

## Case Study

### Building Interprofessional Teams through Evidence Based Practice Training in Falls Prevention

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#### Objectives

1. Analyze an Evidence Based Practice (EBP) program on falls prevention as a vehicle for successful interprofessional team-building.
2. Examine ways that organizational characteristics can affect team functioning.
3. Compare interprofessional team-building in two sites.
4. Discuss elements of interprofessional teams that contributed to practice changes.

#### Background

EBP programs on falls prevention can be effective in reducing the

recurrence of falls in older adults, especially when implemented through an interprofessional team approach. At the same time, conducting the EBP program can reveal characteristics of the implementing team that help make the intervention more or less successful. We examine the implementation of a 24-content hour EBP program on reducing falls at two different sites having different organizational and staffing patterns in order to determine important contributors to and barriers against practice changes in interprofessional teaming.

Evidence-based practice is the “judicious use of current best evidence in conjunction with clinical expertise and patient values to guide healthcare decisions” (Titler, 2008). There is a need to examine how EBP training engenders changes in interprofessional team functioning and development. “Evidence-based practices (health care and otherwise) respond and adapt to the contexts in which they exist, increasing the need for organizational planners and evaluators to have frameworks they can tailor locally to unique project environs”

(Manchester, 2013, p. 25). In settings that support team-based practices, behavioral changes after staff trainings are viewed as ongoing processes that occur within collaborative systems (Titler, 2008).

Our Virginia Geriatric Education Center (VGEC) conducted two case-based EBP trainings in 2015 and the following discussion is intended to illuminate how participants in each setting began planning ways to implement EBPs within the contexts of their respective teams. We hope to illustrate their exploration of opportunities for using EBP to prevent falls in their different organizational settings.

#### The Evidence Based Practice Training Program: Rationale and Function

Falls and the management of falls in older adults should receive interprofessional focus, because falls can be both a sentinel event, signaling the presence of various risk factors, and a triggering event at the start of a cascade of negative consequences. The risk factors for falls are complex and require interprofessional assessment and treatment.

#### Inside This Issue:

VCoA Editorial, 6  
DARS Editorial, 8  
Needed Nutrients, 9

ARDRAF Final Reports, 10  
Cultural Competence, 12  
Moral Bucket List, 14

VCoA Focus: C. O'Hara, 16  
Open Enrollment Clinics, 17  
Calendar of Events, 18

The best treatment plans derive from focused research which produces evidence-based practices. The Virginia Geriatric Education Center (VGEC), an interdisciplinary consortium of Virginia Commonwealth University, Eastern Virginia Medical School, and the University of Virginia, developed a seven-week training program that is built around a comprehensive, interprofessional approach to assessment, treatment, and care designed to strengthen interprofessional teamwork and reduce the risk of falls among the team's patients.

The program includes seven 2-1/2 hour sessions that are supplemented by on-line resources that the VGEC has identified as helpful and relevant. Participants can access these resources outside of these six sessions, and they include required and optional readings. The faculty teaching these sessions, representing Medicine, Nursing, Occupational Therapy, Pharmacy, Physical Therapy, and Social Work, collaborate to introduce evidence-based practices in managing and preventing falls through a case-based, team-oriented approach. The interprofessional teaching team uses actual or composite profiles of older, complex patients as the focus of presentations and interactive discussions among all participants, with the intention of stimulating interprofessional actions among the participant learners.

Over the course of six weeks the EBP program defines falls, identifies risk factors, demonstrates falls risk assessments and interventions, and suggests appropriate interprofessional team approaches for care plans and follow up. On the seventh

week, members of the VGEC teaching team meet with the participant team to discuss if and how changes have been made to interprofessional practice at the site and how the team plans to improve their approach to managing falls moving forward.

In 2015, the VGEC conducted two complete seven week programs; the first (Case Study 1), at a small, rural PACE (Program of All-inclusive Care of the Elderly) site; the second (Case Study 2), at a large, urban, multi-unit health care organization with both in-patient and out-patient services, as well as home visit and long-term care services; in both instances, team-care was the existing practice model. These circumstances offered an opportunity to assess not only how the interprofessional training was received and implemented but also barriers to practice changes and characteristics that differentiated changes in implementation. We considered aspects of stakeholder commitment and organizational characteristics, along with team structure, function, culture, and communication to be potential facilitators and barriers to using the training as a springboard for changing practice around falls prevention.

### **Case Study 1**

The rural PACE had an intact interprofessional team whose members were affiliated with the following disciplines: Advanced Practice Nursing, Health Administration, Medicine, Nursing, Nutrition, Occupational Therapy, Personal Care, Physical Therapy, Quality Assurance, Recreational Therapy, Social Work, and Transportation.

Importantly, the PACE site Director, although not a clinician, was supportive of this EBP-Falls training and attended every session. His commitment was reinforced when the initial estimate of the frequency of falls among PACE participants was shown by analyses of patient records to be a gross underestimate. During the very first EBP session, there was a collective perception among the trainees that falls were not really an area of large concern, since they occurred so infrequently. Seeking clarification, the site Director left the meeting to gather falls data from his office next door. Before the session concluded that day, he returned with the data to show that the falls rate was many times larger than generally perceived.

Trainee team membership was defined broadly, from transportation staff to clinical providers, and input from this broad perspective was considered and respected during the training activities. Trainee team members were united as a single team and most of the team members were co-located when performing their work.

The VGEC interprofessional EBP-Falls training implementation began by engaging the stakeholders at the site. Champions for the program were identified early on and the training team visited the practice site and met the trainee team prior to the first session. From the beginning, trainee team members expressed shared interest in improving their practices around falls prevention and commitment to using the training opportunity to guide change. The site Director was fully engaged throughout the train-

ing, demonstrating the importance of the issue and the training as a pathway to finding better solutions for the organization.

During the training and team discussions, the trainee team identified several salient matters: that social workers and pharmacists were not fully engaged as team members; that, although occupational and physical therapists knew about fear of falling as a risk factor for falls, social work had a greater appreciation of its prevalence; and that using evidence based assessment tools is important. Further, that program participants received their pharmacy services in a variety of ways and, therefore, pharmacist input was often not available to the trainee team. The training team members identified the need for consistent medication assessment related to falls risk and identified opportunities to engage a pharmacist in the process. There was also an expressed intention to increase the number of disciplines involved in team meeting discussions related to patients who fall or are at risk for falling, notably paraprofessional nurses, the transportation staff manager, and the site Director. Trainee team members recognized that falls were a significant issue among their patient population and were committed to doing something about it. Individual team members were able to identify opportunities for practice change and were supported by their other team members.

## Case Study 2

The large, multi-unit organization had interprofessional teams by practice setting, including in-patient and out-patient, and home visits.

Trainee team members were affiliated with the following disciplines: Kinesiotherapy, Medicine, Nursing, Advanced Practice Nursing, Occupational Therapy, Physical Therapy, Pharmacy, and Social Work.

This program included trainee team members from two separate teams providing care for different groups of patients receiving care from the institution. There was also a falls prevention physical therapist at the facility who was able to work with both teams to identify opportunities for the teams to incorporate the training content into the team practices. Team members included in the training were primarily the health care provider members and some team members worked virtually (through the EHR) with the rest of the team rather than participating in team discussions and decisions directly. Not all of the team members who work within each of the teams participated in the training, but the allocation of the time of a large number of providers to participate demonstrated institutional commitment to the program.

