or ill loved ones, dedicating an average of 20 hours per week to this work. As the population ages, the number of available caregivers will shrink; by 2030, there will be just four caregiving-aged adults (45-64) for every person aged 80 or older.

"Family caregiving is truly the backbone of long-term care, making up more than 80% of care provided," said Dr. Richard W. Lindsay, co-founder of The Lindsay Institute for Innovations in Caregiving. "The creation of tech solutions is crucial to allow fewer caregivers to do more and to help care from a distance."

The Hack took place November 2-3, 2019 at Troutman Sanders LLP in downtown Richmond. Interdisciplinary teams from the College of William and Mary, George Mason University, James Madison University, University of Lynchburg, University of Virginia, Virginia Commonwealth University, and Virginia Tech worked with faculty coaches, family caregivers, and technology and business mentors as they developed prototypes of their tools.

Virginia Tech's winning entry, **Omplace**, is an app designed to help a primary caregiver provide better care by connecting them with secondary caregivers. Omplace (pronounced ohm-place) enables users to coordinate care for a loved one by sending specific requests to a circle of contacts and transmitting details to a receipt-like printer in the care recipient's home. "The printout, the OmScript, was very unique, and made it possible for people who aren't accessing technology to at least see the printed version," said author and AARP caregiving expert Amy Goyer, who was one of the judges.

Second prize went to the Virginia Commonwealth University team for its app, **New Boots**, which seeks to guide people through the process of becoming caregivers for the first time.

The College of William and Mary's team took third place for **CollHome**, an online platform that organizes groups of college volunteers to install and service in-home technology solutions for caregivers. "We liked that it was intergenerational, that younger students would be having interactions with older adults," author and judge Amy Goyer said.

Virginia Tech's winning team not only received a \$3,500 cash prize and an additional \$1,000 for each student from event sponsor Genworth, but also will have the opportunity (as will VCU's team) to develop their app further at Startup Virginia, a nonprofit business incubator in Richmond. Thanks to Alz You Need, the Virginia Tech and VCU teams also received invitations to participate in the Silver Moonshots Virtual Accelerator, a six-week startup boot camp.

The esteemed panel of judges selected the winners based on the technology's originality, usability, feasibility, and level of development. The judges were:

- Nick Bawa, CEO and Co-Founder, Covintus
- Marcia DuBois, Deputy Commissioner, Division for Community Living, Virginia Department for Aging and Rehabilitative Services
- Amy Goyer, Author and Family Caregiving Expert, AARP
- Deb Mitra, SVP — Business Strategy, Genworth
- Leda Rosenthal, Founder and CEO, Alz You Need

- Richard Wintch, Executive Director, Startup Virginia

Additional technologies developed at the Hack event included:

- **Helpvault**, created by the George Mason University team, is an app and website that provides one-stop access to home care aides, volunteer help, self-care services, a care scheduling app, medical records, and important documents.
- **Checkpoint Care**, created by James Madison University, aims to establish trust and accountability between primary caregivers and in-home aides by providing a shared calendar, daily checklist, and care recipient profile.
- **Uplift**, developed by the University of Lynchburg team, seeks to promote caregivers' emotional and social wellness and connect them with a global caregiver community.
- **HAVEN** (Home Automated Video-Enabled Notifications), developed by the University of Virginia team, is a system that uses AI to analyze video footage in a care recipient's home and alerts a caregiver when an adverse event, such as a fall, is detected.



*Caregivers and university teams meet*

“With the Hackathon, we see imaginative ways to lighten the burden on caregivers,” said AARP board member Robert

Blancato. AARP and Genworth supported the 2019 Caring for the Caregiver Hack as Presenting Sponsors. Platinum Sponsors were Troutman Sanders and the Virginia Center on Aging at VCU.

