

## Case Study

### Addressing the Spiritual Needs of People Aging with Dementia and/or Lifelong Disabilities

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Certificate in Aging Studies

#### Educational Objectives

1. Present the need for spiritual care as part of holistic care for people living with dementia and/or lifelong disabilities.
2. Distinguish the difference between spirituality and religion.
3. Discuss how to assess the spiritual needs of people living with dementia and/or lifelong disabilities.
4. Show through case study examples specific ways to address the spiritual needs of people living with dementia and/or lifelong disabilities.

#### Introduction

Just as caring for the physical and emotional needs of people aging with dementia and lifelong disabilities is essential for their well-being,

so is providing spiritual care. Yet often this component of holistic care is neglected.

“Indeed, in today’s care system, the physical needs of patients are obviously recognized; that after all is why they are in the system. If the right personnel are available, and if time permits, a patient’s psychosocial needs can also be addressed. But all too often their spiritual needs are not recognized or considered legitimate targets for intervention; certainly these needs are not frequently acknowledged, recognized and dealt with by medical professionals” (Sapp, 1999).

A visit to a new doctor’s office usually begins with questions about medical status, past and present. Similarly, a visit to a new psychiatrist or social worker begins with questions about mental and social health and history. Spiritual health and well-being are rarely, if ever, assessed. Such an assessment can provide valuable insight into a person’s total health or disease. Yet, rarely is more spiritual/religious information gleaned by those caring for elders than someone’s faith affiliation and perhaps place of

worship; that is, scratching the surface.

According to the 2014 Pew Research Center Religious Landscape Study, about 72 % of people over 75 consider their faith to be very important to them. The Alzheimer’s Association’s 2017 *Alzheimer’s Disease Facts and Figures Report* states that one-third of people over 85 have Alzheimer’s disease, and nearly one half have some form of dementia. So, at a time when they may need their faith to help them cope with dementia and other major life transitions, elders are often unable to initiate and sustain faith practices and spiritual disciplines that bring them peace, comfort, a feeling of closeness to God. This is also true for people aging with lifelong disabilities, who may not have the physical, cognitive, or communication abilities to initiate, ask for or sustain faith practices essential to their well-being. Family and professional caregivers often do not assess spiritual needs or assist with vital religious and spiritual practices which could enhance quality of life for those they’re caring for.

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The Federal Government mandates that skilled nursing facilities must promote each resident's quality of life (42 CFR §483.15). Yet, spiritual/religious care in long term, assisted living, and nursing care facilities is often relegated to volunteers who provide generic worship services, religious music programs, or friendly visits. While these programs might be quite valuable, they do not address the unique spiritual needs of everyone and cannot meet the challenging needs of residents for day-to-day spiritual support through life's transitions.

If 72% of elders over 75 consider their religious faith to be important, then facilities are not doing enough to maintain or enhance elders' quality of life. This is especially true in regard to residents who, due to dementia or lifelong disabilities, cannot practice their religion and nurture their spirit without assistance. Administrators, doctors, nurses, social workers, recreational therapists and all staff, not just chaplains, should seek to understand and address the spirituality of residents. Most facilities caring for elders do not have chaplains on staff, so this needs to be a part of everyone's responsibilities.

### **Spirituality and Religion**

Although there is no single, broadly accepted definition of spirituality, many agree that it involves the search for meaning to life. Spirituality, in contrast to religion, pertains to a sense of relatedness to nature, all humanity, and the Transcendent. Although it need not be the case, spirituality is often contextualized within a religious tradition, a specific system of belief, worship, and

conduct (Post and Whitehouse, 1999). Fischer, in her book *Winter Grace* (1998), says that spirituality doesn't mean just one compartment of life, but the deepest dimension of all of life; spiritual life is not a static state but movement, growth, and process.

Comparing spirituality to religion on its website, [www.reComparison.com](http://www.reComparison.com) says: "*Spirituality is about finding one's own path, which may require the assistance of religious practices or spiritual leaders, but which can also be achieved alone or through unconventional means. Spirituality is more about an inner quest than an outward performance, so it can be harder to recognize and it can also be much more individual than religion. People may achieve spirituality in their own unique way. Some people have found a spiritual connection through prayer or meditation, while others were struck by spirituality while walking, surfing, gardening or even working. Typically, spirituality involves feeling a connection to a higher power or to a larger reality, or finding a deeper understanding of one's own nature. An individual may spend a lot of time thinking about spirituality, but without being part of a particular religion.*"

Emile Durkheim (1912) maintained that religion involves a unified system of beliefs and practices relative to sacred things. This then evolves into a moral community called a church (community of faith.) The defining characteristic of a religion is that it is an organized form of belief, [www.reComparison.com](http://www.reComparison.com) suggests. "*Someone who is part of a particular religion will usually*

*join in with organized activities or rituals, and they will probably follow the teachings or philosophies either of a living spiritual leader or of an important religious figure such as Jesus, Moses or Buddha. Religion is, therefore, often based on the past, while spirituality tends to be more about individual development in the present.*"

Sam Harris, neuroscientist, philosopher, best-selling author, and self-proclaimed atheist, claims, "Spirituality must be distinguished from religion because people of every faith, and of none, have had the same sorts of spiritual experiences" (2005).

Everyone is a spiritual being, but not everyone adheres to a particular religious belief or becomes part of a religious organization. Whether persons living with dementia and/or a lifelong disability live at home with caregivers or in a facility, finding ways to help them explore and nurture spirituality is essential to providing quality care, as is enabling them to practice their faith, if they've become part of a particular religious group.

### **Identifying and Addressing Spiritual Needs**

Humankind experiences deep needs for security, trust, reassurance, love, inclusion, joy, hope, and acceptance, among others spiritual needs. How each person feels and experiences these is as unique as there are people on the earth. So, spiritual care must be person-centered, uniquely addressing the specific needs of each individual in the specific way he needs them addressed. Conducting a spiritual assessment

can help discern each person's needs. It is important to ask about rather than assume needs. A spiritual assessment should not be done with a clip in hand, but rather over time through conversation and relationship. For someone living with dementia, it is best to conduct an assessment during the early stages. If the person with dementia or a lifelong disability is unable to communicate well, then talk with the person's family or caregivers to discern past and present spiritual and/or religious needs and practices.

A sample Spiritual Assessment Tool from *When Words Fail: Practical Ministry to People with Dementia and their Caregivers* (Berry, 2016) asks:

- What gives you hope?
- What gives you purpose?
- What gives you comfort?
- What helps you feel closest to God and/or most whole? (prayer, meditation, nature, art, service projects, family, friends, faith community involvement, holy scriptures, worship, music, or others)
- What (if any) religious rituals, symbols, and practices are important to you? (prayer, meditation, holy scripture reading, worship, music, icons, candles, scents, or others)

Thibault and Morgan, in *No Act of Love Is Ever Wasted* (2009), assert that, denied the ability to grasp words, persons with dementia (or lifelong disabilities) often relate to symbols that remind them of the presence of God, like the Bible, a cross or crucifix, icons, statues, flowers, sacred pictures, stained glass windows, candles, rosaries, and even the smell of incense; all

speak to the senses of those who have cognitive impairment and cannot comprehend the meaning of words. This is true for persons living with lifelong disabilities, as well.

