

Case Study

Utilizing Older Adult Standardized Patients to Enhance the Education of Health Professional Students

by Kimberly Davis, RN, MS, CNE

Educational Objectives

1. Identify the uses of standardized patients in geriatrics education.
2. Compare the advantages and limitations of older adult standardized patients.
3. Discuss how competencies can guide simulation development.
4. Describe methods for evaluation of learner performance when using older adult standardized patients.

Background

While the nation's population of individuals over 65 years of age is growing at a rapid pace, and older adults typically have a higher utilization of health services, it is well documented that there are not enough healthcare providers trained in the care of the older adult as a specialty (IOM, 2008). The health

professional curriculum is uniquely poised to address the best practices in care of the older adult, but there is a need to examine how to integrate better this recognized body of literature into the training of health professional students. Simulation is one method that can be used to train health professional students in effective assessment and communication skills (Ryall, Judd, & Gordon, 2016). Utilizing the older adult standardized patient (SP) in simulations facilitates a realistic yet safe learning environment and may be a productive way to train health professional students in the best practices of geriatrics care.

The following discussion is intended to describe the process of creating and implementing simulations with older adult SPs, so that these may be incorporated as course enhancements for health professional students.

Standardized Patients in the FDP

As part of its interprofessional 200-hour Faculty Development Program (FDP), our Virginia Geriatric Education Center (an interdisciplinary consortium of Virginia Common-

wealth University, Eastern Virginia Medical School, and the University of Virginia) conducts annual training on best practices that includes older adult standardized patients to enhance the curriculum of health professional students. An SP is someone trained to play the role of a patient in a specific medical scenario, thereby allowing health care professionals, from students to practitioners, to encounter a range of patient characteristics in which they might be assessed. SPs "stay in character" in portraying health and social conditions, for instance, and offer valuable feedback after the scenario (Plaksin, et al., 2016.)

Educational themes that might be enhanced by the use of older adult SPs include cultural competency, functional assessment, health literacy, polypharmacy concerns, delivering bad news, interprofessional team education and practice, working with caregivers and families, and advanced directives. Benefits of using an older adult SP include validation of learned content, mutual rewards for both the SP and student learner, and better understanding of the affective domain in patient care, something that is often

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difficult for students to grasp. Other advantages to using SPs are that they enable a richer, mixed modality in teaching and allow for the use of hybrid simulation, in which the addition of simulation equipment, e.g., an injection bag, can produce a more realistic scenario to increase the value of the learning experience (Ryall, Judd, & Gordon, 2016). Additionally, older adult SPs bring valuable life experience and often have flexible schedules; limitations include health or memory concerns, technology barriers, and fatigue.

Evaluation

There are multiple opportunities to evaluate learning when using SPs in simulation for clinical training. Formative (in process) learning may be used when students are provided with feedback during the simulation to guide the progression of the scenario. Summative (end of process) learning may be used when students receive feedback at the end of the simulation, during the debriefing session. The debriefing should last at least as long as the clinical scenario and include feedback from the SP and faculty educator/trainer on interviewing style, manner during the patient-provider encounter, effectiveness of probing questions to obtain diagnoses, etc.

Students may be asked to complete a pre-test to verify they have completed preparatory readings and are prepared to engage in the simulation, and it may be desirable to require a passing grade for students to gain entry to the simulation. The post-test may produce valuable information about the effectiveness of the simulation and verify successful completion of the student

learning objectives. Students should also receive surveys wherein they can offer feedback on the experience, which may then be used to assess effectiveness and adjust future clinical simulations. In conducting the standardized patient modality it is important that faculty educators/trainers have scenario progression checklists to fill out during the simulation which will document successful completion of the simulation objectives. Additionally, it can be valuable to ask the students to complete peer-evaluation forms, a 360 degree assessment of the others in their student team; this is especially helpful when such teams are interprofessional.

Competencies

Simulation objectives should be kept succinct and be realistic with consideration for the amount the student can accomplish within the allotted time frame. When writing simulation objectives, it is very important to utilize discipline-specific competencies, such as the American Association of Colleges of Nursing's *Recommended Baccalaureate Competencies and Curricular Guidelines for the Nursing Care of Older Adults* (2010), a guide for undergraduate nursing students. At the same time, complement these with interprofessional competencies, such as *Core Competencies for Interprofessional Collaborative Practice* (2011); or the Partnership for Health in Aging's *Multidisciplinary Competencies in the Care of Older Adults at the Completion of the Entry Level Health Professional Degree* (2010). Additionally, the American Geriatrics Society (AGS) may be used as a resource to identify exist-

ing formal geriatrics competencies for multiple health professional disciplines (http://www.americangeriatrics.org/health_care_professionals/education/curriculum_guidelines/competencies/existing_formal_geriatrics Competencies).

The following case studies illustrate how an SP can assume the characteristics of a patient and assist learners in achieving defined health care practice objectives. The SP may be used to guide assessment of student learning, in the first case, their ability to employ fall risk assessment tools, such as are described in the Stopping Elderly Accidents, Deaths, and Injuries (STEADI) guidelines found at the Center for Disease Control and Prevention (CDC)

(www.cdc.gov/steady/index.html).

This first case study example allows faculty to observe the student's accuracy in using fall risk assessment tools, as well as the ability to communicate effectively with the patient, family member, and health care team.

Case Study 1

Mrs. Janet M. is a 73-year old, who is brought to the primary care clinic by her daughter. She is widowed, lives alone, and her daughter provides support by visiting her weekly. Her medical history includes hypertension, arthritis, and type 2 diabetes with peripheral neuropathy. Medications include lisinopril, metformin, and acetaminophen. Vital signs at visit: temperature – 98.7 F; pulse – 74; respiratory rate – 18; blood pressure – 158/90. Mrs. M.'s daughter reports that she is concerned about her mother's recent changes in mobility and

some increased confusion. The patient is status post fall at home yesterday with no reported injury. The patient will be experiencing some mild confusion during the visit with the healthcare team.

Student Learning Objectives

1. Perform a safety assessment.
2. Conduct a fall risk assessment.
3. Demonstrate therapeutic communication with the patient and family.
4. Demonstrate effective communication with an interprofessional team of healthcare providers.
5. Describe how an interprofessional team-focused approach to patient care can help decrease a patient's risk of falls.