**About The Lindsay Institute for Innovations in Caregiving:** The Lindsay Institute for Innovations in Caregiving is an initiative of VirginiaNavigator, a statewide public/private partnership non-profit that helps Virginia’s older adults, people with disabilities, veterans, caregivers, and families find vital information and community programs so they can live with independence, dignity and hope.

As the number of Virginians over 65 doubles by 2030 to 1.8 million, and with over one million caregivers across the state providing 88% of all eldercare, the Lindsay Institute and its esteemed Advisory Council are working together to keep caregivers from neglecting their own health while they care for a loved one.

For more information, please visit

[caregivinginnovations.org](http://caregivinginnovations.org).

## Human-Animal Interaction Benefits for Older Adults

*Addressing Social Isolation: A Resource Page for Practitioners, Caregivers, and Those Who Work with/Know Someone Who Is Socially Isolated*

“Human-Animal Interaction across the Lifespan” is a first-of-its-kind course taught at VCU by Dr. Shelby McDonald. Through this course, Dr. McDonald is sharing her expertise about how human welfare and animal welfare overlap and how families are often composed of more than just humans.

As part of an assignment for this course, Elena Papanassiou and Taylor Wilkerson (both second year clinical Master of Social Work students at the time) created a resource web page that informs caregivers and those working with socially isolated populations about the potential benefits of owning a pet or interacting with one. The page includes current research about social isolation and how it affects older adults, the positive outcomes associated with human-animal interaction, considerations of the research, and links to resources that can help older adults decide if a pet is right for them. They hope this page can serve as a foundational resource for those wanting to know more about the potential of human-animal interaction across disciplines. Visit their site at <https://spark.adobe.com/page/38Oe10a6gHd98>.

### Visit Our Websites

VCoA: [vcoa.chp.vcu.edu](http://vcoa.chp.vcu.edu)

DARS: [www.vadars.org](http://www.vadars.org)

## COMMONWEALTH OF VIRGINIA

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### Alzheimer's and Related Diseases Research Award Fund

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#### Delayed Final Project Reports from the 2018-2019 Alzheimer's Research Award Fund

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 delayed final project reports submitted by investigative teams funded during the 2018-2019 round of competition are given below. Both awards were enhanced by a \$50,000 donation from Mrs. Russell Sullivan of Fredericksburg, in memory of her husband who died of dementia. To receive full reports, contact the investigators or the ARDRAF administrator, Dr. Constance Coogle ([ccoogle@vcu.edu](mailto:ccoogle@vcu.edu)).

**GMU**                    **Janusz Wojtusiak, PhD, and Catherine Tompkins, PhD\***

*Analysis of Wandering Patterns of Individuals with Alzheimer's Disease*

A significant number of people with dementia are at risk of wandering and possibly getting lost. GPS trackers provide detailed location data that can be used to build models capable of predicting likely areas in which searching for the missing needs to be done. This study focused on collecting initial tracking data for people with Alzheimer's disease (AD) using GPS trackers, along with their medical history and sociodemographic data and using that data to test the feasibility of finding patterns of movement and wandering. The pilot project was also intended to initiate a long-term data collection and research project to improve safety and model the progression of AD. The investigators created procedures needed for participant enrolment and data collection for the project. They investigated a number of methodological aspects of modeling movements of people with AD. Specifically, they developed novel approaches to analyzing GPS data, particularly by focusing on linking participant movements to landscape information extracted from maps and improving prediction of location when a person is missing up to five hours. Local movement trajectories around frequently visited locations was also modeled. Dr. Wojtusiak may be contacted at (703) 993-4148, [jwojtusi@gmu.edu](mailto:jwojtusi@gmu.edu); Dr. Tompkins may be contacted at (703) 993-2838, [ctompkin@gmu.edu](mailto:ctompkin@gmu.edu).