The VGEC EBP-Falls training implementation in this site similarly began with securing stakeholders. In this case, however, champions were not identified immediately and engagement involved multiple pre-training meetings, in large part to work through the bureaucratic issues (scheduling, who would be made available to participate in the training, location of the training, information technology firewalls) inevitable in a large organization. Trainer team members had no contact with the trainee teams prior to the start of the training to establish rapport and shared goals. Members

of two clinical teams participated in the trainings and, while the teams had some commonalities in the ways that they were addressing falls, there were also differences unique to each clinical team. Overall institutional buy-in and support for the training as a means to foster practice change were less evident to the participants, but the trainee teams were actively engaged in the training program, and team members who may not have interacted with each other previously were able to learn from each other's experiences.

The participation of the falls prevention physical therapist, who was a champion for improving practice and could support practice change over time, contributed to the success of the program. She was able to translate the training practically for the specific setting, making it more directly relevant to the trainees. During the training and group discussion, the trainee team identified several salient matters: that, although assessments might be performed, they were not being used by the team as effectively as they could be to inform team decisions and interventions; that the role of one member of the trainee team was to focus on falls and she was able to share opportunities for improvement with the other team members that were specific to the care setting; and that there were ways that team members might collaborate more effectively with the falls prevention physical therapist. Social work was added as part of one of the teams to address falls because of the training, yet physical therapy remained as a referral from the team. Previously, the kinesthesiologist or occupational therapist

had not been involved after a fall as a matter of course; but, after the training, there was a new-found realization that the composition of the post-fall team needed to become more comprehensive.

### **Commonalities and Differences between Sites**

As illustrated in these two cases, there were a number of commonalities between the sites. Training participants were generally open to changing their way of working to achieve the team goal of managing and preventing falls. In both instances, we saw a clearly stated intention to foster greater inclusion of all relevant providers in team meetings. There was also a sense that expanded communications would result in better outcomes. Having champions in each setting to provide continuity after the training enhanced the opportunity to foster change in practice for the long term. During both of the trainings, input from all team members was respected and carefully considered during in-depth discussions. Attendance at both sites was robust, and ultimately, buy-in from both was strong.

We learned some lessons in comparing and contrasting the two sites. In dealing with the challenges encountered, it became apparent that degree of engagement by program leadership affected attendance by a site's training participants. The leadership needs to walk the walk as well as talk the talk. We found that we needed the leaders not only to encourage attendance initially, but also to attend regularly in order to maintain level of attendance. When all team members are

not present in the training, the team is then tasked with bringing those absent members up to speed on the team's direction. For example, one participant told us, "I am receiving more timely information on Falls Risk Ratings for newly admitted patients from the staff who have attended. Will need to encourage that same communication from the staff who did not attend."

### **Key Elements for Success**

We have noted several important contributors to successful interprofessional practice change when examining these two cases. First, securing stakeholders, that is, having buy-in from organizational leadership, is essential for success. Stakeholders need to see how comprehensive training on multifactorial risk assessments and interventions can reduce serious fall-related injuries. This commitment will lead them to invest the requisite human and fiscal resources, such as allocating staff training time and improving upon data collection methods in electronic medical records. It is also helpful to engage stakeholders collaboratively in program planning to ensure that training goals are in line with the quality improvement aspirations of the health practice itself. Second, our trainings served as an effective stimulus for fostering changes in interprofessional team-building. As one participant told us, "Providers have become closer as a result of the training. As a team, they now have a stronger sense that they can make an impact on the lives of those they serve. By working more closely together they feel they can collectively use what they learned

to make a difference in how they look at falls and the ways to prevent them." Third, we realized the importance of reinforcing different elements that contribute to practice changes. Success is enhanced when we can consistently use the beginning of each session to help trainee teams reflect on how the previous session's content was or should be synthesized and applied to practice. The more that the team reviews and contemplates the content presented, the better able we are to achieve optimal assimilation. Finally, these two cases illustrate the benefits of expanding the disciplines and providers involved in interprofessional teams dealing with falls prevention and management.

We were singularly successful in teaching the advantages to be gained when teams operate in both lateral and vertical modes on the professional continuum. Training resulted in greater involvement of paraprofessional staff in the conduct of fall risk and balance assessments. As examples, at the large, multi-unit site, we learned that the falls champions included a CNA and an LPN; we learned that the definition of a fall was not uniformly applied to dementia patients; so the unit addressed this internally by developing a falls template; similarly, the other team at this site expressed their intention to develop an interdisciplinary falls protocol as soon as they could reconvene their falls committee. At the rural PACE site, the home care department is now rotating participation by the home care nurses on the falls team to make sure that there is representation from those who see the participant in environments where the

latter are either in total control or have no control; the transportation department is assigning someone to the falls team meetings; and the social workers are taking turns participating as well.

### Expectations for the Future

The extent to which EBP training ultimately facilitates collaborative-care role sharing will be the strongest indication of success. As the teams we have trained evolve through the behavioral changes that characterize levels of use (Hall & Hord, 2010) of an EBP in a team context, we should see observable and evaluable markers or anchors indicative of evolution (Manchester, 2013). Teams should progress from: 1) initially trying out EBPs in coordination with others on the team and learning the mechanics of the practices (Mechanical Level), to 2) becoming comfortable performing the EBPs (Routine Level), to 3) looking for ways to improve procedures and refine the practices (Refinement Level), to 4) full collaboration in performing the EBPs by filling in performance gaps as different team members step into shared roles and provide diverse skills (Integration Level). Finally we would like to see teams exploring new ways to implement the EBPs for sustained team performance within their health care systems (Renewal Level).

The professionals at each of our training sites had a sophisticated appreciation of evidence-based practices. Both groups were eager to incorporate new assessment tools. The rural site was intent on vigorously re-examining their assessment procedures and supple-

menting their practice with screening and assessment instruments promoted in the evidence-based literature. Similarly, participants at the corollary site were committed to having the Timed Up and Go Test (Podsiadlo & Richardson, 1991) administered by the occupational therapist during home care visits; there was also an interest in applying the Home Safety Self Assessment Tool (Horowitz et al., 2013; Tomita et al., 2013). Both sites stated their intention to incorporate a falls efficacy scale, specifically the FES-International (Yardley et al., 2005). Finally, our analysis of learner attitudes as factors that affect health care professional programming (structures, processes, outcomes) remains of tantamount importance as we plan for our next EBP training series.

### Study Questions

1. How can organizational policies or structures promote or inhibit the adoption of effective interprofessional teams?
2. What elements in each of the two settings seem crucial to fostering effective interprofessional team work?
3. Which aspects of the EBP training contributed to success in encouraging the application of evidence based practices?
4. What changes in interprofessional team functioning and development can be fostered through EBP training?

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## Editorials

### From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

#### *Disappearing before My Eyes*

My mother would've been 94 years old the week after she died. She passed quietly with dementia late the night of Labor Day, just hours after I'd called her to tell her that it was Labor Day and people were having cook outs and picnics everywhere. We'd just been together a week before and, after the nurse put her on, I was alarmed that it was 10:30 in the morning and she was still in bed, this woman who was up at dawn every day. With typical bluntness, she said she felt "crappy" and she sounded down, her tone off. Immediately after our conversation, I called my daughter to ask her to visit her grandmother. She did, taking her son who was my mother's favorite great grandson. By blessing or divine intervention, the last thing I said to my mother and the last thing my daughter said to her was, "I love you." She said the same to us.