Pre-Briefing

Faculty serve as facilitators for each simulation and are assigned four health science students to play the roles of physical therapist, registered nurse, family member, and peer evaluator. All students receive the case scenario and expectations, and then scripts for playing the role of the family member and peer evaluator. The students who are assigned the role of the physical therapist and registered nurse are instructed to (a) ask the SP three priority safety questions; (b) complete a comprehensive fall risk assessment using the CDC's STEADI guidelines to include Timed Up and Go, 30-second Chair Stand, and the 4-Stage Balance Test; and (c) demonstrate effective communication with the family member, patient, and all members of the health care team throughout the scenario progression. Students are given 15 minutes to review their assigned roles with faculty.

The script for the family member includes the following information: When asked, the concerned daughter, Susan, admits her mother has fallen once in the past week (yesterday) with no apparent injury. She says that Ms. M. has had increased confusion, especially at night, over the past 6 months, as well as occasional incontinence because "she can't get to the bathroom in time." The daughter demonstrates a calm demeanor, but is obviously very worried. She questions the nurse and physical therapist as to what is going on, and states, "Her confusion seems to be getting worse. She never used to be like this," and asks whether she can get help by obtaining a mobility device such as a walker or cane.

The peer evaluator receives the objectives for this simulation so he or she can provide feedback during the debriefing as to whether objectives were met.

The older adult SP will have received the learning objectives and script ahead of time and have had time to practice the role. Advanced time for preparation is important to ensure an adequate comfort level for the SP and because the SP needs to be able to prompt scenario progression if needed. In this scenario the SP will be prompted to "raise red flags" when answering safety questions and to score poorly on the fall risk assessment tests.

(See Table #1, Simulation for Standardized Patient, Page 4)

(See Table #2, Simulation Scenario, Page 5)

Debriefing

Questions to guide debriefing are supplied and the debriefing session should last at least as long as the simulation. Reflection should be encouraged and faculty should consider themselves strictly as facilitator so that students account for most of the dialogue. Dreifuerst (2012) has developed a debriefing method, Debriefing for Meaningful Learning, which may be used to create quality debriefing sessions.

Questions that were prepared for this case study include asking students to reflect on what went well and what they may wish to do differently, and asking the family member and SP to offer comments.

Faculty facilitators should then lead a discussion by asking the following questions: why did they choose the three safety questions they chose and what concerned them about their findings? What are some age-related predisposing factors and precipitating factors that can lead to changes in mobility and this patient's increased fall risk? Once a fall risk is identified, what interventions and follow up should be implemented? How can an interprofessional team-focused approach help decrease a patient's risk of falls? And lastly, what is one thing you learned today that you plan to take with you into practice? It is important that the students make the connection that the patient's safety is the most important aspect of this patient interaction.

Current Status in Simulation for Standardized Patient:	
Name	Janet M.
Date of Birth	3/2/1944
History of Present Illness	You fell yesterday while at home. You were able to call your daughter who decided not to call EMS. There was no apparent injury.
Last Night	Your daughter decided to stay overnight with you and you became really confused as the evening progressed. Your daughter became concerned and called for an appointment with your primary care doctor this morning.
Mental Status	You know your name, and where you are, but not what day it is. You state that you “forget a lot of things, but that’s how old people are.”
Pain	Your right hip is a little sore from the fall yesterday. You took some Tylenol at 6 AM today.
Scenario Part 1	The student nurse and physical therapist should ask you three priority safety questions. Your daughter has been prompted to report many safety concerns, but you will adamantly deny any of the concerns are true. If the students are calm, and help to reorient you to where you are, you can calm down a little bit, but should remain mildly anxious. If the students are not “therapeutic,” you are to stay anxious.
Scenario Part 2	The students will complete three tests based on the CDC’s STEADI guidelines. 1) Timed Up and Go. You show slow tentative pace, short strides, shuffling, and turning. Complete the test in about 20 seconds. 2) 30-Second Chair Stand Test. You are able to stand six times in the 30 seconds. Show hesitation and tell the students it “hurts” your muscles. 3) 4-Stage Balance Test. You are able to complete the first two tests but lose your balance on the third test. You cannot do the fourth test. These are: a). feet side by side for 10 seconds; b) instep of one foot touching the other for 10 seconds; c) one foot in front of the other, and after five seconds you lose your balance; and d) stand on one foot, the students should not ask you to complete this.
Scenario Part 3	The students should interact effectively with you and your daughter. After the tests are done, ask what you should do to help your balance. Ask the physical therapist about mobility aids/equipment to help you with your balance. Ask “What can I do to make myself get stronger.”
Debriefing	After concluding Scenario Part 3, the group will be debriefed by the faculty. Early in the debriefing, the students will be asked what they did well. If you have any comments to share with the students about this, please do.

Clinic Scenario Progression Outline				
Time	Objectives	Settings	Prompts/Dialogue	Expected Outcomes
0-5 min	Prioritize healthcare interventions related to an older adult patient in primary care	HR 74 RR 18 Temp 98.7 BP 158/90 SpO2 100%	Patient: "I don't know why I need to come to the doctor's today. I feel fine. My legs get stiff and I just get a little dizzy sometimes. That's all."	1. Knock on door 2. Wash hands 3. Identify self and role 4. Patient ID, allergy, fall risk, 5. ABC, LOC: disoriented to time 6. Vitals: SpO2 100%, HR 74, RR 18 BP 158/90 7. Therapeutic communication with an older adult 8. Ask three priority questions about patient's safety
5-10 min	Perform a fall risk assessment	As above	Patient cooperates during assessment, but is unable to safely complete any of the fall risk assessment tools.	9. TUG = 20 seconds 10. 30-Second Chair Stand = 6 11. 4 Stage Balance Test = a. 12 seconds b. 10 seconds c. 5 seconds d. did not assess
10-12 min	Demonstrate therapeutic communication with a patient and/or family	As above	Patient becomes more cooperative.	12. Interacts with patient's daughter using effective communication strategies
0-12 min	Demonstrate direct and accurate communication with members of the inter-professional team	As above	Physical therapist and nurse work well as a team.	13. Physical Therapist and Nurse demonstrate work well together to complete the fall risk assessments.

Case Study 2

The following case study is used as a simulation twice a year for students at VCU School of Nursing (SON) and would follow the same protocol as was outlined in case study #1. This case presents students with an opportunity to interact with a SP in an acute care setting who is experiencing an acute episode of delirium following a fall that resulted in a broken hip and subsequent surgery. The SPs who

participate in this simulation are retired VCU SON alumni which we feel adds a valuable dimension for the nursing students (Davis & Nye, 2017).