**ODU**                    **Patrick C. Sachs, PhD, Peter A. Mollica, PhD, MB(ASCP), Robert D. Bruno, PhD,  
and Shu Xiao, PhD\***

*Investigating the Effects of Sub-Nanosecond Pulsed Electric Fields as a Potential Protein Disaggregation Agent in Huntington's Disease and Alzheimer's Disease Neurons*

Application of electric fields has been shown to have disruptive effects on the protein-protein interactions found within the amyloid aggregates seen in AD and Huntington's disease (HD). One of the central challenges is penetrating the cell with sufficient energy to alter cellular structures while simultaneously avoiding cell damage. The use of ultra-short picosecond pulsed electric fields (psPEF) provides a new potential technique because their duration and power delivery is insufficient to cause membrane damage, but sufficient to impact the interior portions of the cell. The investigators adapted their specially made 3-D bioprinter with a customized Computer Numerical Control electrode head attached to a psPEF generator. Using human HD induced pluripotent stem cell-derived neuronal cells, they tested various intensities of psPEF exposures ranging from 2.5 kV/cm to 40 kV/cm and found that at the highest exposure, no cell death was witnessed after seven days post-exposure and the highest amount of intracellular protein disaggregation was achieved. At the psPEF intensities applied, pathogenic protein disaggregation occurred 24 hours post-exposure and aggregate reformation didn't begin until 6-7 days post-exposure. Expression levels of selected DNA repair genes remained unaffected at all psPEF exposures. This work recognizes the application of psPEF and the potential for therapeutic applications in neurodegenerative diseases where intracellular protein aggregation is present.

Dr. Sachs may be contacted at (757) 683-7090, [psachs@odu.edu](mailto:psachs@odu.edu); Dr. Mollica may be contacted at (757) 749-0090, [pmollica@odu.edu](mailto:pmollica@odu.edu); Dr. Bruno may be contacted at (757) 683-7091, [rbruno@odu.edu](mailto:rbruno@odu.edu); Dr. Xiao may be contacted at (757) 683-2408, [SXiao@odu.edu](mailto:SXiao@odu.edu).

## COMMONWEALTH OF VIRGINIA

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### Alzheimer's and Related Diseases Research Award Fund

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#### Request for Applications

**Purpose:** The Commonwealth of Virginia established the Award Fund in 1982 to promote research into Alzheimer's and related diseases. Because of a commitment to program balance, the Fund encourages scientifically rigorous applications from a broad spectrum of disciplines. Studies may involve:

- (1) the underlying causes, epidemiology, diagnosis, or treatment of Alzheimer's and related diseases;
- (2) policies, programs, and financing for care and support of those affected by Alzheimer's and related diseases;
- (3) or the social and psychological impacts of Alzheimer's and related diseases upon the individual, family, and community.

**Funding:** The size of awards varies, but is limited to \$45,000 each. Number of awards is contingent upon available funds.

**Eligibility:** Applicants must be affiliated with colleges or universities, research institutes, or other not-for-profit organizations located in Virginia. The Fund encourages partnerships between community-based agencies/facilities and academic institutions in Virginia.

**Schedule:**

**Letter of Intent:** By **February 6, 2020** prospective applicants are required to submit a non-binding letter of intent that includes a tentative project title, contact information for the principal investigator, the identities of other key personnel and participating institutions, a non-technical abstract, the specific aims, and a 4-5 sentence description of the project in common, everyday language for press release purposes. Letters on letter-head with signature affixed must be uploaded to [go.vcu.edu/ardraf-loi](http://go.vcu.edu/ardraf-loi). Potential applicants will be contacted if LOIs are deemed inappropriate.

**Applications:** Applications, sent by couriers who date stamp on or before the due date, with an electronic copy also e-mailed simultaneously, will be accepted through the close of business **March 12, 2020**. NOTE: significant changes to the application form and guidelines were instituted in 2018.

**Announcement of Awards:** Award decisions will be announced by June 22, 2020.

**Funding Period:** The funding period begins July 1, 2020 and projects must be completed by June 30, 2021.

**Review:** Three qualified technical reviewers, one of whom is identified by the applicant, will review proposals for scientific merit. The Awards Committee will make the final funding decision.