For the last 20-30 years she was notorious for telling the same stories: how her brother Frankie had a rabbit and a goat who chewed up the kitchen pots, during the Depression in urban Boston; the time she got my brother and me and a car load of Cub Scouts lost in a snowstorm coming back from a visit to a miniature railroad park; how furious my father was when she came home to tell him that she'd spent \$100 on credit to buy an old Studebaker Land Cruiser. Recently, she'd

barely remember these stories with prompts.

She lived in her own house, two stories with a walk down cellar, for 50 years plus one month, 48 years by herself. She'd always been forgetful and could get lost so easily when driving that it was legendary. For decades she'd frequently go up or down the stairs and arrive having forgotten why she'd made the trip. We joked that, no matter what happened to her memory, she'd be in great cardiovascular shape because of all the climbing. And so it was.

She began to fall, first while raking in her back yard at 92, then while walking back from the grocery store, then inside the house at the upstairs landing. We bought her a medical alert watch but she would not wear it. Reluctantly, our family urged that she move into assisted living. Even more reluctantly, she finally agreed, moving in last August. She had a small efficiency apartment but was moved to the memory care floor in a matter of months. By February she had fallen in the facility three times.

The last time, on arriving at the hospital emergency room, she was diagnosed with having, in addition to a fractured pelvis, pneumonia, a urinary tract infection, and dehydration. Each can worsen confusion. After treatment, she was discharged to the same rehabilitation facility where she'd recovered after her previous falls; they knew her and she them, and so she stayed, this time in the skilled nursing section. From living in her own home to the end was just 13 months.

She worked until her mid-80s and

## Editorials

was extremely proud of it, being a medical secretary for some 40 years, and assisting in minor office surgeries in a solo dermatology practice. The dermatologist loved her dedication and work ethic, and didn't want her to retire. He didn't know or care how old she was, and she wouldn't tell him. She lied about her age, anyway. She actually changed her passport by altering her birth date of 1921 to 1927, but I guess she's beyond prosecution now. When I was in the third grade, I got into a fist fight in the school yard because another boy said my mother wasn't 18 as she'd told me.

Like her weight, which she said, with no sense of irony, ranged "anywhere from 99 to 100 pounds," she was a constant in my life, even to the end.

As her memory worsened, contexts offered some cues for conversation but these were increasingly limited. If we were driving, she'd ask me repeatedly when I was going home (to Virginia), how I was getting to the airport, if the car I was driving was my own. In a brief, local drive, she might ask me this a dozen times in 20 minutes, sometimes prefacing the question with, "I know I've probably asked you this before, but I forget what you said." She tried in what were early stages of fading memory to use prompts, such as asking what my daughter did for a living; when I replied, "Which daughter?" she'd know that I had two, and so on. Later she abandoned all pretexts of remembering and I ceased asking, "Do you remember...?" Instead, I told her of my days and events. Near the end, she related many times that she liked that I talked with her, that we

had conversation.

About 10 days before she died, she dozed off several times while we were visiting at her brother and sister-in-law's house, something she'd never done before. And her stamina evaporated as a day progressed: she could manage to stand or seat herself when exiting or entering my rental car at the start of our day but needed a fireman's hug to accomplish the same at its end.

During my last visit, we drove one day to Pembroke where we'd had a cottage near a pond. Her Uncle Billy and Aunt Millie had built it before World War II, and she and her sisters and female cousins visited there often during the war while the males, barely men, were away in the Navy. Being home-made, the cottage had quirks like a half-sized doorway entrance on the side to a cellar with a bar and neon signs. My parents bought it from Billy and Millie in the late 1950s and owned it for a few years. During that time my mother's sister and brother-in-law bought a nearby cottage and we cousins had great fun there during summers. I helped my mother out of the car and pushed her in a transport wheelchair up nearer the cottage. My friend Paul Raia of the Alzheimer's Association of Massachusetts and New Hampshire had advised me to stop asking, "Do you remember when...?" but rather to recall events for her with statements like "I remember when you and I..."

I described my memories of times in Pembroke as a kid, like her taking us to the Town Landing for swimming, which she did even though by her own admission she

"swam like a rock"; visiting our cousins' cottage and provoking a stern uncle with our failures to be quiet while staying overnight. After the cottage, we then drove to a much loved establishment on the pond where we used to have burgers and hot dogs as kids; it's a honky tonk now but it still had the side window where they sold ice cream cones. We ordered two and she loved it. Later we drove to an Italian restaurant just up the street from her house of 50 years to have pizza inside. When I returned her to her skilled nursing facility that afternoon, she thanked me for "all the wonderful memories." She said that it meant so much and that she'd treasure them. When I picked her up the next day, she remembered nothing.

That next day, my last in person with her on this earth, we went to Castle Island, a pre-Revolutionary War fort built by the British to help defend Boston Harbor. Again, she had taken my brother and me there as kids. It's recently been enhanced with a long pedestrian causeway that encloses as a lagoon the South Boston beach where she would take us to swim. We spent a couple of hours there enjoying a strong ocean breeze that refreshed an otherwise warm day. We sat on a bench and I recounted memories for her of climbing trees there as a young boy, having PB&J sandwich picnics there, and pointing out the nearby bath house where the "L Street Brownies" take their daring plunges into the water every February. Again, she said she loved the memories and would cherish them.

Maybe she did. Maybe in some way, at some level unrecognizable

## Editorials

to those outside, these memories brought her comfort or pleasure. My friend Paul Raia advised me to think of the moment, not the durability, of these experiences. Perhaps it's like enjoying a soap bubble, blown up and shining with multi-colored luminescence. It's there for just a moment before bursting. The fact that we know it'll break and vanish doesn't prevent us from blowing up another. With dementia, maybe it's all bubbles near the end.

### 2015/16 DARS Meeting Calendar

#### Commonwealth Council on Aging

January 27, May 1, July 13, September 21, 2016

#### Alzheimer's Disease and Related Disorders Commission

December 1, 2015; March 22, May 1, August 30, December 6, 2016

#### Public Guardian and Conservator Advisory Board

November 19, 2015; March 17, May 1, September 15, November 17, 2016

For more information, call (800) 552-5019 or visit <http://vda.virginia.gov/boards.asp>.

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

Jim Rothrock

### *Fall Brings Leaves and Change at DARS*

As always, there is lots of activity at our agency. We recently lost Bob Brink, who had served as our Deputy Commissioner in the Aging Unit. He was reassigned to the Office of the Governor as the Senior Legislative Advisor. He will be missed, as he had visited all of our Triple As and had even authored several editorials for this publication. Moreover, he was a joy to work with, and his staff benefitted from his solid wisdom and sound leadership. Plans for his replacement will be available by the next *Age in Action* issue.

We also lost Charlotte Arbogast since the last edition. She had been our first Dementia Services Coordinator and had served in this capacity quite well. She was promoted to a new position in our state's Medicaid Agency, DMAS, in their long term care unit, where she will continue to serve "our folks."