Ms. Hazel J. is an 85-year old woman who lives alone in her own apartment. Her husband passed away several years ago. Her daughter, Cecily, lives nearby and checks in on her weekly. Ms. J. reports her apartment is "pretty safe," although she admits to "almost" having fall-

en a few times in the past month. She pays her own bills, receives Social Security income, and has enough money to pay for housing and food but admits "there's not a lot extra." Ms. J. has Medicare for health insurance. She is independent with all of her Activities of Daily Living (ADLs). She cleans her own apartment, is able to walk to the grocery store once a week for groceries, and cooks for herself. Ms. J. has a past medical history that includes coronary artery

disease, hypertension, hypothyroidism, osteoporosis, peripheral vascular disease with lower leg neuropathy. She wears glasses for distance and reading, upper and lower dentures, and recently agreed to start wearing bilateral hearing aids. Her medications include synthroid, calcium with vitamin D, and lisinopril.

Two days ago Ms. J. fell while at home and was admitted to the surgical unit following open reduction internal fixation (ORIF) of the right hip. She is now 24 hours post op, but was very confused and agitated overnight, pulling at her urinary catheter and peripheral IV, as well as trying to get out of bed without assistance. After she pulled her urinary catheter out, the night shift nurse called the physician and received telephone orders to put Ms. J. in soft wrist restraints.

She has calmed down at this point and has been sleeping for the last two hours. She is drowsy but easily awakens. She has a peripheral IV with normal saline at 75mL/hr. Her urinary catheter put out 300 mL amber urine overnight before she pulled it out early this morning. She is wearing oxygen at 2L nasal cannula and her oxygen saturation is 100%. Her temperature is 97.9 F, heart rate - 88, respirations - 20, and blood pressure - 148/88. She last received Percocet for pain six hours ago. She is tolerating a regular diet and drinking well, drinking 500mL of water overnight. A physical therapist has been able to conduct an initial assessment of the patient and her weight bearing status is as tolerated. Although she has orders to get out of bed to ambulate, so far she is unable to do more

than sit at the edge of the bed.

Student Learning Objectives

1. Perform a safety assessment.
2. Demonstrate therapeutic communication with the patient and family.
3. Demonstrate effective communication with an interprofessional team of healthcare providers to include the registered nurse, social worker, and nurse practitioner/primary physician.
4. Identify three risk factors that result from the use of restraints, specific to the older adult patient.
5. Describe three evidence-based interventions for the agitated older adult that can be used as alternatives to physical restraints.

Conclusion

Using older adult SPs in clinical simulations can enhance the existing curriculum for health professional students. In turn, faculty who are trained in best practices related to curriculum development will be able to incorporate competencies in the care of older adults into the classroom and clinical activities of health professional students. Doing so has the potential to improve the preparation of the future healthcare workforce and the delivery of responsive, interprofessional care with older adults.

Study Questions

1. What are the advantages and limitations of using older adult standardized patients?
2. What geriatrics competencies might you use to guide development of simulations as curriculum enhancement?
3. Discuss three effective ways to evaluate student learning perfor-

mance in a simulation with older adult standardized patients.

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About the Author



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Editorials

From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

Oral Health and Aging

Many of us equate oral health with brushing our teeth and mouthwash. We underestimate both the importance of our mouths as the portal to our bodily systems, and the connection between oral health and overall wellness. Moreover, when we consider “good health,” we may think health care, and having access to others who will treat us and being able to afford the treatment. Taking steps to care for ourselves, to prevent the need for the treatment, tends to be somewhat a secondary consideration.

At the same time, there's an almost weird separation between medical and dental when we think of health. In reality, health and wellness are essentially linked to oral health, in a relationship that goes both ways. Poor oral health can not only cause oral disease, but also oral disease can affect heart, lung, bone, liver, and other organ functioning; in turn, the treatment of problems in these organs may well involve medications that damage oral health, such as creating dry mouth, lessening salivary gland functioning, stimulating orofacial pain, and osteonecrosis (bone death) of the jaw.

The effects of oral disease on overall health are alarming. Oral disease has an impact on physical, psychological, social, and economic health and well-being, often resulting in

pain, diminished function, and reduced quality of life,” notes the recent *Oral Health Strategic Framework 2014-2017* from the U.S. Department of Health and Human Services.

Back in 2000 the Surgeon General's report on oral health, *Oral Health in America*, referred to poor oral health as a “silent epidemic.” Many are just beginning to see the implications for geriatrics and older adults.

For these and other reasons, our Virginia Geriatric Education Center, a consortium of VCU, University of Virginia, and Eastern Virginia Medical School, has been especially pleased to add dentistry (Dr. Trish Bonwell of VCU) to the interprofessional team members who comprise the Plenary that oversees all of our programs. As a welcome bonus, Dr. Jaisri Thoppay, VCU Director of Oral Medicine in the School of Dentistry, is one of our 2016-2017 Faculty Development Program (FDP) Scholars, spending September through June with us. Both Dr. Bonwell and Dr. Thoppay have added considerable content on oral health to the FDP's 200-hour curriculum. Notably, the Scholars in this year's FDP include faculty from medicine, nursing, occupational therapy, pharmacy, physical therapy, and social work, so the exchanges have been truly interprofessional.

So, why is oral health so important? Reasons include oral-systemic relationships, as implied above. Poor oral health can lead to oral disease which can affect various parts of our bodies. There are oral-systemic relationships that are associated

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with cardiovascular disease, diabetes, pneumonia, and bacterial endocarditis, to name a few (Paju & Scannapieco, 2007; Blaizot et al., 2009). Let's discuss these briefly.

Pneumonia is a significant respiratory disease and especially consequential with older adults. Our mouths can serve as an entry point for respiratory pathogens. Poorly cleaned teeth or dentures may store these pathogens for some time, increasing the prospect of their being aspirated into the airway and traveling to the lungs. Inflammation from periodontal (gum) disease can lead to both gingivitis and poorer overall health, such as by entering the circulatory system, triggering the liver to produce more C-reactive protein which can lead to thickening of the heart's arterial walls and a build-up of plaque. Controlling the inflammation from periodontal disease has also been shown to lessen arthritis flare-ups elsewhere in the body.