Depending on the person's level of cognition, further conversations might explore such questions as: What religious or spiritual influences shaped your life? What prevents you from exploring and nurturing her spirit?

When people lose the ability to nurture their spirits and/or practice their faith in ways that give them purpose, comfort, peace, and a sense of community, part of providing holistic care is helping them do those things.

### Case Study #1

Emily, an 85-year-old woman with debilitating rheumatoid arthritis, COPD, and dementia, has now been diagnosed with Stage 4 stomach cancer. She's been admitted to hospice in the long term care facility where she lives. A lawyer has her POA, and there is no known family.

Emily's contracted hands and legs hurt, and she often cries in pain. Because she's prone to sliding out of her wheelchair, she can often be found sitting by the nurses' station where they can keep an eye on her. This is often a noisy place, and she gets visibly upset when things get chaotic. Although her speech is predominantly garbled, with some "choice" words she's retained, she routinely rejects caregivers when they need to provide hands-on care. Staff have tried to determine what might improve Emily's quality of

life. They've experimented with music, pet and art therapy, and visiting children, all of whom she also rejects.

The hospice staff has had some luck providing essential care at times, assessing physical needs, providing medication, and soothing baths, but the hospice chaplain has been unable to discern her spiritual needs. All anyone knows about Emily's faith background is her church's name, listed in the chart. However, since she has lived in the facility for 10 years, she's been unable to attend church, and no one can recall a minister visiting in recent years.

One day the facility's social worker decides to try a new tactic. It is a beautiful spring day, so he knocks on the door to Emily's room, where she's sitting in a wheelchair in the semi-dark. When he asks Emily if she would like to go outside, Emily surprisingly looks up and clearly replies, "Yes." Before Emily can change her mind, he wheels her out under the portico and sits on a bench beside her. "Let's not talk," he suggests, "but listen to nature around us." Knowing that Emily was usually sitting near the nurses' station where constant noise bombarded her, the chaplain thought perhaps a quiet break would be nice.

For 30 minutes they sat in silence, soaking up the sun and sounds. Gentle breezes swayed the trees, the sweet scent of flowers wafted through the air, and the laughter of children playing in a nearby schoolyard drifted across the street. Emily seemed mesmerized and did not fall asleep, as the chaplain

assumed she would. When lunchtime arrived, the social worker hesitated to bring up the need to return inside, expecting loud objections. Instead, when he told her, Emily nodded in agreement. As she was wheeled past the nurses' station, people noted the transformation of her usual anxious expression to one of calmness and serenity. They watched her wheel by in amazement.

This was a new beginning for Emily. Being outside, where she was rarely able to go, nurtured her spirit. It transported her to a place of solace and peace. The social worker detailed their initial visit outside into Emily's care plan, and other staff began taking her outside for a walk or to sit, when able. The hospice chaplain and various staff members began having success as they gently tried to assess Emily's spiritual needs and found out other ways to help her tap into her faith. They discovered that scripture reading and hymn singing were important to Emily, too, both things she could not initiate on her own due to dementia and her physical limitations. They began singing old hymns or reading scripture together on sunny days outside or rainy days inside. Emily began to open up. The physical pain was still present, but her ability to cope with it got better. Her physical affect improved as her quality of life was enhanced. She lived more joyfully until her death six months later.

### **Case Study #2**

Born with cerebral palsy, 71-year-old John has lived in a long term care facility since his mother's death 15 years ago. Despite chronic

urinary tract infections, he is reasonably healthy. Although he does not have much controlled use of his arms or legs, he gets along well in his motorized wheelchair.

His speech, however, is almost unintelligible, and because of almost constant movements due to the CP, John cannot use a computer for communication. Instead, he uses a pointer attached to a helmet on his head. With it, he can painstakingly point to letters and spell words on a laminated board which someone must remove from his wheelchair's backpack and set up. Because this type of communication is slow going, others often don't take the time, or energy, needed to listen to him. Communicating with fellow residents is complicated by his disability, as well as theirs.

John is an intelligent man whom others often mistakenly consider to be mentally challenged because of his communication difficulties. Usually kind and with a quiet disposition, John's inability to be understood sometimes leads to angry outbursts. He's immediately ashamed when this happens and apologizes. Lately, however, his frustrations have been building up and something really seems to be bothering him.

He used to attend church with his mother, and sometimes his eldest brother, but he hasn't been in many years since his mother died and his brother moved out-of-state. He enjoys the facility's Sunday worship service, though, and staff often find him sitting silently in the chapel in quiet contemplation. The minister has noticed how John's become increasingly vocal during

the weekly worship service's prayer time, trying to communicate as best as he can. As the minister pulls out John's board and watches his word spelling, John shares numerous prayer requests, spelling them out laboriously as others wait. His requests usually focus on the needs of other residents and staff whom he's obviously been listening to. Everyone is moved by John's obvious concern for them and genuine interest in their wellbeing.

Because the minister has had to limit John's prayer requests to one per service, so that others would also have a chance to share, she has decided to stay after the weekly service and begin spending one-on-one time with John. She's only there part-time each week, for the worship service and a Bible study, but the minister can tell something has been bothering John and wants to discern what it is.

In their new weekly half-hour sessions when she can focus on John, the minister learns of his frustration over not being able to help people and feeling useless. Throughout his life, prior to living in the facility, John did visitation of sick people with his mother and prayed with her over their needs each day. Until now, John says, no one had asked him about his faith or feelings of not having a purpose. He expresses relief over just being able to talk about this.

The minister encourages John to continue getting prayer requests from others, praying for them and assisting her by filling her in each week on the needs of this congregation. John expresses joy over this newfound ministry and purpose.

He spends more time listening to others and sitting quietly at the bedside of people who are sick. Staff begin sharing requests with him, too, and are more intentional about helping him communicate. John seems more happy and fulfilled.

## Conclusion

Everyone needs the chance to nurture their spirit, whether through conventional religious practices such as worship, scripture reading, ministry projects, and prayer, or through spiritual disciplines like communing with nature, caring for animals, quiet meditation, or inspirational music. Even with dementia or a lifelong disability, elders need spiritual care unique to themselves which may enhance their quality of life. Everyone involved in their care, family or professional, can and should take an active role in accessing and addressing spiritual needs.

“People gradually lose their cognition” (but) “they do not lose the presence of their creator within them. Although they may no longer be able to articulate their faith, the essence of their faith lives on in their soul which outlives their body and its ability to function” (Swinton, 2012)

“A smile, nod, tear or twinkle in the eye can be revealing,” says Pat Otwell in *Guide to Ministering to Alzheimer’s Patients and Their Families* (2007). “Just because those faith experiences cannot be articulated, it does not mean that they do not, and cannot, occur at every stage of the dementia disease (or lifelong disability). After all, words are inadequate to articulate

“holy moments” that transpire between anyone and God.”