Yet, along with the changing of the season, we have ushered in Mrs. Devin Bowers as the second Dementia Services Coordinator (DSC) and finalized the *Dementia State Plan 2015–2019*. Mrs. Bowers holds a Master of Public Health degree from George Mason University and a Post-Baccalaureate Graduate Certificate in Aging Studies

from Virginia Commonwealth University. Prior to accepting the position of DSC, Mrs. Bowers contributed to the work of the Department for Aging and Rehabilitative Services (DARS) in various capacities. These included supporting the position of the DSC for six-months while contributing to the development of the report, *Dementia Care Best Practices in the Commonwealth*. After the conclusion of the project, Mrs. Bowers assumed the role of Chronic Disease Self-Management Education (CDSME) and Options Counseling Coordinator, completing grant management activities and spearheading the submission of a grant proposal to the federal Administration for Community Living.

Mrs. Bowers' other achievements include being selected as one of the first Virginia Center for Health Innovation Fellows. In this capacity, she contributed content to the Virginia Health Innovation Network in the form of articles and interviews, and authored blogs on various topics, including educating physicians about dementia, aging challenges faced by the Lesbian Gay Bisexual Transgender (LGBT) population, and aging initiatives on the federal level.

As a student in the Department of Gerontology at VCU, Mrs. Bowers assisted with the creation of an economic impact analysis report for the Virginia Association for Home Care and Hospice, and was recognized as the 2015 Gerontology Student of the Year for outstanding scholastic achievement and demonstrated service in the field.

Additional experience in the field

## Editorials

of aging includes working with the Richmond-based nonprofit, Ramp Access Made Possible by Students (RAMPS) as the Program Outreach Coordinator. Mrs. Bowers supported the Executive Director in the coordination of modular wheelchair ramp builds for low income older adults and individuals living with disabilities. Also, while completing graduate coursework at GMU, Mrs. Bowers interned with the Fairfax-based chapter of the Alzheimer's Association, contributing to strategic planning and implementation of the Physician Outreach Program. Mrs. Bowers decided to pursue a career in aging, with a particular emphasis on assisting persons with dementia (PWD) and their caregivers, after her grandmother was diagnosed with Alzheimer's disease. This diagnosis coincided with Mrs. Bowers' first semester at GMU and set her on a trajectory for a career in aging and dementia.

Due to her personal connection, she is looking forward to improving the lives of PWD and their caregivers by achieving the goals and objectives of the *Dementia State Plan*. Going forward, she plans to tackle establishing a student loan forgiveness or tuition assistance program for health students specializing in geriatrics, encouraging and initiating participation in CDSME for PWD and their caregivers, increasing awareness of the Medicare Annual Wellness Visit, and developing a consortium network for dementia research. The Alzheimer's disease and Related Disorders Commission and the first DSC, Charlotte Arbogast, worked to update the *2011 Dementia State Plan* by integrating findings from the Dementia Care Best Practices

report, mentioned previously, and holding five public listening sessions across the Commonwealth. Comments were also received from professionals and family caregivers by mail, telephone and email. The comments greatly informed the Dementia State Plan update and helped to create a document, which reflects the special needs and concerns of Virginians.

With skilled professionals like Mrs. Bowers, I am confident that we will continue to support in so many ways the services needed by our Vintage Virginians.

### Not Enough of Two Good Things

In the midst of pervasive high blood pressure and other health risks among so many older adults, there's growing evidence that we need to get more of two nutrients: potassium and magnesium.

Higher potassium intake is associated with both lower blood pressure and lower risk of stroke, and may offer some protection against osteoporosis. Higher magnesium intake may lower risk of type 2 diabetes. As in most cases, there are cautions, however. People with kidney disease or those taking an ACE inhibitor for high blood pressure (Capoten, Lotensin, Accupril, etc.) need to check with their physician before taking potassium supplements. Fortunately, nature offers many sources of potassium and magnesium. This is, in part, why the DASH (Dietary Approaches to Stop Hypertension) and OmniHeart programs place emphases on veg-

etables and fruits rich in these nutrients. Fruits, raisins, and dark green leafy vegetables, for example, are good sources of potassium, while leafy greens, beans, nuts, and coffee are good for magnesium. Experts recommend that we consume about 4,700 mg a day of potassium and about 320 mg a day (women) or 420 mg a day (men) of magnesium. The great majority of us get less.

The September 2015 issue of *Nutrition Action Healthletter*, published by the Center for Science in the Public Interest, lists foods rich in potassium and magnesium. These include, in mg per serving:

#### Potassium

Baked Potato (small) with skin 750  
Beet greens (1/2 cup cooked) 650  
Halibut (4 oz. cooked) 600  
Yellowfin tuna (4 oz. cooked) 600  
Sweet potato (small) with skin 540  
Acorn squash (1/2 cup cooked) 450  
Non-fat plain yogurt (6 oz.) 430  
Banana (1) 420  
Cantaloupe (1/4) 370  
Pistachios (1/4 cup) 310

#### Magnesium

Brazil nuts (1/4 cup) 125  
Almonds (1/4 cup) 95  
Cashews (1/4 cup) 90  
Spinach (1/2 cup cooked) 80  
Peanuts (1/4 cup) 65  
Dark chocolate (1.4 oz.) 60  
Navy beans (1/2 cup cooked) 50  
Brown rice (1/2 cup cooked) 40  
Oatmeal (1/2 cup cooked) 30

Some foods are "double dippers," being good sources of both potassium and magnesium. These include yellowfin tuna, beet greens, spinach, Swiss chard, pistachios, beans (Navy, pinto, Great Northern, and lima), and plain yogurt.

## COMMONWEALTH OF VIRGINIA

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

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#### 2014-2015 FINAL PROJECT REPORT SUMMARIES

The Alzheimer's and Related Diseases Research Award Fund (ARDRAF) was established by the Virginia General Assembly in 1982 and is administered by the Virginia Center on Aging at Virginia Commonwealth University. Summaries of the final project reports submitted by investigators funded during the 2014-2015 round of competition are given below. To receive the full reports, please contact the investigators or the ARDRAF administrator, Dr. Constance Coogle ([ccoogle@vcu.edu](mailto:ccoogle@vcu.edu)).

**GMU**                    **Robin Couch, PhD**  
*Neuroprotection and Alzheimer's Disease*

Nerve growth factor (NGF), a protein naturally produced in the brain, is capable of preventing neuronal cell death, such as that associated with Alzheimer's disease (AD). Recent preclinical and clinical AD studies have noted a reduction in the rate of cognitive decline upon treatment with NGF. However, because NGF is unable to penetrate the blood brain barrier, current means of delivering NGF directly to the brain are highly invasive and cost prohibitive. Oral drugs capable of stimulating the upregulation of NGF in the brain are preferred. To that end, this research group has identified protein kinase C (PKC) and several of its downstream effectors as critical to the upregulation of NGF protein. They used a series of protein specific agonists and antagonists to validate select members of the PKC signal transduction pathway, thereby highlighting them as promising targets for the development of new therapeutics for the treatment of AD. (Dr. Couch may be contacted at (703) 993-4770, [rcouch@gmu.edu](mailto:rcouch@gmu.edu).)