Bacterial endocarditis is an infection of the inner lining of the heart, most often of the heart valves, characterized by fever, enlarged spleen, and heart murmur. Poor oral health and oral disease are associated with this dangerous condition.

Medications to treat various seemingly benign as well as obviously more serious health conditions can produce xerostomia or "dry mouth." In fact, dry mouth is an acknowledged side effect of some 400 prescription and over-the-counter medications, including drugs to treat depression, anxiety, pain, allergies and colds (antihistamines and decongestants), asthma, obesity, epilepsy, hypertension

(diuretics), diarrhea, nausea, psychotic disorders, urinary incontinence, and more.

Many of these medications have an antiadrenergic/anticholinergic effect, meaning that, among many other reactions, they block systems that help promote watery secretions from glands, like saliva. Studies indicate that dry mouth can create problems with swallowing, chewing, and dental decay. These, in turn, may affect diet and nutrition.

Again, medical and dental health are too often kept in separate compartments. If you ask people, "Who are members of the healthcare team?" you'll likely get responses that list physicians, nurse practitioners, nurses, physical and occupational therapists, etc., and, at some point, perhaps, dentists and dental hygienists. If these are all team members committed to people's well-being, do they all communicate with each other? The short answer is "no."

As the above-referenced *Oral Health Strategic Framework 2014-2017* from the U.S. Department of Health and Human Services, notes:

"This results in a lack of integration between medical and dental records, a lack of use and acceptance of dental diagnostic codes, and separate insurance coverage and payment systems, treatment delivery, and health care systems. Interprofessional education and collaborative practice present tremendous possibilities for integrating oral and primary health care and improving patient-centered care. While community and clinical approaches have been

shown to reduce oral diseases, lessen dental care costs, and improve the quality of individuals' lives, these approaches are not being used to the greatest extent possible.

The cost of dental care and lack of dental coverage are often cited as reasons individuals do not seek needed dental care. Publicly-financed reimbursement programs covering the provision of oral health services are often limited in scope or are non-existent for adults. For example, Medicare coverage provides 22 preventive screenings for eligible individuals, but does not include oral health services. Medicare is limited in scope of coverage for dental care and, typically, must be related to a covered medical procedure provided in a hospital setting. While most state Medicaid programs cover emergency dental procedures for low-income adults, only 28 states provide dental benefits to Medicaid-enrolled adults beyond medically necessary care in emergency circumstances."

The *Oral Health Strategic Framework* identifies five needed goals to address the importance of oral health.

GOAL 1. Integrate Oral Health and Primary Health Care

"The American health system has historically separated oral health care from overall health care in the health professions' education, practice, and payment systems. The lack of interoperability between medical and dental records further adds to segmentation of health care delivery..... Frontline primary care professionals, specifically nurses,

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physicians, and physician assistants are members of the medical delivery system who are most likely to see vulnerable and underserved populations with limited or no access to dental services. This group of primary care professionals has the capacity to incorporate oral health information and the provision of preventive oral health services into their existing day-to-day practice.”

GOAL 2: Prevent Disease and Promote Oral Health

“Older adults are keeping more teeth than previous generations, yet develop new decay at rates equal to or higher than those in children. Prevention of oral disease can be enhanced through the increased delivery of clinical and community preventive services that remain underutilized.”

GOAL 3: Increase Access to Oral Health Care and Eliminate Disparities

“There are more than 47 million individuals living in designated dental shortage areas... To advance the oral health of the nation, the dental public health community should emphasize prevention and greater access to providers who are knowledgeable, sensitive, and responsive to diverse populations....Improve the knowledge, skills, and abilities of providers to serve diverse patient populations....Promote health professionals’ training in cultural competency.”

GOAL 4: Increase the Dissemination of Oral Health Information and Improve Health Literacy “Accord-

ing to the Institute of Medicine (IOM) Report, Advancing Oral Health Care in America, many patients and health care professionals are unaware of the risk factors and preventive methodologies for oral diseases. Moreover, many do not clearly understand the relationship between oral health and overall health and well-being. ...Oral health information should be integrated into the health record and be readily available to health providers.”

GOAL 5: Advance Oral Health in Public Policy and Research

“Most dental, oral, and craniofacial conditions arise from complex interactions of biological, behavioral, environmental, and higher system-level factors. Thus, oral health-related research must involve a number of approaches, including basic research, interventional studies, behavioral science and public health research, population-health studies, clinical trials, and community-based studies.”

So, of course we should continue with our oral health routines of brushing, flossing, and mouthwash. This is an important base. In addition, the sooner we recognize the importance of oral health to our well-being as older adults, the better we age. We need to consider our dentist as part of our health care team, and to share our oral health data, including our dentist’s name and contact information, with our primary care physician or provider. For those of us in health professions, we should work together more to incorporate oral health into primary care.

From the Commissioner, Virginia Department for Aging and Rehabilitative Services

Marcia C. DuBois
Director, Division for the Aging
Virginia Department for Aging
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Virginia’s Department for Aging and Rehabilitative Services (DARS) is celebrating a number of new initiatives that expand programs benefitting older Virginians, including Chronic Disease Self-Management Education (CDSME), dementia services, and, most recently, legal services for older adults. We are delighted to announce the roll-out of Virginia’s first statewide legal helpline for older Virginians scheduled to launch this spring. The expansion will also provide opportunities to increase elder law education and create a repository of legal resources.

As Virginia’s senior population grows, so too does the need for legal advice. Meeting the legal needs of Virginia’s increasing socially or economically disadvantaged population of older adults remains an ongoing challenge. The 2010 United States Census data determined that 18% of Virginia’s population, approximately 1.4 million individuals, was 60 years of age or older. By 2030, an estimated 24% of Virginia’s population or approximately 2.3 million will be 60 or older, an increase of 64% in two decades. The growth in the number of vulnerable older adults requiring legal services is expected

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to rise proportionally with the senior population. Despite this, the funds required to meet the legal needs of older Virginians most in need are shrinking.

In 2016, to better address the legal needs of Virginia's older adults, DARS applied for and received a three-year competitive grant from the U.S. Department of Health and Human Services, Administration for Community Living (ACL), to expand and improve Virginia's statewide legal delivery system for older adults. The grant's primary goal is to maximize provision of high-quality legal assistance through a variety of low-cost, sustainable delivery methods. Toward that end, the grant focuses on several priority issues, including abuse, neglect, and financial exploitation, for persons with the greatest need.