## Study Questions

1. How were John’s and Emily’s spiritual needs assessed? How was their quality of life enhanced when spiritual needs were addressed?
2. Why should assessing the spiritual needs of people be a regular part of providing holistic care and what are the benefits?
3. What resources are needed to meet the spiritual needs of people? Are those resources readily available in care facilities or private homes where people with dementia and/or long term disabilities reside? What changes could be implemented to ensure they are available?

## References and Recommended Readings

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## About the Author



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## Editorials

### From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

#### *Lewy Body Dementia*

Dementia isn't a specific disease in itself but a term that describes a set of **symptoms** that can reflect many different and sometimes overlapping conditions or causes. Dementia includes progressive impairments in memory and recognition, changes in personality, and losses in reasoning ability and self-care that interfere with daily life. Dementia is the result of brain disease or injury from such causes as Alzheimer's disease, Dementia with Lewy Bodies (DLB), vascular dementia, frontotemporal lobe dementia, or Traumatic Brain Injury (TBI).

So, while Alzheimer's disease is the most common and widely known cause of dementia, it is not the only cause. Dementia with Lewy Bodies (DLB), in fact, may be the second most common cause of progressive dementia but it is certainly less well known.

Alzheimer's and DLB have similar causes in that each is the result of inappropriate deposits of protein in the brain, called neurofibrillary tangles and amyloid Beta plaques in Alzheimer's and called Lewy bodies in DLB, named after Dr. Frederick Lewy. Lewy discovered the abnormalities in how the brain processes the protein alpha-synuclein while working in Dr. Alzheimer's laboratory in the early 1900s.

It turns out that these Lewy bodies are found in the brains of people who have Alzheimer's disease or have Parkinson's disease. It's the relationship between DLB and Parkinson's that is significant: some who have Parkinson's eventually develop dementia and some people with DLB eventually develop Parkinson's symptoms; the latter include various problems with movement, like muscle rigidity, shuffling gait, and bent posture, and clinically are called parkinsonisms.

A family caregiver or health care provider may notice behaviors in the person under consideration. Common early symptoms in Alzheimer's include difficulty remembering recent conversations, names, and events; apathy, depression; perhaps loss of smell. Common early symptoms with DLB may be similar to Alzheimer's but with sleep disturbances, hallucinations, and parkinsonianisms. The movement problems are hallmarks of DLB, "core clinical features."

Recently, I participated in a fine webinar hosted by the federal Health Resources and Services Administration (HRSA) which featured Angela Taylor, Director of Programs at the Lewy Body Dementia Association. I am indebted to her for much of the following information.

DLB affects men more than women, with age of onset being anywhere from 50 to 85.

Cognitive or brain processing problems with DLB are somewhat similar to those with Alzheimer's and include forgetfulness, trouble with problem solving or analytical think-

ing; difficulty planning or keeping track of sequences; disorganized speech and conversation; difficulty with sense of direction or spatial relationships between objects.

Someone with DLB often has fluctuations in concentration, alertness, episodes of confusion, and excessive daytime sleepiness. Also, as mentioned, parkinsonisms are characteristic of DLB, including rigidity or stiffness, a shuffling walk, balance problems or falls, tremors, slowness of movement, decreased facial expression, and a change in posture.

While hallucinations and delusions are more symptomatic of delirium than of dementia, individuals with DLB tend to have these, as well as a heightened sensitivity to antipsychotic medications that may be used initially to treat these symptoms. So these medications can be dangerous in people with DLB.

Sleep disorders are common. A person with DLB may act out dreams, sometimes striking or otherwise injuring a bed partner. Insomnia and restless leg syndrome are common. Again the connection of DLB to movement disorders.

Lastly, there are distinctive autonomic dysfunctions, meaning involuntary or unconscious actions, such as dizziness or fainting, difficulties with regulating body temperature, urinary incontinence, constipation, and unexplained blackouts or transient loss of consciousness.

All of these symptoms present great challenges to family caregivers. More so because there's so little public awareness of DLB. Caregiv-

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er burden occurs early and may be higher than in Alzheimer's disease because of the disparate symptoms and the reality that clinicians may be late in diagnosing what may seem like an odd and diverse set of symptoms.

Things are not hopeless, however. If the individual with DLB is diagnosed early, he or she often is more responsive to interventions than with a diagnosis later in the progression of the disease. Persons with DLB have been found to be more responsive to cholinesterase inhibitors, the types of drugs usually prescribed for those with Alzheimer's. Medications for controlling parkinsonisms like dopamine promoters may help. But treatment is a balancing act; medications for one symptom can worsen another.

Caregivers need to be alert, therefore, for medication sensitivities, including the need to minimize the use of neuroleptics/antipsychotics, which are powerful tranquilizers prescribed to reduce confusion, delusions, and hallucinations; specifically, avoid older antipsychotics like haloperidol. In someone with DLB, these drugs may worsen the individual's cognition or behavior, producing apathy or limiting movement, just what's not desired in someone with DLB.

The Lewy Body Dementia Association (LBDA) endorses a comprehensive treatment plan, one that includes appropriate medications for the person with DLB, a regimen of physical exercise, alertness to medication sensitivities and adverse drug effects, and a focused attempt to improve the quality of life for

both the person with LBD and the family caregiver. LBDA offers a robust array of information and resources designed to increase the caregiver's understanding of the disease.

LBDA recommends as the current treatment strategy the goal of improving quality of life. It states that many symptoms can be managed or reduced with medications, as well as with nonpharmacological treatments. Because there's such a strong movement disorder component of DLB, it recommends that the individual participate in occupational therapy (OT), physical therapy (PT), and speech therapy. Again, caregiver education and support are critical.

If you are caring for someone who has been diagnosed with LBD or if you suspect that someone you know may have LBD, visit the association's website at [LBDA.org](http://LBDA.org).

The LBDA.org website features tabs on Support groups; LBD Caregiver Link; Publications; Information about LBD for the general public; Support resources for LBD families, including local and virtual support groups, phone and email support; LBD stories written by LBD families; Educational resources, such as webinars for LBD families and healthcare professionals; Research news, including notices of clinical studies that are now recruiting participants; and other ways to get involved with LBDA.

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

Kathryn A. Hayfield

### *Message from the New DARS Commissioner*

Hello!

I am pleased to have this opportunity to introduce myself to you and to the community of organizations and service providers who strive to make Virginia a better place for older adults to thrive.