**Application:** Application forms, guidelines, and further information may be found at [go.vcu.edu/ardraf](http://go.vcu.edu/ardraf) or by contacting the Award Fund administrator:

Constance L. Coogle, Ph.D.  
Phone: (804) 828-1525,  
E-Mail: [ccoogle@vcu.edu](mailto:ccoogle@vcu.edu)

For door-to-door delivery (FedEx, UPS, etc) the street address is 900 E. Leigh Street, 7th Floor–Room 7216, Richmond, VA 23298.

## VCoA Represented at Gerontological Society of America's Annual Meeting

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The Gerontological Society of America held its annual scientific meeting this past November in Austin, Texas. The Virginia Center on Aging was well-represented by faculty and staff who presented one paper, one poster, and participated in three symposia.

**Marrs, S. A., Inker, J., Waters, L., McIntyre, M., & Gendron, T.** (2019, November). *Knowledge of Ageism and Attitudes about Aging as a Core Competency for Health Professionals*. Paper presented at the meeting of the Gerontological Society of America, Austin, Texas.

**Ansello, E., & Marrs, S. A.** Stakeholder Engagement in the Plenary as a Model for Professional-Community Partnerships. (2019, November). In *Partnering in Geriatrics Workforce Enhancement Programs: Models to Enhance Collaboration and Engagement*. Symposium conducted at the meeting of the Gerontological Society of America, Austin, Texas.

**Ansello, E.** Community Networks Addressing Aging with Lifelong Disabilities (2019, November). In *"Pretty Good" Practices: Geriatrics Workforce Enhancement Programs and Lifelong Disabilities*. Symposium conducted at the meeting of the Gerontological Society of America, Austin, Texas.

**Waters, L., Brennan, M., Martinchek, M.** An Update on the Return of the Geriatrics Academic Career Awards Program (2019, November). In *Policy Series: HRSA Geriatrics Education Initiatives: A Policy and Program Update*. Symposium conducted at the meeting of the Gerontological Society of America, Austin, Texas.

Zanjani, F. A., Brooks, M., **Waters, L., Parsons, P., & Slattum, P.** *Reducing Opioid Overdose Risk in a Community Care Coordination Clinic: Richmond Health and Wellness Program*. Poster presented at the meeting of the Gerontological Society of America, Austin, Texas.

## Five Gifts of Aging Acceptance

By Kathy Sporre

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It is understood through research that part of ageism is due to the fear of dying; especially in western culture. Because of our fear of dying, aging becomes a bad thing to do since it brings us closer to what we fear. To combat this, we try to avoid or at least deny that we are getting older with each passing day. If we carry the baggage of negative stereotypes of aging that we learned as children, we will also try to avoid the unavoidable.

Many of us go to great lengths to feed this denial in order to maintain our youthfulness. When we do so, through the myriad of ways society has created to help us feed the monster of age denial, we are missing out on the gifts we can receive by accepting our aging process.

### Five Gifts Of Aging Acceptance

**The ability to receive.** It almost goes without saying that with acceptance comes the ability to receive. Acceptance removes the barriers that denial creates and opens the way for the gifts of aging to flow into our lives. When we aren't fighting useless battles against aging, we are free to acknowledge and receive the rewards of longevity. Our minds are clear to see the small ripples of benefits aging breaks across our life's shores. Take a walk along the beach that has been your life up until now and intentionally seek those treasures cast up from the deep. Everyone's shore will be strewn with a different variety of "pearls" and treasures. What are yours?

**The ability to live in the present.** When we are able to accept, we are more able to live in the present moment. We are not fighting the battles of yesterday through regrets or the fears of tomorrow. We are present to what is going on around us right here and now. We are able to give more attention to the people and things that are right in front of us. That is a gift to them as well as to ourselves. Are you paying more attention to the people and things in your life right now as you are to your regrets and fears? Don't miss out on the present. Remember: the present is a gift.