**UVA**                    **Erin Pennock Foff, MD, PhD, and Benjamin Purow, MD**  
*Investigating the Role of miR-762 in Mediating Disease in C9ORF72-Based Frontotemporal Degeneration*

It is known that amyotrophic lateral sclerosis and frontotemporal dementia can be caused by a common genetic mutation in the C9ORF72 gene. The investigators discovered that a particular regulatory microRNA had high predicted affinity to bind this mutation, and questioned whether inappropriate binding of that molecule could contribute to disease process. In this funded project, they were able to demonstrate that: a) the predicted microRNA shows altered activity in blood and stem cells derived from patients with the disease, b) specific genes are misregulated in the cells in a manner consistent with microRNA disruption, and c) those disruptions may be contributing to some of the known features of the disease, including excitotoxicity to glutamate. These results constitute the most critical first steps in validating the investigators' proposed mechanism's potential role in mediating part of the disease phenotype. These initial data have also contributed to a new initiative in the lab to build more sophisticated model systems using three-dimensional stem cell cultures that will better approximate normal brain structure and cellular interactions. (Dr. Foff may be contacted at (434) 243-1006, [epf4b@virginia.edu](mailto:epf4b@virginia.edu); Dr. Purow may be contacted at (434) 982-4415, [bwp5g@virginia.edu](mailto:bwp5g@virginia.edu).)

**Warren Memorial Hospital**      **Jonathan Winter, MD and J. William Kerns, MD**  
*Pharmacologic and Non-Pharmacologic Management of Behavioral and Psychological Symptoms of Dementia (BPSD): A Mixed-Method Pilot*

Because antipsychotic medications (APs) for treating the behavioral and psychological symptoms of dementia (BPSD) can cause rare severe side effects (SE), an FDA Black Box Warning (BBW) was issued to reduce their use. This mixed methods study explored why roughly 20 percent of Virginia nursing home patients still remain on APs. Quantitatively, they trended the prescribing rates of all psychotropics in Virginia's Medicaid dementia population since the FDA BBW. Not only has AP utilization not decreased, but use of alternative medications for BPSD that have not been shown to be safer or more efficacious are increasing. Qualitatively, they assessed the experiences and perceptions of POAs and nurses (caregivers) about decision-making processes concerning pharmacologic/non-pharmacologic approaches to BPSD management. Caregivers feel that non-pharmacologic strategies (NPS) can work for most BPSD, but have limits. Community POAs also feel "on their own," in developing and utilizing NPS, with little help from physicians and inadequate supporting resources. Furthermore, caregivers see pharmacologic strategies as effective, especially if the 'right' medication is used in addition to NPS. What's more, no caregiver reported ever knowingly observing the severe SE of APs described by the BBW. These severe SE of APs were rarely discussed by physicians and poorly understood by caregivers. (The investigators may be contacted at (540) 631-3700, [jwinter@valleyhealthlink.com](mailto:jwinter@valleyhealthlink.com), [bkerns@valleyhealthlink.com](mailto:bkerns@valleyhealthlink.com).)

**GMU**      **Joseph J. Pancrazio, PhD**  
*Analysis of Amyloid Beta Effects with Living Neuronal Networks*

Assays based on dishes of cells offer a means of screening potential therapeutics and accelerating the drug development process. In this study, the investigator used dishes of interconnected brain cells or neurons on electrical recording devices called microelectrode arrays to examine the effects of amyloid- $\beta$  1-42 (A $\beta$ 42), a biomolecule implicated in the Alzheimer's disease process. The research showed that a special form of A $\beta$ , oligomeric but not the monomeric, diminishes electrical activity from the network of neurons on the microelectrode arrays. This observation is important because clinical and animal model results suggest that the neuroactive form of A $\beta$  is the oligomer and so the assay method is sensitive to the pathologically relevant form of the molecule. The effects of the oligomer are persistent over a period of at least 24 hours and do not appear to be associated with cell death. In addition, the researcher demonstrated that the excitatory receptors in the brain, that are triggered by the neurotransmitter glutamate, play a role in the effects of A $\beta$ 42 on neuronal network activity. Exposure to blockers of these receptors modulated the time course of A $\beta$ 42 oligomer effects on the neuronal networks. Pretreatment of the neuronal networks with two model therapeutics, methylene blue and memantine, reversed the effects of oligomeric A $\beta$ 42. These findings suggest that cultured neuronal networks may be a useful platform in screening potential therapeutics for A $\beta$  induced changes in neurological function. (Dr. Pancrazio may be contacted at (703) 993-1605, [jpancraz@gmu.edu](mailto:jpancraz@gmu.edu).)

**UVA**      **Zhiyi Zuo, PhD**  
*Environmental Enrichment Reduces Postoperative Cognitive Dysfunction*

Postoperative cognitive dysfunction (POCD) often occurs in patients 60 years of age or older. It not only affects daily living, but also is associated with increased death after surgery. Recent studies indicate that inflammation in the brain, an abnormal process for many chronic brain diseases including Alzheimer's disease, may be involved in POCD. This investigation employed environmental enrichment (EE) to test whether that non-pharmacological intervention could reduce POCD in aged mice. The results showed that EE reduced surgery-induced learning and memory impairment. The reduced brain cell generation needed for learning and memory was also attenuated after surgery. These results provide initial evidence to suggest that improved environment after surgery may be a potential way to reduce POCD. These data should help in the design of clinical studies to test the beneficial effects of EE in humans. (Dr. Zuo may be contacted at (434) 924-2283, [zz3c@virginia.edu](mailto:zz3c@virginia.edu).)

Virginia  
Tech

**Doris T. Zallen, PhD, Golde Holtzman, PhD, and Kye Kim, MD**  
*Evaluation of a Web-Based Decision Aid for People Considering a Genetic Testing for Alzheimer's Risk*

This team of investigators developed an online decision-aid prototype as an educational tool to help in making decisions about whether or not to use the APOE genetic test to estimate genetic risk for Alzheimer's disease. This prototype was evaluated by over 1,200 participants in a two-part (before and after) survey-based study. Both the quantitative data (the responses to the survey questions) and qualitative data (additional written comments from the participants) reveal a high level of satisfaction with the tool as a means of providing information relevant to this decision. Using feedback obtained in response to a request for suggested improvements to the tool, the prototype was re-designed to provide a greater ease of functionality and greater accessibility on a wide variety of platforms. In addition to validating the usefulness of this tool for individual decision-making, this study identified areas which may be the subject of future consideration by the medical community and by government agencies. These areas include: a) ways of encouraging the further creation of online tools as educational aids in making genetic-testing and other health-care decisions, and b) the consideration of policies to help ensure that consumers have adequate information as they consider genetic testing for Alzheimer's disease and other disorders. The enhanced decision aid will now be made available online at no cost to the wider public. (Dr. Zallen may be contacted at (540) 231-4216, [dtzallen@vt.edu](mailto:dtzallen@vt.edu); Dr. Holtzman may be contacted at (540) 239-2949, [holtzman@vt.edu](mailto:holtzman@vt.edu); Dr. Kim may be contacted at (540) 981-8025, [kykim@carilionclinic.org](mailto:kykim@carilionclinic.org).)