Although DARS received the grant, the most effective implementation will require DARS to work in partnership with key stakeholders. These stakeholders include: the Area Agencies on Aging (AAAs) and the legal providers (most often, regional legal aid programs) that AAAs contract with to offer legal services with Older American Act funds; the Virginia State Bar, the Virginia Bar Association, the American Bar Association and various local bar associations; Adult Protective Services, the Long-Term Care Ombudsman Office and other state and federal offices serving Virginia's older adults; law schools and legal clinics; financial institutions; and a variety of private and public organizations offering both legal and non-legal services to older adults throughout the Commonwealth.

The grant provides resources to:

- 1) improve Virginia's legal delivery system structure, including efforts to assist various legal providers to collaborate better;
- 2) improve data collection and reporting systems to document and develop responses to the legal needs of Virginia's older adults;
- 3) improve public awareness about the delivery system, in order to make the services more readily available to Virginians who might be more isolated because of geography, disability, or other factors;
- 4) better coordinate and streamline access to legal and non-legal services so that limited services can have a maximum benefit; and
- 5) increase legal assistance on priority issues to targeted populations through educational efforts and the encouragement of *pro bono* participation.

One concrete result of the grant will be creation of a free, telephone call-in, Senior Legal Helpline (SLH), which is scheduled to begin receiving calls in April 2017. Virginia Poverty Law Center attorneys will respond to callers, providing free information, legal advice, brief services and referrals as appropriate on a variety of legal matters; these include public benefits, advance directives, consumer fraud and abuse, and other matters.

SLH attorneys will be able to refer appropriate, more complex, legal matters to AAA providers, legal service offices, other free and low-cost legal providers, and the private bar referral program. In addition, the SLH will be part of Virginia's No Wrong Door (NWD) system, thereby allowing callers the opportunity to determine more easily their eligibility for and access to

other, non-legal services. Although the SLH will focus on specific priority matters for older adults in the greatest need, the program has no income or resource restrictions.

Another positive development will be to improve access to elder law educational and training materials. Statewide legal training events will be offered through partnerships with local bar and other organizations. In addition, the DARS website will serve as a depository for an organized collection of links to these materials and others. The site will be available for free, not just to legal and non-legal providers, but to the general public, as well.

We would like to note that one very supportive stakeholder in DARS' efforts to expand and improve the legal delivery system has been the Virginia State Bar (VSB). Recently, VSB began its own on-line, free legal question-and-answer service called "free legal answers" (virginia.freelegalanswers.org). Participants can request an answer to a specific, civil legal question on-line. Volunteer attorneys respond to questions, typically within three business days. This VSB free service is limited to individuals living at or below 200% of poverty guidelines, but it is open not only to Virginia's older adults but also to Virginians of any age.

DARS is excited to begin the roll-out of new services funded by this grant. By forming a network of partners dedicated to giving older Virginians free and easy access to legal advice and tools, we hope to create a long-lasting, statewide legal delivery system that is responsive to many of the basic legal

Editorials

concerns facing Virginia's aging population. For more information about this program, please contact:

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Legal Services Developer
Virginia Department for Aging and
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Division for the Aging
1610 Forest Avenue; Suite 100
Henrico, VA 23229
(804) 662-9310 (ph);
(804) 662-7035 (fax)
david.hominik@dars.virginia.gov

2017 DARS Meeting Calendar

Commonwealth Council on Aging
April 12, July 12, September 20

**Alzheimer's Disease and
Related Disorders Commission**
June 13, August 22, December 12

**Public Guardian and
Conservator Advisory Board**
June 22, September 14, November 9

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

Visit Our Websites

Virginia Center on Aging
www.sahp.vcu.edu/vcoa

Virginia Department for Aging
and Rehabilitative Services
www.dars.virginia.gov

Twenty Years on the Road to Women's Wellness

Women's Health Virginia is hosting its 20th annual conference on women's health, *Twenty Years on the Road to Women's Wellness*, on **Friday, June 9th**, in Charlottesville. The program will highlight recent advances in the understanding, prevention, diagnosis, and treatment of conditions that are significant for women and girls and challenges ahead.

The day's opening presentation focuses on progress by the Office of Research on Women's Health of the NIH on the strategic goals of its Vision for 2020. National and Virginia experts will then discuss developments in precision medicine and their impacts on cancer prevention, diagnosis and treatment, with attention to lung and breast cancers; increasing understanding of autoimmune diseases and promising treatments; and the changing picture of women's addiction to food, tobacco, drugs, and other substances. The day wraps up with an examination of progress in understanding the aging processes and the impacts of lifestyle and behaviors during earlier years on aging.

The conference will be at the Holiday Inn University Area in Charlottesville.

For more information about the program and registration, visit www.womenshealthvirginia.org or call (434) 220-4500.

Watch for Medicaid Fraud or Abuse

If you suspect that Medicaid fraud or elder abuse and neglect has occurred in a Medicaid facility or has been committed by someone working for a Medicaid provider, immediately contact Adult Protective Services and your local law enforcement agency. Then, report the incident to the Medicaid Fraud Control Unit (MFCU) of the Office of the Virginia Attorney General at (800) 371-0824 or (804) 371-0779.

You may also contact the MFCU Outreach Coordinator in your region.

How to Contact your Medicaid
Fraud Control Unit Community
Outreach Coordinators:

Central Virginia Region
Randy Davis
(804) 786-7750
rdavis@oag.state.va.us

Mountain Empire Region
Amy Duncan
(276) 628-1799
aduncan@oag.state.va.us

Northern Virginia Region
Michele Leith
(703) 246-3675
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The Virginia Center on Aging's 31st Annual Legislative Breakfast

VCoA hosted its 31st annual breakfast on January 25, 2017, at St. Paul's Episcopal Church in Richmond. Attendance was large and lively. We welcomed members of the General Assembly, their staffs, the Executive Branch, state departments, Councils, and colleagues in agencies and organizations across Virginia.

VCoA hosts this annual breakfast to inform the General Assembly, which created it in 1978, of progress in meeting our three fundamental mandates: interdisciplinary studies, research, and information and resource sharing. We take this opportunity each January to review our activities in the calendar year just concluded. As has been the case for so long, partnerships with many others enabled us to achieve success in helping older Virginians and their families. VCoA trained, consulted, researched, or collaborated in every region of the Commonwealth in calendar year 2016.