Some of you may know me already from my years at DARS as the Assistant Commissioner and Director of the Division of Rehabilitative Services, where I most recently oversaw efforts to promote and secure employment of Virginians with disabilities. My former responsibilities at DARS included 10 years as the agency's liaison to the Virginia General Assembly. I led a diverse statewide system of community based programs for the agency, including brain injury, independent living, personal assistance services, employment support services and our Virginia Assistive Technology System, a program that in recent years has worked to improve awareness among older Virginians of the many forms of and their access to assistive technology that can improve their daily lives.

On a personal level, I also relate to the individuals we serve through

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the Department for Aging and Rehabilitative Services. My husband of thirty years, Jay, was diagnosed with Parkinson's disease more than a decade ago. Like others with disabilities, he strives to maintain his independence and live a full life and we struggle to balance the need for safety with the dignity of risk. Jay wants to direct his own care to the maximum extent possible. Like many families, we face the difficulty of finding home care providers who respect his desire for self-direction and see their role as helping him lead an active life. I am privileged to join my-coworkers at DARS and our many community partners to strengthen the systems available for people to live more independently and to age gracefully.

Gov. Ralph Northam and his cabinet, including fellow physician and Health and Human Resources (HHR) Secretary Daniel Carey, took office in January and began work on negotiating new legislation and crafting the Commonwealth's budget. As the General Assembly session ended without an agreement, Gov. Northam, who is determined to pass Medicaid expansion, called on House and Senate leaders to return to Richmond April 11th. If indeed Medicaid is expanded, it will be in no doubt due in large part to Gov. Northam's desire to improve access to health care as he strives to lead a Commonwealth that works better for all people, no matter who they are or where they live.

In this, he is joined by Sec. Carey, Centra's former senior vice president and chief medical officer. You may recall that Centra last year

became a partner in the No Wrong Door (NWD) initiative. I recently attended my first NWD Resource Advisory Council meeting, which includes representatives from health and human service agencies, long-term services and supports providers and advocates. I applaud the group's vision to transform the way people access services in their community by bringing together a network of partners, the power of technology and the importance of individual choice.

Significantly, HHR Deputy Secretary Marvin Figueroa has joined the council. Mr. Figueroa previously was senior policy advisor for Senator Mark R. Warner, who as governor advocated for creation of a network of service providers for older adults, family caregivers, veterans, and individuals with disabilities, regardless of where the individual first seeks support. Mr. Figueroa advised Sen. Warner on health care issues, and he brings that expertise to the leadership team as it provides guidance and oversight for NWD's statewide expansion and long-term sustainability.

In April, I look forward to addressing the first Dementia Friendly Virginia Statewide Workshop, held in partnership with LeadingAge Virginia and n4a. This initiative seeks to bring states, counties or cities, local communities and even neighborhoods together to improve the quality of life for individuals living with dementia and their caregivers. Herndon was the first Dementia Friendly community in Virginia and representatives will report on the town's progress to help provide inspiration.

The April workshop will help equip participants to assess readiness to champion and convene a dementia friendly community effort and establish next steps for moving forward with a dementia friendly initiative in Virginia. Approximately 140,000 individuals with Alzheimer's disease or other dementias and more than 450,000 care partners live in Virginia, so this initiative is extremely relevant as we determine avenues for providing much needed support.

Later this spring, we will learn the recipients of the 2018 Best Practices Awards, which bring attention to noteworthy initiatives and encourage organizations to develop and support programs and services that assist older adults to age in their community. Each year, the Commonwealth Council on Aging, which advises the Governor on issues affecting the 1.6 million Virginians ages 60 and older, recognizes innovative programs that may be replicated across the Commonwealth.

Themes that emerged from this year's 13 nominees included caregiving education and respite and supports for older adults to age in place. I am sure these same themes will be among those our advisory board members consider as they commence work on the upcoming Dementia State Plan and Virginia State Plan, which serve to encourage organizations to develop and support programs and services that assist older adults.

In the coming months, I plan to meet with Virginia's AAAs and their leadership and look forward to visiting with many of the groups



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and service partners who comprise the backbone of our Commonwealth's efforts.

I look forward to joining you in celebrating May as Older Americans Month to promote this year's theme, "Engage at Every Age."

Visit DARS' updated Office for Aging Services web page at [www.vda.virginia.gov](http://www.vda.virginia.gov) and its new providers' portal at <https://sp.wwrc.net/VDAproviders>.

### 2018 DARS Meeting Calendar

**Commonwealth Council on Aging**  
July 11, September 19, and December 19

**Alzheimer's Disease and Related Disorders Commission:**  
June 19, August 21, and December 11

**Public Guardian and Conservator Advisory Board**  
June 21, September 6, and November 8

### 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.vda.virginia.gov](http://www.vda.virginia.gov)

## Alzheimer's Disease and Dementia Care Seminar

Take the path to certification as a Certified Dementia Practitioner (CDP) through the National Council of Certified Dementia Practitioners. Professionals from non-profit organizations, county government, and faith based organizations are invited to attend, along with any family caregivers.

This is the required seminar for those pursuing CDP certification, to qualify through the National Council of Certified Dementia Practitioners, and is made possible and very affordable with the help of our partners. To see if you qualify, please visit the NCCDP website at [www.nccdp.org](http://www.nccdp.org). You are also welcome to just come for the education. Lunch will be provided, thanks to AARP.

**What:** The seminar will cover the following modules: Diagnosis, Prognosis, Treatment, Communication, Feelings, Depression, Repetitive Behavior, Paranoia, Hallucinations, Wandering, Hoarding, Aggressive Behaviors, Catastrophic Reactions, Intimacy and Sexuality, Personal Care, Pain, Nutrition, Activities, Environment, Staff and Family Support, Diversity and Cultural Competence, Spiritual Care, and End of Life.

**When and Where:** The same program is often on two dates. Saturday, **May 12, 2018**, 9:00 a.m. to 5:00 p.m., Insight Memory Care Center Mazaway Education and Support Center, 3955 Pender Drive, Suite 100 Fairfax, VA 22030; Fri-

day, **June 1, 2018**, 9:00 a.m. to 5:00 p.m. George Mason University, Peterson Family Health Sciences Hall, Room 2409, 4400 University Drive, Fairfax, VA 22030.

**Cost:** \$25 for the student handbook. Course fee is graciously covered by Virginia Geriatric Education Center, Geriatrics Workforce Enhancement Program.

**Trainer:** Christi Clark, ALA, CMIS, CDP, CADDCT, is the Assistant Director at Insight Memory Care Center and has over 15 years of experience in long term care. Christi is a licensed Assisted Living Facility Administrator, where she has worked in both marketing and operations roles. As a Certified Memory Impairment Specialist, Certified Dementia Practitioner, and Certified Alzheimer's Disease and Dementia Care Trainer through the National Council of Certified Dementia Practitioners, she has dedicated the last 10 years working specifically with those affected with various forms of memory impairment, their families, and the community.