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## Cultural Competence Trainings for Healthcare Professionals Working with LGBT Elders

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by Jay White, MS  
Director of Professional and  
Community Development,  
VCU Department of  
Gerontology

Nationally, efforts are underway to address the needs of the country's LGBT (Lesbian, Gay, Bisexual and Transgender) elders. SAGE, the world's oldest and largest non-profit agency dedicated to serving the needs of LGBT elders, recently received a three year, \$900,000 grant from the U.S. Department of Health and Human Services, Administration on Aging, to create a clearinghouse of information, assistance, and resources for agencies that provide services to the aging LGBT population. There's good reason for this.

There are currently between 1.4 and 3.8 million LGBT Americans over the age of 65, according to the National Gay and Lesbian Task Force. By 2030, this number is expected to increase to 8 million. Between 2000 and 2011, the number of Gay and Lesbian-identified households in Virginia increased from 13,802 to 19,812, a 30% increase. Further, though advances have been made in reporting, the Human Rights campaign suggests that the United States Census undercounts the number of Gay and Lesbian families by as much as 62%. Moreover, these figures do not include the Bisexual or Transgender population.

How well will LGBT older adults be able to age in place? If they have healthcare needs in later life, how well will these needs be met? While significant strides have been made in recent years to address issues of LGBT social inequities, a pervasive fear remains among the current

aging LGBT population that they will be the victims of apathy, discrimination, or even abuse as they age into healthcare communities. The Joint Commission initiated regulations in 2006 against anti-LGBT bias in care but the National Gay and Lesbian Task Force maintains that these have never been enforced. Given this situation and the lack of data regarding LGBT seniors living in assisted living facilities and long term care communities, it is reasonable to conclude that there is a deficit in cultural competence and sensitivity initiatives.

In response, the VCU Department of Gerontology partnered with Mad Stu Media (producers of the documentary *Gen Silent*) and the LGBT Aging Project. Thanks in large part to a grant from the Virginia Center on Aging's Geriatric Training and Education (GTE) initiative, the partners developed a curriculum entitled "A Caring Response for

LGBT Clients.” Since 2011, representatives from the Department of Gerontology have traveled throughout Virginia to train direct care professionals, administrators, staffs at AAAs, and other aging services providers on best practices for working with LGBT elders. As of fall 2015, the project has trained over 1,500 healthcare professionals and aging services providers on this topic.

The training enjoys acclaim for its integration of clips from the *Gen Silent* documentary, which recounts true-life stories of LGBT elders so afraid of aging into the long term care continuum that they consider going “back into the closet” in order to survive. Further, the curriculum engages participants in sobering facts about LGBT elders, healthcare issues, and matters of social networks and risks for isolation.

According to the pre-post test data (see Tables 1 and 2) generated for the GTE final report, the “Caring Response” project enjoyed a 95.6% mean efficacy rate from trainees at its original five participating agencies (N=158) in 2011. One participant stated, “*I am now considering HR policies and creating a welcome statement for the agency. Would like to extend training to*

*ALL direct care staff for the agency.*”

The project also assessed level of comfort caring for members of the LGBT community, both pre-and post-training. Ratings were measured on a Likert scale, with 1 representing the lowest value and 5 representing the highest value. A paired-samples *t*-test was conducted to compare level of comfort working with an LGBT older adult pre-and post-training.

Since the US Supreme Court’s ruling legalizing same-gender marriage in June of 2015, attitudes regarding LGBT civil rights appear to be evolving across the country. However, today’s older LGBT adults grew up in a different, more biased time. They may still fear discrimination from healthcare professionals and other community members, whether living in a congregate or independent setting. It is important to continue to engage those working in the long term and aging services industries in a proactive and person-centered approach to care for a diverse population.

**Resources for Further Reading**

Fredriksen-Goldsen, K. I., Kim, H.J., Emlert, C. A., Muraco, A., Erosheva, E. A., Hoy-Ellis, C. P., Gold-

sen, J., & Petry, H. (2011). *The aging and health report: Disparities and resilience among lesbian, gay, bisexual, and transgender older adults*. Seattle: Institute for Multigenerational Health.

Gendron, T., Maddux, S., Krinsky, L., White, J., Lockeman, K., Metcalfe, Y., & Aggarwal, S. (2013). Cultural competence training for healthcare professionals working with LGBT older adults. *Educational Gerontology*, 39(6), 454-463.

Johnson, M., Jackson, N., Arnette, J. & Koffman, S. (2005) Gay and lesbian perceptions of discrimination in retirement care facilities. *Journal of Homosexuality*, 49(2), 83-102.

National Resource Center on LGBT Aging. (2012). *A self-help guide for LGBT older adults and their caregivers & loved ones: Preventing, recognizing, and addressing elder abuse*. Retrieved from [www.lgbtagingcenter.org/resources/pdfs/SELFHELP\\_elderAbuse\\_Guide.pdf](http://www.lgbtagingcenter.org/resources/pdfs/SELFHELP_elderAbuse_Guide.pdf).

Van Wegenen, A., Driskell, D. & Bradford, B. (2012). I’m still raring to go: Successful aging among lesbian, gay, bisexual, and transgender older adults. *Journal of Aging Studies*; 27, 1-14.

**Table 1**

**Difference Pre to Post Test**

Site	n	M	SD	t	p
Site A	44	.32	.52	4.07	<.001
Site B	26	.38	.50	3.95	<.001
Site C	19	.21	.54	1.71	.10
Site D	35	.66	.54	7.21	<.001
Site E	8	.50	.76	1.87	.10

**Table 2**

Site	Would recommend (%)
Site A	95
Site B	97
Site C	96
Site D	100
Site E	90

## The Moral Bucket List

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by David Brooks

*The following is excerpted from an Op-Ed essay by David Brooks that appeared in the New York Times on April 11, 2015 (<http://nyti.ms/1Fy2QmR>). Mr. Brooks often appears on NPR's *All Things Considered* and NBC's *Meet the Press*. He is a member of the American Academy of Arts and Sciences and the author of "The Road to Character," from which this essay is adapted.*

About once a month I run across a person who radiates an inner light. These people can be in any walk of life. They seem deeply good. They listen well. They make you feel funny and valued. You often catch them looking after other people and as they do so their laugh is musical and their manner is infused with gratitude. They are not thinking about what wonderful work they are doing. They are not thinking about themselves at all.

When I meet such a person it brightens my whole day. But I confess I often have a sadder thought: It occurs to me that I've achieved a decent level of career success, but I have not achieved that. I have not achieved that generosity of spirit, or that depth of character.

It occurred to me that there were two sets of virtues, the résumé virtues and the eulogy virtues. The résumé virtues are the skills you bring to the marketplace. The eulogy virtues are the ones that are talked about at your funeral, whether you were kind, brave, honest or faithful. Were you capable of

deep love?

We all know that the eulogy virtues are more important than the résumé ones. But our culture and our educational systems spend more time teaching the skills and strategies you need for career success than the qualities you need to radiate that sort of inner light. Many of us are clearer on how to build an external career than on how to build inner character.

But if you live for external achievement, years pass and the deepest parts of you go unexplored and unstructured. You lack a moral vocabulary. It is easy to slip into a self-satisfied moral mediocrity. You grade yourself on a forgiving curve. You figure as long as you are not obviously hurting anybody and people seem to like you, you must be O.K.....