You can see our 2017 Legislative Breakfast Power Point presentation by visiting our website at www.sahp.vcu.edu/vcoa.



Top Left: Delegate Betsy Carr; Ruth Anne Young, VCoA; and Connor Kish, Legislative Aide to Del. Carr

Top Center: Judge Jim Almand, Public Guardian and Conservator Advisory Board and Delegate Ken Plum

Top Right: Jeffrey Ruggles, VCoA; Vernon Wildy, Commonwealth Council on Aging; Bob Schneider, Chairman, VCoA Advisory Committee

Bottom Left: Amy Marchean, DARS; Beverly Morgan, Department of Behavioral Health and Developmental Services; Beverley Soble, VCoA Advisory Committee; and Carter Harrison, Alzheimer's Association

Bottom Center: Lynne Seward, A Grace Place and Sandra Rollins, South Richmond Adult Day Care Center

Bottom Right: Joe DiPiro, Dean of VCU School of Pharmacy and Deborah Noble-Triplett, VCU Senior Vice Provost



Top Left: Delegate Sam Rasoul between Paula Kupstas and Ruth Anne Young, both of VCoA

Top Center: Debbie Leidheiser, Chesterfield Senior Advocate; Barry Green and Carolyn Comerford, both of Senior Center of Greater Richmond

Top Right: Rachel Ramirez, Lifelong Learning Institute (LLI); Karen Moeller, Greater Richmond Age Wave Coalition; Lurene Reck, Seniors Helping Seniors, Chesterfield; Wayne Phillips, LLI Board

Middle Left: Kathy Vesley, Bay Aging and Tim Catherman, Department of Aging and Rehabilitative Services

Middle Center: Greg Prince, VCU School of Allied Health Professions; Ed Ansello, VCoA, Charlie Martino, Riverside Center for Excellence in Aging and Lifelong Health; Bill Hazel, Secretary of Health and Human Resources

Middle Right: Colleen Wilhelm, Family Lifeline; Lynne Seward, A Grace Place; Amy Strite, Family Lifeline

Bottom Left: Theodore Knight, Chesterfield County Sheriff's Office and Andrew Daire, Dean of VCU School of Education

Bottom Center: Patty Slattum, VCU School of Pharmacy and Peter Boling, VCU School of Medicine

Bottom Right: Senator Monty Mason and Catherine Dodson, VCoA

Students as Teachers and Models in Interprofessional Geriatrics Education

by Edward F. Ansello, PhD,
Pamela Parsons, PhD, RN,
GNP-BC, and
Leland H. Waters, PhD

This article is appearing simultaneously in the spring 2017 issue of AGHEXchange, a publication of the Association for Gerontology in Higher Education.

Students are modeling good interprofessional/interdisciplinary geriatrics clinical care. Healthcare academics are taking note during observational rotations that the academics undertake as part of a faculty development program. Students and faculty are learning from each other. It's happening at the Richmond Health and Wellness Program (RHWP), a community partnership between Virginia Commonwealth University (VCU) and a housing corporation at five Section 8 rental-assistance complexes for older adults and adults with disabilities in the city of Richmond, a Health Professional Shortage Area.

The RHWP was established in the fall of 2012 with a purpose of improving the health of residents in Richmond, while also training students to care for older adults. RHWP has students from the VCU Schools of Nursing, Pharmacy, Medicine, Social Work, and Allied Health, and the Department of Psychology. These students are mentored and coached by faculty from each school to deliver appropriate, evidence based recommendations.

The clinic does not replace existing providers. Instead, the clinic serves as a care coordination model to improve the health of residents and improve communication between their providers.

The RHWP began with a health clinic located at Dominion Place, a privately-owned apartment building with Project-Based Section 8 Rental Assistance for older adults and adults with disabilities, located near the VCU campus. Dominion Place and VCU partnered to establish the RHWP clinic as a result of the combination of proximity, mutual needs and benefits, and the commitment of community-focused leaders.

VCU's Richmond campus and Dominion Place are directly adjacent, creating a natural opportunity for university-community partnership. Pamela Parsons, PhD, a VCU professor, geriatric nurse practitioner, and RHWP director, recognized that locating a free health wellness clinic at a senior apartment building had great potential to improve health care access for low-income older adults and provide valuable practical experience for students.

She also knew that Dominion Place was a housing development with some existing wellness programming for its residents. The owner of Dominion Place, Beacon Communities, agreed that the clinic would enhance its wellness and recreational programming and offered free space to host it on site. Dominion Place ensured that residents also had input into the clinic and its offerings before it opened.

RHWP received pilot funding from

the VCU Council for Community Engagement in June 2012. In 2013, it received a three year, \$1.5 million grant from the Health Resources and Services Administration (HRSA) of the USDHHS to cover the costs of the medical supplies and equipment used in the clinic, as well as faculty time for clinic services and student supervision. Students receive academic credit for their clinic work.

Before the clinic opened, residents often used ambulances and emergency departments for routine care. Indeed, one study of documented transports to hospital emergency departments in 2012 found that of the 153 transports, 151 were deemed non-emergent. In annual unit inspections, Dominion Place staff discovered that many residents were taking expired medications and using other residents' prescriptions, including medications not ordered by their care providers. Pilot data by VCU staff suggested that residents were taking an average of nine medications daily for an average of five chronic conditions.

Once the clinic opened, the student health care teams began meeting with residents to develop individual health plans, manage chronic conditions, assist with medications, and help residents enhance self-management skills. Most of the clinic's work involves care related to diabetes, high blood pressure, and medication management.

The RHWP clinic offers care coordination, immunizations, blood pressure and glucose monitoring, smoking cessation, and patient education to augment residents' existing health care services and help

them maintain well-being between doctor visits. Interdisciplinary teams of students and faculty supervisors staff the clinic during its weekly hours.

Students work in four-person interprofessional teams, gaining experience with health care providers and students from other disciplines to offer community care to older adults with chronic health conditions and limited health literacy. Students interchange their roles as the key participant leading in the history-taking, assessment or care plan during the visit. The students collectively gather information from the resident, then assist the resident with goal setting and strategies to achieve goals as a team.

Students at RHWP are leaders who, as defined by the World Health Organization, learn from each other to improve health outcomes. For instance, a medical student reported learning how to use a glucometer from a social work student who had previously been taught by a pharmacy student.

The RHWP has expanded to involve five housing complexes, each situated in “Healthcare Hotspots” or population clusters with a high burden of chronic illness, and each with a clinic staffed by interprofessional teams of faculty and students.