**The ability to make moments count.** As we learn to live in the present, life will seem to slow down. Through our increased awareness, we will see and experience more than possible when we are a million miles away fighting past (regrets) or future (fear) battles. Our awareness of all that surrounds us will come into greater focus, and we will clearly see that our attention is called for right here and now. It is good to be mindful of where our attention is. If it is present in the moment, we are showing more respect, care, and love to the people in our lives. Moments will not be wasted and cherished memories will be made. Are you here for those you love or are you somewhere far in the past or the future?

**The gift of authenticity.** When we can truly accept ourselves for who we are, wherever we are on life's journey, we free ourselves to truly be who we are, authentically. There is no need for any pretenses to prove to others and ourselves that we are something we are not. We are genuine beings who are grounded in truth. Our foundation is strong when we are true to ourselves... The best relationships are those based on authenticity because they are not conflicted with deception. Deception is not of the light. It is of the dark and it takes a lot of energy to pretend we are what we're not. Like a spring of pure water, our authenticity will find its way to the surface. Are you using your energy to fight the truth or allowing yourself to be filled with energy by accepting the truth?

**The gift of freedom.** If we accept ourselves as who we are at any given moment in time, we will free ourselves from negative feelings like jealousy and anger that often accompany the desire to be other than who we are. When we see a young person with all the supple qualities of youth which we wish we could hold onto forever, we can look, appreciate, remember and let go. We don't climb on the elevator to the lower levels of anger and resentment or jealousy over what another person has that we covet. We had our time in that place and despite the appearance of youthfulness, life wasn't all a bed of roses then – remember? In fact, life is better now in many ways. Start counting them. When we are able to accept our aging process or anything else for that matter, we no longer have to fight against something. We are truly free.

*Kathy Sporre maintains the blog [refinedbyage.com](http://refinedbyage.com) and invites your participation.*

## **31st Annual Virginia Geriatrics Society Conference, April 24-26, Short Pump Hilton**

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This popular conference is intentionally interprofessional, designed for wide-ranging and engaging continuing education (20 hours), with practical, useful, high-quality information for primary care providers who take care of older adults.

Presenters will include pharmacists, psychologists, and an occupational therapist, in addition to physician specialty content experts. Highlights this year include a session with John Morley, an internationally-recognized scientific expert on gerontology, and Paul Aravich, distinguisher professor from Eastern Virginia Medical School, who will partner to discuss how best to ensure healthy aging; Morley will also speak in another session on preventing dementia.

A group of sessions specific to diagnosing and managing dementia and related challenging clinical issues will form a portion of Saturday's program.

Specialists will offer updates on the latest recommendations in rheumatology, cardiology (CHF), sleep medicine, diabetes, osteoporosis, and medications for depression. There will be two hours on management of chronic pain, including use of CBD and physical (non-drug) measures, that will satisfy Virginia state CE requirements. Hear updates on topics related to hospice, home health, and nursing home care. See special demonstrations on wound care and use of assistive devices, plus provider wellness.

Keep an eye open for more developments and spread the word to your geriatric care colleagues! *Continuing education credits are pending approval for physicians, nurses, pharmacists, and physician assistants.*

Book your room at the beautiful Hilton Short Pump. Rates start at just \$155, so reserve today to take advantage of this special pricing. Call the Hilton Short Pump at (804) 592-3623 and mention Virginia Geriatrics Society.

Registration will open soon at:  
<http://www.viriniageriatricsociety.org/>

# Calendar of Events

## February 17-21, 2020

*Activities and More...Preparing Activity Professionals for the Future of Long Term Care.* Presented by the Virginia Health Care Association/Virginia Center for Assisted Living. DoubleTree by Hilton Hotel Richmond - Midlothian. For information, visit [www.vhca.org](http://www.vhca.org).