So a few years ago I set out to discover how those deeply good people got that way. I didn't know if I could follow their road to character (I'm a pundit, more or less paid to appear smarter and better than I really am). But I at least wanted to know what the road looked like.

I came to the conclusion that wonderful people are made, not born...built slowly from specific moral and spiritual accomplishments.

If we wanted to be gimmicky, we could say these accomplishments amounted to a moral bucket list, the experiences one should have on the way toward the richest possible inner life. Here, quickly, are some of them:

**The Humility Shift.** We live in the culture of the Big Me. The meritocracy wants you to promote yourself. Social media wants you to broadcast a highlight reel of your life. Your parents and teachers were always telling you how wonderful you were.

But all the people I've ever deeply admired are profoundly honest about their own weaknesses. They have identified their core sin, whether it is selfishness, the desperate need for approval, cowardice, hardheartedness or whatever. They have traced how that core sin leads to the behavior that makes them feel ashamed. They have achieved a profound humility, which has best been defined as an intense self-awareness from a position of other-centeredness.

**Self-Defeat.** External success is achieved through competition with others. But character is built during the confrontation with your own weakness. Dwight Eisenhower, for example, realized early on that his core sin was his temper. He developed a moderate, cheerful exterior because he knew he needed to project optimism and confidence to lead. He did silly things to tame his anger. He took the names of the people he hated, wrote them down on slips of paper and tore them up and threw them in the garbage. Over a lifetime of self-confrontation, he developed a mature temperament. He made himself strong in his weakest places.

**The Dependency Leap.** Many people give away the book "Oh, the Places You'll Go!" as a graduation gift. This book suggests that life is an autonomous journey. We master

certain skills and experience adventures and certain challenges on our way to individual success. This individualist worldview suggests that character is this little iron figure of willpower inside. But people on the road to character understand that no person can achieve self-mastery on his or her own. Individual will, reason and compassion are not strong enough to consistently defeat selfishness, pride and self-deception. We all need redemptive assistance from outside.

People on this road see life as a process of commitment making. Character is defined by how deeply rooted you are. Have you developed deep connections that hold you up in times of challenge and push you toward the good?

**Energizing Love.** Dorothy Day led a disorganized life when she was young: drinking, carousing, a suicide attempt or two, following her desires, unable to find direction. But the birth of her daughter changed her. She wrote of that birth, "If I had written the greatest book, composed the greatest symphony, painted the most beautiful painting or carved the most exquisite figure I could not have felt the more exalted creator than I did when they placed my child in my arms."

That kind of love decenters the self. It reminds you that your true riches are in another. Most of all, this love electrifies. It puts you in a state of need and makes it delightful to serve what you love. Day's love for her daughter spilled outward and upward. As she wrote, "No human creature could receive or contain so vast a flood of love and joy as I

often felt after the birth of my child. With this came the need to worship, to adore."

She made unshakable commitments in all directions. She became a Catholic, started a radical newspaper, opened settlement houses for the poor and lived among the poor, embracing shared poverty as a way to build community, to not only do good, but be good. This gift of love overcame, sometimes, the natural self-centeredness all of us feel.

**The Call within the Call.** We all go into professions for many reasons: money, status, security. But some people have experiences that turn a career into a calling. These experiences quiet the self. All that matters is living up to the standard of excellence inherent in their craft.

Frances Perkins was a young woman who was an activist for progressive causes at the start of the 20th century. She was polite and a bit genteel. But one day she stumbled across the Triangle Shirtwaist factory fire, and watched dozens of garment workers hurl themselves to their deaths rather than be burned alive. That experience shamed her moral sense and purified her ambition. It was her call within a call.

After that, she turned herself into an instrument for the cause of workers' rights. She was willing to work with anybody, compromise with anybody, push through hesitation. She even changed her appearance so she could become a more effective instrument for the movement. She became the first woman in a United States cabinet, under Franklin D. Roosevelt, and emerged as one of the great civic figures of

the 20th century.

**The Conscience Leap.** Commencement speakers are always telling young people to follow their passions. Be true to yourself. This is a vision of life that begins with self and ends with self. But people on the road to inner light do not find their vocations by asking, what do I want from life? They ask, what is life asking of me? How can I match my intrinsic talent with one of the world's deep needs?

Their lives often follow a pattern of defeat, recognition, redemption. They have moments of pain and suffering. But they turn those moments into occasions of radical self-understanding, by keeping a journal or making art. As Paul Tillich put it, suffering introduces you to yourself and reminds you that you are not the person you thought you were.

The people on this road see the moments of suffering as pieces of a larger narrative. They are not really living for happiness, as it is conventionally defined. They see life as a moral drama and feel fulfilled only when they are enmeshed in a struggle on behalf of some ideal.

This is a philosophy for stumblers. The stumbler scuffs through life, a little off balance. But the stumbler faces her imperfect nature with unvarnished honesty, with the opposite of squeamishness. Recognizing her limitations, the stumbler at least has a serious foe to overcome and transcend. The stumbler has an outstretched arm, ready to receive and offer assistance. Her friends are there for deep conversation, comfort and advice.

External ambitions are never satisfied because there's always something more to achieve....

The stumbler doesn't build her life by being better than others, but by being better than she used to be. Unexpectedly, there are transcendent moments of deep tranquility. For most of their lives their inner and outer ambitions are strong and in balance. But eventually, at moments of rare joy, career ambitions pause, the ego rests, the stumbler looks out at a picnic or dinner or a valley and is overwhelmed by a feeling of limitless gratitude, and an acceptance of the fact that life has treated her much better than she deserves.

Those are the people we want to be.

### Visit Our Websites

Virginia Center on Aging  
[www.sahp.vcu.edu/vcoa](http://www.sahp.vcu.edu/vcoa)

Virginia Department for Aging  
and Rehabilitative Services  
[www.dars.virginia.gov](http://www.dars.virginia.gov)

## Focus on the Virginia Center on Aging: Courtney O'Hara



Courtney O'Hara is the newest member of VCoA's team, focusing on abuse in later life. She has taken on the role of Program Manager for the Central Virginia Task Force on Domestic Violence in Later Life, a regional partnership of organizations, working since 1998 to raise awareness and improve the community response to women aged 50 and older who experience domestic, sexual, or family violence.

The Task Force's purposes include: Providing a forum for resource sharing and interaction among service providers and agencies; Promoting cross-training and collaboration among service providers and agencies; Supporting and recommending policy and program initiatives; and Seeking funding for training, outreach and services to address the needs of this underserved population.

Courtney joined VCoA in February 2015. Previously, she served as the only Domestic Violence Victim Services Advocate at Chesterfield County's Domestic and Sexual Violence Resource Center. During her time there, she assisted over 300 victims of domestic and sexual violence a year, offering individual, group, and court-based advocacy. These services involved counseling, information and referral, safety planning, legal advocacy, court accompaniment, technical assistance and consultations to county

professionals, and coordination of community awareness and outreach projects.

Courtney attended Virginia Polytechnic Institute & State University, graduating in 2002 with a Bachelor of Arts in Communication. It was during her freshman year that Tech's football team made it to its first (and, only, as of this writing) National Championship bowl game. She calls it the Golden Age of Hokie Sports. She left Blacksburg for graduate school at Longwood University, where she received a graduate assistantship at their Academic Support Center. At the Support Center, she worked with students with disabilities, coordinating their tutoring services and proctoring their exams.