Although community members drive the care at RHWP, students are leaders, too. As the frontline practitioners in the model, students in the interprofessional teams interview the community members, develop assessments, and collaborate on a plan. This independence

allows students to develop leadership skills. In addition, RHWP staggers the start of student rotations at RHWP sites so that students from different professions will often be the most expert when a particular rotation begins.

Community-defined needs drive ongoing innovation at RHWP. In August 2014, based on the experience of faculty with the individuals, RHWP expanded to include a behavioral health clinic staffed by students and faculty from the Department of Psychology and the Psych-Mental Health Nurse Practitioner program. Students contribute through on-going PDSA (Plan Do Study Act) evaluations to the improvement of their experiences and of the RHWP. They engage in brief post-surveys that measure how interprofessional care improves health, their satisfaction with the program, how their team worked, as well as giving opportunities for suggesting improvements.



Students from nursing, pharmacy, and social work examine an RHWP community member under the guidance of a pharmacy faculty member

By the end of 2016, 673 students have participated in these interprofessional teams at RHWP over the 13 semesters since its inception, an average of 52 students a semester; the greatest numbers have been from nursing, medicine, pharmacy, and social work, but there was a

large influx of students from occupational therapy starting in spring 2016.

Importantly, the RHWP program has been recognized for both its learning opportunities in interprofessional geriatrics and its positive impact on patient care coordination. VCU has awarded Dr. Parsons and co-director Dr. Patty Slattum of the School of Pharmacy with multi-year support in an innovation competition, and a major national healthcare provider has visited RHWP to explore its role as a model of cost effective care coordination.

Students teaching faculty? Yes. Our Virginia Geriatric Education Center, which co-sponsors the RHWP, also conducts the 200-hour, September through June, Faculty Development Program (FDP) for health care professionals with an academic appointment. Among its goals are infusing an interprofessional mindset for geriatrics care and modeling effective team practice. FDP Scholars (learners) must each complete a 20-hour rotation at one of the five RHWP clinical sites. During their rotations, the FDP Scholars observe at least one interprofessional clinic visit. They note the functioning of the student team. Some Scholars had previously never seen such immediate, patient-focused interprofessionalism in practice. The Scholars must also complete a case study report on their RHWP rotation, as part of their FDP course work.

And so the cycle of learning continues, we hope. Students and faculty learning from each other, to the benefit of good geriatrics care.

Webinars on Later Life Pain

The Translational Research Institute on Pain in Later Life (TRIPLL) of Weill Cornell Medicine is presenting a webinar series on Pain and Decision Making. The TRIPLL webinar series is a web-based training resource for health professionals, researchers, and community practitioners interested in various health and research topics related to later life pain. Please see below for more details and links to register.

Upcoming Webinars

April 24, 2017

1:00 p.m. - 2:00 p.m. EST

Presenter: Jon Lurie, MD,
Dartmouth University

Patient Expectations and Decision Support Strategies in Pain Care

May 22, 2017

1:00 p.m. - 2:00 p.m. EST

Presenter: Adam Hirsh, PhD,
Indiana University-Purdue University Indianapolis

Racial and Ethnic Pain-Related Disparities: Provider & Contextual Factors & Potential Solutions

June 26, 2017

1:00 p.m. - 2:00 p.m. EST

Presenter: Joseph Kable, PhD, University of Pennsylvania

The Impact of Expectations and Persistence on Achieving Long Term Goals

For more information, please contact Jacquie Howard at jah3011@med.cornell.edu, or visit www.tripll.org.

Virginia Senior Games Looking for Sponsors



"Life Begins at 50 with Fitness and Gold!" This is what the Virginia Senior Games are all about as they enter their 39th year of promoting healthy lifestyles for Virginia residents, age 50 and better. The purpose of the Games is to promote physical and social wellness for Senior Adults. Presented annually by the Virginia Recreation and Park Society, the Games attract approximately 1,000 senior athletes who compete in over 20 Olympic-style events for Gold, Silver, and Bronze medals. The Virginia Senior Games are recognized by the National Senior Games, located in Baton Rouge, LA, and they are positioned to expand with the ever-increasing older adult population.

The County of Henrico will be hosting the Virginia Senior Games from **May 9-13, 2017**. They are looking for organizations to sponsor this great event that encourages people to stay active and have fun in the process. As a Virginia Senior Games sponsor, companies will have the opportunity to market directly to active seniors from all over the Commonwealth of Virginia, while also showing support for the healthy lifestyles they have embraced.

For more information, contact the Virginia Recreation and Parks Society at (804) 730-9447 or visit www.virginiaseniorgames.org.

NURSE Corps Scholarship Program

Too many Americans, particularly in underserved areas, go without checkups, preventive screenings, vaccines, and other care, simply because there are not enough health care professionals to provide care and treatment in their communities. The NURSE Corps Scholarship Program enables you to fulfill your passion to care for underserved people in some of the neediest communities across the country.

The 2017 NURSE Corps Scholarship Program is **accepting applications through May 11, 2017**. If awarded a scholarship, you will receive financial support, including: tuition; eligible fees; annual payment for other reasonable costs, such as books, clinical supplies/instruments, and uniforms; and a monthly stipend. In exchange you must work at a facility with a critical shortage of nurses, a Critical Shortage Facility (CSF), upon graduation.

Those interested in applying should read the annually updated Application and Program Guidance. They must be sure to understand the terms and conditions of the NURSE Corps contract, which outlines the requirement for fulfilling the minimum two years of service at an eligible Critical Shortage Facility.

For more information, visit bhw.hrsa.gov/loansscholarships/nursecorps/scholarship?utm_campaign=Now+Open%3A+NURSE+Corps+Scholarship+Program&utm_medium=email&utm_source=gov-delivery.

F.A.M.I.L.I.E.S. Program Expands Statewide: Opportunity to Enroll

The Virginia Department for Aging and Rehabilitative Services (DARS) is pleased to announce the expansion of its F.A.M.I.L.I.E.S. program. Thanks to a federally funded grant, F.A.M.I.L.I.E.S., short for Family Access to Memory Impairment and Loss Information, Engagement and Support, provides counseling and support for caregivers at no cost over several months. This program was originally offered in the Greater Williamsburg and Charlottesville areas and is now available statewide, with opportunities to participate in person and via telehealth opportunities.