**Registration:** Go to [InsightMCC.org/CDP-GMU](http://InsightMCC.org/CDP-GMU). You can also register by calling Cathy Tompkins at (703) 993-2838. Space is Limited. Payment for the student handbook must be received one week in advance of the class to ensure course enrollment. No form of taping is allowed nor are laptops permitted in the seminar. Questions? Please contact Cathy Tompkins at (703) 993-2838 or [ctompkin@gmu.edu](mailto:ctompkin@gmu.edu).

**Delayed Final Project Report from the 2016-2017 Alzheimer's Research Award Fund**

The Alzheimer's and Related Diseases Research Award Fund (ARDRAF) was established by the Virginia General Assembly in 1982 and is administered by the Virginia Center on Aging at Virginia Commonwealth University. The awards this year were enhanced by a \$25,000 donation from Mrs. Russell Sullivan of Fredericksburg, in memory of her husband who died of dementia. Sullivan awards are indicated by an asterisk (\*). Summaries of two delayed final project reports submitted by investigators funded during the 2016-2017 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)).

**UVA Matthew J. Barrett, MD, MSc, Jason Druzgal, MD, PhD, and Scott Sperling, PsyD  
Nucleus Basalis of Meynert Degeneration in Parkinson Disease Cognition**

Dementia in Parkinson disease (PD) is a major source of morbidity. Degeneration of the nucleus basalis of Meynert (NBM) contributes to dementia in PD via loss of cholinergic innervation to the neocortex. The NBM has been identified as a potential intervention point to treat dementia in PD, and deep brain stimulation has been proposed as a potential therapy. As a preliminary step toward testing this therapy in PD, we determined whether MRI measures of NBM volume correlate with cognition in PD. Because it is difficult to accurately measure the NBM using MRI, we measured cholinergic nucleus 4 (Ch4) of the basal forebrain, which includes the NBM, using available cytoarchitectonic maps. The investigators found that reduced Ch4 density was associated with worse global cognition and worse performance on measures of attention, processing speed, and visuospatial function in early-stage and late-stage PD cohorts. The finding of a significant association between Ch4 density and cognitive measures in an early-stage PD cohort supports an early intervention targeting this region to prevent future degeneration. The investigation to identify a genetic marker as a predictor of Ch4 density continues, but preliminary data indicate there is no relationship between the APOE e4 allele, a risk factor for Alzheimer disease, and Ch4 density. The results provide evidence that reduced Ch4 density identifies more advanced PD, i.e., more advanced extra-nigral pathology. Future research will investigate whether Ch4 density may serve as a surrogate biomarker in PD. (Dr. Barrett may be contacted at 434/243-2012, [mjb5t@virginia.edu](mailto:mjb5t@virginia.edu); Dr. Druzgal may be contacted at (434) 982-1736, [tjd4m@virginia.edu](mailto:tjd4m@virginia.edu); Dr. Sperling may be contacted at (434) 982-1012, [sas7yr@virginia.edu](mailto:sas7yr@virginia.edu).)

**William & Mary Oliver Kerscher, PhD, and Munira Basrai, PhD\*  
STUbl-Dependent Clearance of Transcriptionally-Active, Aggregate-Prone Proteins from the Nucleus**

Altered gene expression is a hallmark of neurodegenerative disorders including Huntington's Disease. The main goal of this study was to investigate if STUbls, a unique class of enzymes involved in targeted protein degradation, can prevent the abnormal transcriptional activity associated with a mutant, aggregation-prone fragment of huntingtin (mHtt), the causative agent of Huntington's disease. Specifically, as part of this project the investigators examined: 1) the physical interaction of STUbls with mHtt, 2) the effect that STUbls have on the transcriptional activity of mHtt in a tissue culture model of Huntington's disease, and 3) whether these enzymes counteract the abnormal transcriptional activity of mHtt on a genome-wide scale. It was found that increasing the levels of STUbls reduces the chromatin association of mHtt aggregates. Furthermore, STUbls specifically reduced mHtt-induced transcription in unique reporter gene assays. Whole-genome mRNA sequencing of mHtt-expressing cells, with and without STUbls, were also completed. As a next step, bioinformatic analysis of these transcriptome data will be used to identify the endogenous gene targets of chromatin associated mHtt. Overall, the results are consistent with the investigators' model that STUbls may be neuro-protective and the exciting new finding that enhanced STUbl expression levels can reduce the chromatin association and abnormal transcriptional activity of mHtt. These results implicate RNF4, an enzyme involved in targeted protein degradation, as an important player and potential therapeutic target for Huntington's Disease. (Dr. Kerscher may be contacted at (757) 221-2229, [opkers@wm.edu](mailto:opkers@wm.edu); Dr. Basrai may be contacted at (301) 402-2552, [basrain@nih.gov](mailto:basrain@nih.gov).)

## Ruth Anne Young Recognized with Nexus Award

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VCoA's Ruth Anne Young has labored in the field of abuse in later life, working tirelessly over the years to confront elder abuse, neglect, and exploitation. She has staffed federal and state-funded projects to train service providers, law enforcement, prosecutors, judges and others in effective strategies to prevent or respond to abuse in later life. She currently staffs a project funded by the Virginia Department of Criminal Justice Services to partner with the Virginia Supreme Court to educate district and circuit judges on matters related to adjudicating such cases.

Ruth Anne's efforts have been recognized. The Virginia Sexual and Domestic Violence Action Alliance named her recipient of its 2017 Nexus Catalyst Award. In its notification, the Action Alliance stated it was "absolutely delighted to honor you for your exceptional and inspiring work on behalf of survivors of sexual and intimate partner violence in Virginia."

A "catalyst" is one whose enthusiasm and energy precipitates significant positive change. The Catalyst Awards recognize individuals and/or organizations who have made superior contributions to improving services for survivors of sexual and intimate partner violence and creating a Virginia free of violence.

The Action Alliance noted Ruth Anne was being honored with the **Nexus Award** "for being an individual who has created a high level of cooperation among members of the justice system and/or other systems within a local community. You exemplify the collaboration and unity of purpose in bringing together diverse individuals and disciplines to create a community that promotes safety for victims and accountability for perpetrators."

We, too, honor Ruth Anne.

## Age Wave Engages Communities through Scholar Projects

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by Catherine MacDonald,  
Greater Richmond Age Wave

The Greater Richmond Age Wave Scholar Program joins students and community partners to design, develop, and implement projects in the region and beyond. Students achieve learning goals while partners benefit from their skills and gerontological expertise. The following are updates from several past and current Scholars; other projects are currently underway. To learn more about the Age Wave Scholar program or to sponsor a Scholar, contact Catherine MacDonald at [macdonaldcs@vcu.edu](mailto:macdonaldcs@vcu.edu).

### Age Wave City Council Scholar Launches East End Initiative, Invites Collaboration

Age Wave City Council Scholar Annie Rhodes, a VCU Gerontology graduate, began collaborating with

Richmond 7th District Councilwoman Dr. Cynthia Newbille in summer of 2017. Rhodes' project successes include six community flu shot clinics, City Council involvement in the East End initiative, partnerships established with health and wellness organizations, and creation of an inclusive legislative packet for the 2018 General Assembly.