## February 22-23, 2020

*Virginia Pharmacists Association Midyear Conference.* Hotel Roanoke, Roanoke. For information, visit [www.virginiapharmacists.org](http://www.virginiapharmacists.org).

## February 29, 2020

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

## March 16-18, 2020

*Virginia Assisted Living 2020 Spring Conference.* Presented by the Virginia Assisted Living Association. Hilton Norfolk the Main, Norfolk. For information, visit [www.valainfo.org](http://www.valainfo.org).

## March 18, 2020

*Residential Care/Assisted Living Administrator Exam Prep Course.* Hosted by the VCU Department of Gerontology; taught by two licensed ALF Administrators. For information and to register, visit [vcuagewaveevents.virginiainteractive.org](http://vcuagewaveevents.virginiainteractive.org).

## March 24-27, 2020

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

## March 31, 2020

*Faithful Aging Conference.* Presented by Pinnacle Living; supported by the University of Lynchburg's Beard Center on Aging. For information, visit [www.lynchburg.edu/academics/academic-community-centers/beard-center-on-aging/](http://www.lynchburg.edu/academics/academic-community-centers/beard-center-on-aging/).

## April 14-18, 2020

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

## April 17, 2020

*Lifelong Learning Institute in Chesterfield Summer Catalog release.* On site and online. For information, visit [www.LLIChesterfield.org](http://www.LLIChesterfield.org) or e-mail [info@LLIChesterfield.org](mailto:info@LLIChesterfield.org).

## April 24-26, 2020

*Annual Virginia Geriatrics Society Conference.* Hilton Richmond Short Pump Hotel, Richmond. For information, visit [www.virginiageriatricsociety.org](http://www.virginiageriatricsociety.org).

## May 7-9, 2020

*American Geriatrics Society 2020 Annual Scientific Meeting.* Long Beach, CA. For information, visit [www.meeting.americangeriatrics.org](http://www.meeting.americangeriatrics.org).

## May 12, 2020

*Connect. Collaborate. Contribute: Communities for the Future.* 2020 Virginia Governor's Conference on Aging. Richmond. For information, visit [www.vgcoa.com](http://www.vgcoa.com).

## May 27-29, 2020

*Solving the Puzzle: Joining Together to Protect Elder Virginians.* Annual Conference of the Virginia Coalition for the Prevention of Elder Abuse. Kingsmill Resort and Conference Center, Williamsburg. For information, visit [www.vcpea.org](http://www.vcpea.org).

### Age in Action

Volume 35 Number 1: Winter 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](mailto:ksivey@vcu.edu).

**Spring 2020 Issue Deadline for Submissions:  
March 15, 2020**



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at Virginia Commonwealth University, Richmond, Virginia  
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*Third Alzheimer's Disease Conference*  
**What Happens after the Diagnosis of Dementia:  
Care Strategies for Caregivers and Providers**

**Presented by the Hampton University School of Pharmacy & School of Nursing, Hampton University Center for Gerontology Excellence, and the Virginia Geriatric Education Center**

**March 26, 2020**  
**Hampton University Student Center Ballroom, Hampton**  
**8:30 a.m. - 3:30 p.m.**

**Keynote Speakers**

Fayron Epps, PhD, RN

Gerontologist and Nurse Scientist, Nell Hodgson Woodruff School of Nursing, Emory University, Atlanta, GA

Marissa Galicia-Castillo, MD

Geriatrician, Glennan Center for Geriatrics and Gerontology, Eastern Virginia Medical School

Ethlyn McQueen-Gibson, DNP, MSN, RN-BC

Director, Center for Gerontology Excellence, Hampton University

An Expert Panel Discussion will address audience questions and concerns. Continental breakfast, lunch, CMEs and CEUs will be provided. For information, email [ethlyn.gibson@hamptonu.edu](mailto:ethlyn.gibson@hamptonu.edu) or [travonia.brownhughes@hamptonu.edu](mailto:travonia.brownhughes@hamptonu.edu).

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