Courtney's graduate studies focused on community and college counseling. She ultimately chose a community setting to put her studies into practice, securing an internship at a psychiatric hospital in Richmond, Virginia. As she was set to start work at the hospital, her husband found his dream job in Raleigh, North Carolina. Newly married, they decided long distance just wouldn't work. Courtney soon found herself at the doorstep of Triangle Family Services (TFS), a non-profit organization that prides itself on being a "safety net for the community." That net encompassed a wide range of services, including a program for those convicted of domestic violence related crimes. In 2004, it was called DOSE, an acronym for "Domestic Offenders Sentenced to Education." While TFS continues to use the term DOSE, it now stands for "Developing Opportunities for a

Safe Environment” and it’s one of the largest abuser treatment programs in the state, touting a 98% success rate.

When Courtney began her work at TFS, she knew little about the dynamics of domestic violence. After leading batterer intervention groups for over a year, and ultimately earning her Master of Science degree from Longwood, she was both educated and passionate about the issue. This internship, which had quickly turned into full time employment, came to an abrupt end in 2005. Family had called her back to Virginia. She was determined to remain a player in the field of domestic violence and, therefore, ecstatic to see the opening at Chesterfield County.

Courtney is just as determined to be a force in ending violence against women today as she was a decade ago. She’s also excited about moving from direct service to macro level work at the VCoA, believing that she now has a greater opportunity to bring about system change. She’s also enjoying the opportunity to learn more about “later life.” In addition to on the job education, she’s now seeing a great example of it in her newly retired father-in-law. She actually cautions against using the term “retired” to describe him. He was home for less than a week before he had secured another job, one he loves so much that he can’t stop talking about it. To Courtney, he illustrates that your “later life” can be a time in which you’re more fulfilled than ever.

On a more personal note, Courtney is an avid runner. She’s currently an assistant coach for the Sports Back-

ers Half Marathon Training Team. In 2007, she was the one being coached, joining the full marathon training team and officially catching that famous “running bug.” She began coaching four years ago and finds it incredibly rewarding. The training starts in the late summer and ends fourteen weeks later. The culmination is in November, on race day. Her chief coaching goal is ensuring that her team crosses the finish line, with smiles on their faces.

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## **Medicare Part D Open Enrollment Clinics**

Make sure you’re right with Medicare. The following enrollment clinics will be provided by the Rappahannock Area Agency on Aging, CMS, and VICAP. Please print, complete, and bring the Part D Required Form to the enrollment event of your choice (found at [www.raaa16.org/make-sure-youre-right-with-medicare](http://www.raaa16.org/make-sure-youre-right-with-medicare)). To RSVP and confirm clinic locations, please call (540) 371-3375.

### **October 21, 2015**

Rowser Building, Stafford  
10:00 a.m. - 3:00 p.m.

### **October 27, 2015**

King George Citizens Center  
King George  
9:00 a.m. - 4:30 p.m.

### **November 5, 2015**

Marshall Center, Spotsylvania  
9:00 a.m. - 4:30 p.m.

### **November 13, 2015**

John F. Fick III Conference Center  
Fredericksburg  
9:00 a.m. - 12:00 p.m.

### **November 20, 2015**

Caroline County Community Center, Milford  
9:00 a.m. - 4:30 p.m.

### **November 24, 2015**

Shiloh Olde Site Baptist Church  
Fredericksburg  
9:00 a.m. - 4:30 p.m.

### **December 7, 2015**

Rappahannock Area Agency on Aging, Fredericksburg  
9:00 a.m. - 4:30 p.m.

## Calendar of Events

### October 15-16, 2015

*New Frontiers for Cancer Care in Virginia: Prevention, Early Detection, Treatment, and Survivorship and Palliative Care.* Presented by Cancer Action Coalition of Virginia. Staunton, VA. For information, visit [www.cancercoalitionofvirginia.org](http://www.cancercoalitionofvirginia.org).

### November 1-4, 2015

*Be the Voice.* 2015 LeadingAge Annual Meeting and Expo. Boston, MA. For information, visit [www.leadingage.org/annualmeetingexpo](http://www.leadingage.org/annualmeetingexpo).

### November 11, 2015

*Prepare to Care: Getting Your Ducks in a Row.* 29th Annual Caregivers Conference of the AARP Virginia and the Northern Virginia Dementia Care Consortium. 8:00 a.m. - 3:30 p.m. Korean Central Presbyterian Church, Centreville. For information, visit [www.states.aarp.org/nov11](http://www.states.aarp.org/nov11).

### November 13, 2015

*Certified Dementia Practitioner Training.* Sponsored by the VCU Department of Gerontology. For those who want to increase knowledge or pursue Certified Dementia Practitioner (CDP) certification. 8:30 a.m. - 5:00 p.m. Brookdale - Imperial Plaza, Richmond. For information, visit [https://training.vcu.edu/course\\_detail.asp?ID=14332](https://training.vcu.edu/course_detail.asp?ID=14332).

### November 17-18, 2015

*Virginia Association for Home Care and Hospice Annual Conference and Trade Show.* The Doubletree by Hilton, Charlottesville. For information, visit [www.vahc.org](http://www.vahc.org).

### November 18-22, 2015

*Aging as a Lifelong Process.* 68th Annual Scientific Meeting of the Gerontological Society of America. Walt Disney World Swan and Dolphin Hotel, Orlando, FL. For information, visit [www.geron.org](http://www.geron.org).

### January 27, 2016

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

### March 3-6, 2016

*Developing Educational Leadership in Gerontology Worldwide.* AGHE's 42nd Annual Meeting and Educational Leadership Conference. The Westin Long Beach, Long Beach, CA. For information, visit [www.aghe.org/events/annual-meeting#sthash.HK9KFKI1.dpuf](http://www.aghe.org/events/annual-meeting#sthash.HK9KFKI1.dpuf).

### March 31 - April 3, 2016

*Transforming the Landscape of Caregiving: From Research to Practice.* 37th Annual Meeting of the Southern Gerontological Society. The Boar's Head, Charlottesville. For information, visit [southerngerontologicalsociety.org](http://southerngerontologicalsociety.org).

### April 1-3, 2016

*The 27th Annual Virginia Geriatrics Society Conference.* Hilton Richmond Short Pump Hotel. For information, visit [www.virginia geriatics society.org](http://www.virginia geriatics society.org) or call (434) 977-3716.

### June 7, 2016

*Annual Conference on Aging: Aging Well in Mind, Body, & Spirit.* Lynchburg College. Presented by the Beard Center on Aging at Lynchburg College. For information, call (434) 544-8456 or visit [www.lyncburg.edu/beard](http://www.lyncburg.edu/beard).

### June 8, 2016

*National Council of Certified Dementia Practitioners Alzheimer's Disease & Dementia Care Seminar.* (Course required for certification as a Certified Dementia Practitioner). Lynchburg College, Lynchburg. Presented by the Beard Center on Aging at Lynchburg College. For information, call (434) 544-8456 or visit [www.lyncburg.edu/beard](http://www.lyncburg.edu/beard).

#### Age in Action

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Director, VCoA

**James A. Rothrock**  
Commissioner, DARS

**Kimberly S. Ivey, M.S.**  
Editor

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