Rhodes' full report can be found at [agewellva.com](http://agewellva.com). Project updates are given at Age Wave Neighborhood Livability Action Team meetings. To join this action team, contact Ken Lantz at [klantz@richmondregional.org](mailto:klantz@richmondregional.org).

### Wish Fulfillment Project Highlights Community Generosity

VCU Gerontology master degree candidate Nicole Hunt has launched an innovative project on person-centered care. As the Age Wave Wish Advocate Scholar, Hunt is working to acknowledge, identify, and carry out the wishes and dreams in long-term care facilities that may not be addressed because of budget restrictions, transportation, and/or physical limitations. Hunt has named the project "Dreams are Forever."

Wishes from long-term care residents at the Trio Healthcare-Elizabeth Adam Crump Health and Rehabilitation Center are sponsored by Anthem HealthKeepers Plus.

So far, wish recipients have enjoyed chess lessons, a comedy show, a projector to watch movies, and dinner out with the family. Next up:

- Continued on page 17

## The Virginia Center on Aging's 32nd Annual Legislative Breakfast

VCoA hosted its 32nd annual breakfast on January 24, 2018, 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. This year we recognized Delegate Ken Plum as calendar 2017 was the 35th year of the Alzheimer's and Related Diseases Research Award Fund (ARDRAF) which he patroned in the General Assembly.

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 2017. We were honored to have Attorney General Herring welcome attendees.

You can see our 2018 Legislative Breakfast Power Point presentation by visiting our website at [www.sahp.vcu.edu/vcoa](http://www.sahp.vcu.edu/vcoa).



**Top Left:** Courtney O'Hara, VCoA; Rick Jackson, Riverside Center for Excellence in Aging and Lifelong Health (CEALH); Ruth Anne Young, VCoA

**Top Center:** Jenni Mathews, VCoA, gives Thelma Watson, Senior Connections, her name tag at the VCoA reception table

**Top Right:** Jessica Samet, Alzheimer's Association and Devin Bowers, Department for Aging and Rehabilitative Services

**Bottom Left:** Dean Joe DiPiro and Patty Slattum, VCU School of Pharmacy; and Charlotte Arbogast, DARS

**Bottom Center:** Catherine Dodson, VCoA, and Senator Emmett and Sharon Hanger

**Bottom Right:** Bill Massey, Peninsula Agency on Aging; Justine Young, Piedmont Senior Services; and Senator Monty Mason



**Top Left:** Cathy Tompkins, George Mason University; Christi Clark, Insight Memory Care Center; Megumi Inoue, GMU; and Emily Ihara, GMU

**Top Center:** Senator Creigh Deeds and Catherine Dodson, VCoA

**Top Right:** Ed Ansello, VCoA, and Attorney General Mark Herring

**Middle Left:** Harvey Chambers, Anthem; Brian Beck and Regina Sayers, Appalachian Agency for Senior Citizens

**Middle Center:** Wayne Phillips, Lifelong Learning Institute of Chesterfield (LLI); Kimberly Rideout, Chesterfield TRIAD; Debbie Preston, Chesterfield Senior Advocate; and Rachel Ramirez, LLI

**Middle Right:** John Skirven, Senior Services of Southeastern Virginia; Delegate Ken Plum; Bobby Vassar, Bay Aging; and Rick Jackson, CEALH

**Bottom Left:** Attendees at the VCoA Legislative Breakfast

**Bottom Center:** Attorney General Mark Herring gives the Welcome

**Bottom Right:** Delegates Betsy Carr, Kathleen Murphy, and Karrie Delaney

## Sugar Is Everywhere: Other Names for Added Sugar

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Consumers are waking up to the reality that added sugar is virtually everywhere in our food, from the obvious places like sodas, candy, and desserts to the less obvious like tomato sauce, yogurt, and meats. After years of dismissing added sugars as a health risk, focusing instead on saturated fat as the culprit, nutritional scientists and health care providers are advising us to be wary of added sugars in our diets. They carry the prospect of ominous consequences like high blood pressure, diabetes, and heart disease. Sugars not only deliver calories empty of vitamins, fiber, and other nutrients, but they also “crowd out” healthier foods in a person’s diet.

The American Heart Association recommends that we consume less than 100 calories (women) or 150 calories (men) of added sugar a day, but one 12-ounce can of soda carries about 9 teaspoons of sugar and puts most of us at or over the limit.

A study by Yang et al, published in *JAMA Internal Medicine* in 2014 found that most US adults consumed more than 10% of their total calories from added sugars, while 10% of adults consumed 25% of more from added sugars. “Regular consumption of sugar-sweetened beverages ( $\geq 7$  servings/wk) was associated with increased risk of CVD (cardiovascular disease) mortality.” The higher the consumption, the greater the risk.

So where are we getting added

sugar? The list may surprise you.

The following is a summary of words that really mean added sugar; it was first published online in the journal *Lancet* by Barry Popkin and Corinna Hawkes in “Sweetening of the Global Diet, Particularly Beverages: Patterns, Trends, and Policy Responses.” Note that “juice concentrate” alone in this list can refer to over 50 sources, from apple juice to chokeberry to fig or watermelon juice.

### Ingredients That Mean Added Sugar

- agave juice, nectar, sap, or syrup
- beet sugar
- brown rice syrup
- brown sugar
- cane juice
- cane sugar
- cane syrup
- clintose
- confectioners powdered sugar
- confectioners sugar
- corn glucose syrup
- corn sweet
- corn sweetener
- corn syrup
- date sugar
- dextrose
- drimol, dri mol, dri-mol
- drisweet, dri sweet, dri-sweet
- dried raisin sweetener
- edible lactose
- evaporated cane juice
- flo malt, flo-malt, flomalt
- fructose
- fructose sweetener
- glaze and icing sugar
- glaze icing sugar
- golden syrup
- gomme
- granular sweetener
- granulated sugar
- hi-fructose corn syrup
- high fructose corn syrup
- honey
- honibake
- honi bake
- honi-bake
- honi flake, honi-flake
- invert sugar
- inverted sugar
- isoglucose
- isomaltulose
- juice concentrate (over 50 varieties)
- kona ame, kona-ame
- lactose
- liquid sweetener
- malt
- malt sweetener
- malt syrup
- maltose
- maple
- maple sugar
- maple syrup
- mizu ame, mizu-ame, mizuame
- molasses
- nulomoline
- powdered sugar
- rice syrup
- sorghum
- sorghum syrup
- starch sweetener
- sucanat
- sucrose
- sucrovert
- sugar beet
- sugar invert
- sweet n neat
- table sugar
- treacle
- trehalose
- tru sweet
- turbinado sugar
- versatose

## Museum Events for Persons Living with Dementia and their Care Partners

by Devin Bowers  
DARS Dementia Services  
Coordinator

The Smithsonian Institute has developed several tours for people living with dementia and their families or care partners.