DARS has partnered with the Riverside Center for Excellence in Aging and Lifelong Health (CEALH-Williamsburg), the University of Virginia, and the Greater Richmond Chapter of the Alzheimer's Association to deliver this program statewide. Enrollment continues through the end of 2017.

"The goal is to help bring entire families together in big and small ways to help the primary caregiver in caring for a family member with dementia," said Dr. Christine Jensen, CEALH's Director of Health Services Research. "Compassionate, trained counselors assess the individual situation, help with understanding of memory loss and how it may progress, develop an individualized care program for the family, and discuss coping strategies for stress and changes in personality or behaviors."

Developed by the New York University-Caregiver Intervention program, in F.A.M.I.L.I.E.S. caregivers of individuals with Alzheimer's Disease or other types of memory loss receive six free counseling sessions, and one follow up, with trained counselors to help reduce stress and depression, increase family support, enhance knowledge for managing memory disorders, and provide assistance with finding local services and resources.

According to the Alzheimer's Association, the number of people 65 and older living with Alzheimer's disease in Virginia in 2016 was 140,000. This number is expected to jump to 190,000 by 2025. There are more than 450,000 caregivers in the Commonwealth alone who provide unpaid care to these individuals, according to the Association.

The impact of the program is so great that PBS recently visited CEALH in Williamsburg to film a portion of an upcoming documentary featuring the program and highlighting its impact on families.

To determine if you are eligible for this program or to learn more, call Jordan Oliva at the University of Virginia via phone at (434) 924-0453 or e-mail jo4u@virginia.edu.



June is Alzheimer's & Brain Awareness Month and the Alzheimer's Association® needs your help to uncover the truth about Alzheimer's disease and other dementias. Everyone who has a brain is at risk to develop Alzheimer's, a fatal disease that is often misunderstood. During the month of June, you can help by raising awareness and taking action. Visit alz.org/abam to learn how you can participate.

Would You Like to Receive *Age in Action* Electronically?

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Calendar of Events

April 27, 2017

Caregivers Health and Wellness: Navigating Resources, An Interdisciplinary Hands on Hands. Conference presented by Norfolk State University. 8:00 a.m.-4:00 p.m. NSU Virginia Beach Higher Education Center. For information, call (757) 368-4150 or (757) 823-8122 or e-mail mbsawyer@nsu.edu.

May 3, 2017

Chesterfield Triad Senior Day. Healthy Living = Healthy Aging program by Dr. Ayn Welleford. 7:30 a.m. - 12:00 p.m. Victory Tabernacle Church, Midlothian. For information, visit chesterfield.gov/senior_events or call (804) 768-7878.

May 9, 2017

Caring for Someone with Memory Loss: A Positive Approach to Care. Presented by Aging Together, Alzheimer's Association Central/Western VA, Culpeper County Library, Healthy Steps, and Rappahannock Rapidan Community Services. Germanna Community College, Culpeper. For information, visit tinyurl.com/MemoryCare2017.

May 22-23, 2017

Governor's Conference on Aging. Hotel Roanoke, Roanoke. For information, visit www.dars.virginia.gov.

May 22-23, 2017

27th Annual Aging with Developmental Disabilities Conference. Presented by The Association on Aging with Developmental Disabilities (AADD). St Charles Convention Center, St. Charles, MO. For information, visit agingwithdd.org.

May 31 - June 2, 2017

23rd Annual Conference of the Virginia Coalition for the Prevention of Elder Abuse. Virginia Beach Resort & Conference Center. For information, visit www.vcpea.org.

June 5, 2017

Annual Conference on Lifelong Disabilities by the Area Planning and Services Committee (APSC). Doubletree by Hilton, Richmond Midlothian. For information, e-mail eansello@vcu.edu.

June 6, 2017

Aging Well in Mind, Body, and Spirit. Annual Conference on Aging of The Beard Center on Aging at Lynchburg College, in conjunction with Centra Health. Keynotes on Disrupt Ageism and on Blue Zones: Secrets for Living Longer; 18 other sessions. 8:45 a.m. - 4:45 p.m. Drysdale Student Center, Lynchburg College. A post-conference workshop, *Alzheimer's Disease and Dementia Care Seminar*, will be held the following day. For information, visit www.lynchburg.edu/beard.

June 7-9, 2017

Annual Conference and Expo of LeadingAge Virginia. Norfolk Waterside Marriott, Norfolk. For information, visit www.leadingagevirginia.org.

June 8, 2017

Alzheimer's Education Conference. Presented by the Alzheimer's Association, Central Western Virginia Chapter. James Madison University, Harrisonburg. For information, visit www.alz.org/cwva.

July 20, 2017

3rd Annual Senior Safety Day. Presented by the Senior Center of Greater Richmond, The Office of the Attorney General Mark Herring, and by Richmond's First Baptist Church. First Baptist Church, Richmond. 9:00 a.m. to 3:00 p.m. For information, visit www.SeniorCenterOfGreaterRichmond.org.

October 15-18, 2017

68th Annual Convention and Expo of The American Health Care Association and National Center for Assisted Living. Mandalay Bay Resort, Las Vegas, NV. For information, visit www.eventscribe.com/2017/AHCANCAL.

November 14, 2017

Annual Conference of The Virginia Association for Home Care and Hospice. The Stonewall Jackson Hotel, Staunton. For information, visit www.vahc.org.

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A Balanced Life: Making Meaningful Connections

***The 13th Annual Conference of the Area Planning and Services Committee for
Aging with Lifelong Disabilities (APSC)***

June 5, 2017

**Doubletree by Hilton, 1021 Koger Center Boulevard, Richmond
8:15 a.m. - 4:30 p.m.**

Keynote Address: *Nurturing the Spirit: A Vital Part of Holistic Care*, by Kathy Fogg Berry, MS, Department of Patient Counseling, School of Allied Health Professions, Virginia Commonwealth University, and Chaplain, Westminster Canterbury Richmond

Session Topics:

Supportive Communities
When Words Fail: Practically Addressing the Spiritual Needs of People with Dementia
Art for the Journey: Opening Minds through Art
Social Media and Technology Innovations for Connections
WINGS (Working Interdisciplinary Networks of Guardianship Stakeholders)
End of Life
Closing Plenary Session: Stories of Connections

Registration fee of \$35 includes materials, lunch, and breaks. For information and registration, please go to www.apsc2017.eventbrite.com or contact ansello@vcu.edu.

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