**See Me at the National Museum of African Art.** The experience of looking closely allows us to appreciate beauty, exchange ideas, share memories or simply respond to the work in front of us. We invite individuals living with dementia, together with their family members or care partners, to join us for an interactive and multi-sensory tour of the museum. This group meets on the fourth Tuesday of each month.

**See Me at the National Portrait Gallery.** The Gallery tells the story of America by portraying the people, including artists, politicians, scientists, inventors, activists, and performers, who shape the nation's history, development and culture. This group meets on the second Tuesday of each month.

**See Me at the Smithsonian American Art Museum.** This museum's collection captures the aspirations, character, and imagination of the American people throughout three centuries, revealing key aspects of America's rich artistic and cultural history. This group meets on the first Wednesday of each month.

**See Me at the Freer/Sackler.** The Freer Gallery of Art and Arthur M. Sackler Gallery preserve and share the treasures of Asia, making inspiring connections between Asia, America, and the world. This group meets on the third Wednesdays of each month.



Entrance to the Smithsonian is free; however, registration for these programs is required. Participants may register by emailing [access@si.edu](mailto:access@si.edu) or by calling (202) 633-2921. For additional information, such as group size or time concerns, please contact Ashley Grady at [GradyA@si.edu](mailto:GradyA@si.edu).

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## Lifelong Learning Institute Fall Catalog



The Lifelong Learning Institute (LLI) in Chesterfield will be releasing its Summer

Catalog on Friday, April 13th, on site and online, and its Fall Catalog on site and online on Friday, August 10th. The LLI is a member-supported organization operated exclusively for the education and social enrichment of adults ages 50 and older.

LLI, founded and co-sponsored by the Virginia Center on Aging, Chesterfield County Public Schools, and Chesterfield County maintains a rich growth environment for mid-life and older adults. In 2017, the LLI offered 645 classes in three full sessions of daytime nonresidential college-level courses and related activities, taught by 218 instructors. The LLI had a total of 1261 members in 2017, representing 47 different zip codes.

Class categories include: Art, Music, Drama, Dance, Computers, Technology, Math, Science, Economics, Finance, Fitness, Health, Wellness, History, Humanities, International Studies, Languages, Literature, Poetry, Film, Leisure Activities, Life Services, Philosophy, Religious Studies, Special Events, Weekly Group Activities, and more. Stop by between 8:00 a.m. and 4:00 p.m. to pick up your copy. You may also view the catalog online at [www.LLICHESTERFIELD.ORG](http://www.LLICHESTERFIELD.ORG).

## Modern Senior Travel and VCU Road Scholar

by Jeffrey Ruggles

When it began, the educational travel program that today goes by Road Scholar was called Elderhostel. Many people still know it by that name (and it is not incorrect: Elderhostel, Inc. is the non-profit organization that has Road Scholar as its trade name). Just as the program name has changed, so has there been an evolution of the kind of travel experience that older adults seek and Road Scholar endeavors to provide.

A few Road Scholar programs may still take place in the summer, offering stays in college dormitories and dining in the campus cafeteria. For the most part, however, that model has been set aside. The older adult of 30-40 years ago had different notions about travel than a counterpart of today, when the Baby Boom cohort is affecting what Road Scholar presents. The 2010s older traveler prefers a private room, goes in all seasons, and looks for a higher quality of dining. Of course, college cafeterias are quite a bit better than they used to be, too.

Of all the things that set the Baby Boomers apart from their predecessors, the most pronounced is probably food. Baby Boomers pay more attention to what they are eating and how it tastes. Ever more people have become aware of food items that they shouldn't eat or prefer to avoid. Road Scholar tour providers have to work with the kitchens that feed their participants to ensure that meal options are available for those

who have identified preferences or have dietary restrictions. In addition, Baby Boomers may well have higher standards for dining (we try not to say: "are pickier"). The expectation today is that special needs or preferences will be accommodated. So, Road Scholar has taken the approach that the customer is always right.



Significant change has come, as well, to the type of content

that Road Scholar programs offer. It used to be that the typical structure was a week-long program with three academic-style topics presented daily in classroom settings at a campus or retreat center. The first evolution was to examine just a single subject in depth over the week. Now programs are shifting away from the classroom altogether toward experiential learning. In practical terms, this translates to learning by doing or by going. Education remains essential to Road Scholar but it now takes many forms. Within Road Scholar there are still classroom-oriented programs but, rather than being the standard format, they are now a specialty category.

Over the years VCU Road Scholar has been primarily a provider of academic classroom programs, even while our lodgings were hotels. In part, this reflected the "no need to fix what ain't broke" philosophy. Another reason has been the Road Scholar emphasis on featuring what is unique or special about each locality. Being in Virginia, VCU has always seen history

as important, and that's a subject well suited for classroom settings.

A VCU Road Scholar program that we have redesigned to reflect the new thinking is "Choose Your Pace: Hiking in Shenandoah National Park." It takes place at Big Meadows Lodge, located atop the Blue Ridge overlooking Page Valley and the South Fork of the Shenandoah River. Food has never been an issue at Big Meadows, where the airy and timbered Spottswood Dining Room features quality choices (and large portions). The revisions we've made are to the program content, which has moved from a combination of classes and hikes to primarily hiking experiences. The remade program also incorporates the "Choose Your Pace" model, which allows participants to select between two levels of activity: one set of hikes that are longer and more difficult, and a second set easier and not so long. A couple of hikes at the beginning of the program that include the whole group should help participants self-define their ability level relative to the group. The Big Meadows revisions will probably skew participation somewhat younger, which is in keeping with other successful Road Scholar National Park programs. As VCU Road Scholar looks forward to preparing programs for 2019 and 2020, one aim will be for a larger portion of experiential education in the mix, yet still working to design programs that are appropriate and enjoyable for older and less mobile participants.

For more information about our VCU Road Scholar programs, please call (804) 828-1525 or email [jruggles@vcu.edu](mailto:jruggles@vcu.edu).



## Age Wave, continued

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exercise equipment requested for increasing strength and endurance. Wish fulfillment serves more than just a momentary purpose. Hunt aims to help reduce generalized decline caused by social isolation in long-term care facilities by promoting activity, socialization, engagement, fun, and person-centeredness.

### Age Wave Scholar Research Provides Guidance for Transportation Advocacy

A recent project by Age Wave Transportation Liaison Scholar Sara Morris, a VCU Gerontology graduate, has shed light on regional transportation issues and helped establish a regional transportation advocacy agenda.

As part of her master degree course work, Morris created and administered a Transportation Preferences Survey to 177 greater Richmond residents, ages 52 to 96; she used a convenience sampling to distribute the surveys to two older adult membership organizations: The Lifelong Learning Institute located in Chesterfield County and the Senior Center of Greater Richmond, a virtual senior center with multiple locations primarily located in the City of Richmond.

Combining findings from Morris' survey, community validation and network experts in the region, Age Wave identified the following seven transportation pillars to support through advocacy at state and local levels: On-Demand Services; Volunteer Driving; Transportation Companies (private and nonprofit);

Personal Vehicles (transportation counseling and empowerment for older drivers); Public Transportation Expansion; Autonomous Vehicles; and Medicaid Expansion.

To learn more about the study and the Greater Richmond Age Wave's advocacy work, visit [agewellva.com](http://agewellva.com).

### Student Team Seeks to Create a NORC in Richmond's 6th District

Age Wave's first Age Wave Scholar team is working with community advocates and Councilwoman Ellen Robertson to identify how the Green Park neighborhood of Highland Park can become a naturally occurring retirement community (NORC). VCU Gerontology master degree candidates Emily Daidone, Evelyn Beaumont, and Caitlin Lange are the Age Wave Scholar Project Lead, Age Wave Richmond City Scholar, and Age Wave Research Scholar, respectively. The team has completed a review of the literature, met with community advocates, and is currently designing a community survey combining evidence-based best practices and community identified need. Future phases are currently in development, so stay tuned.

Age Wave is jointly managed by VCU Gerontology and Senior Connections, the Capital Area Agency on Aging.

## 40th Anniversary Brand Refresh for VCoA

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by Jessica Lyon, VCoA  
Communications Specialist



We at the Virginia Center on Aging are celebrating the 40th anniversary of our dynamic organization. This significant milestone inspired a fresh, new look for the center's logo. Our leadership agreed that the 40th anniversary serves as the perfect time to unveil the new branding. The redesigned logo combines the national advocacy colors of our four program areas, each gradually blending into the next to show that we are united in the same purpose, which is to improve the quality of life for all older Virginians.

The bright blue color represents our Geriatrics Education program, which works to train individuals in interprofessional geriatrics and gerontology. The magenta or reddish purple color represents our Abuse in Later Life program, which strives to strengthen an interdisciplinary community response to elder abuse, neglect, and exploitation. The deep violet or bluish purple color represents our Dementia Research program, which funds seed research grants into the causes, consequences and treatment of Alzheimer's disease and other dementias. The bright green color represents our Lifelong Learning program, which encompasses both our Lifelong Learning Institute in Chesterfield and our VCU Road Scholar adventures across Virginia.

## Calendar of Events

### May 3, 2018

*Spring Appalachian Oral Health Forum.* Provided by the Virginia Rural Health Association in partnership with the Virginia Oral Health Coalition and the Virginia Department of Health. Abingdon. For information, visit [www.vrha.org/calendar\\_content\\_396\\_3733152500.pdf](http://www.vrha.org/calendar_content_396_3733152500.pdf).

### May 4-6, 2018

*Women's Health 2018: Translating Research Into Clinical Practice.* Presented by the VCU Institute for Women's Health and VCU Health Continuing Medical Education, in special collaboration with *Journal of Women's Health* and the Academy of Women's Health. Crystal Gateway Marriott, Arlington. For information, visit <https://vcu.cloud-cme.com/aph.aspx?EID=5196&P=5>.

### May 4, 2018

*Community Engagement Showcase.* Presented by VCU Gerontology and the Greater Richmond Age Wave. Triple Crossing - Fulton, Richmond. For information, visit [agewellva.com](http://agewellva.com).

### May 15, 2018

*Webinar: Assistive Technology and Aging with a Disability.* Presented by Assistive Technology in New Hampshire. This session will discuss and demonstrate assistive technology solutions to enable individuals who experience various disabilities to age in place. 3:00 p.m. - 4:00 p.m. \$25 fee. For information, visit [https://iod.unh.edu/atwebinar18?mc\\_cid=b019f1f126&mc\\_eid=31425fd76d](https://iod.unh.edu/atwebinar18?mc_cid=b019f1f126&mc_eid=31425fd76d)

### May 24, 2018

*Hands on Hands: Habilitation Therapy and Dementia Care.* Conference presented by Norfolk State University with keynoter Paul Raia, PhD. 8:30 a.m. - 4:00 p.m. Norfolk State University, NSU Virginia Beach Higher Education Center. For information, call (757) 368-4152 or (757) 823-8122 or email: [dmontgomery@nsu.edu](mailto:dmontgomery@nsu.edu) or [nworley@nsu.edu](mailto:nworley@nsu.edu).

### May 30-June 1, 2018

*24th Annual Virginia Coalition for the Prevention of Elder Abuse Conference.* 4 Diamond Kingsmill Resort, Williamsburg. For information, visit [www.vcpea.org/vcpea-conference-information](http://www.vcpea.org/vcpea-conference-information).

### June 4, 2018

*Annual Conference on Aging with Lifelong Disabilities.* Presented by the Area Planning and Services Committee (APSC). Doubletree by Hilton, Richmond Midlothian. For information email [DrumhellerE@rrsi.org](mailto:DrumhellerE@rrsi.org).

### June 6-7, 2018

*Annual Alzheimer's Education Conference at James Madison University.* Presented by the Alzheimer's Association, Central and Western Virginia Chapter. Festival Conference and Student Center, Harrisonburg. Registration at [www.alz.org](http://www.alz.org) or at (800) 272-3900.

### June 15, 2018

*Southwest Virginia World Elder Abuse Awareness Day Conference.* Sponsored by the Virginia Tech Center for Gerontology. Wytheville Meeting Center, Wytheville. For information, visit [https://virginiatech.qualtrics.com/jfe/form/SV\\_78V4z5YNnW9zm3r](https://virginiatech.qualtrics.com/jfe/form/SV_78V4z5YNnW9zm3r)

### June 19, 2018

*Helping through the Journey of Dementia: The Right Care at the Right Time.* 8:00 a.m. - 4:00 p.m. Germanna Community College, Culpeper Campus. Partial funding from Virginia Geriatric Training and Education Award Fund. For information, contact (540) 825-3100 x3416 or [kwalker@rrcsb.org](mailto:kwalker@rrcsb.org).

### June 24-26, 2018

*Technology Connecting the Healthcare Eco-System.* 14th Long Term and Post Acute Care (LTPAC) Health IT Summit, Presented by LeadingAge. Washington Hilton Hotel, Washington, DC. For information, visit <https://leadingage.org/ltpac-hit-summit>.

### July 23-26, 2018

*Mobilize: Resistance through Action.* 2018 Conference on Independent Living presented by the National Council on Independent Living. Grand Hyatt, Washington, DC. For information, visit [www.ncil.org](http://www.ncil.org).

#### Age in Action

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Director, VCoA

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

*Age in Action* is published quarterly. Submissions, responses to case studies, and comments are invited and may be published in a future issue. Mail to: Editor, *Age in Action*, P.O. Box 980229, Richmond, VA 23298-0229. Fax: (804) 828-7905. Email [kivey220@yahoo.com](mailto:kivey220@yahoo.com).

**Summer 2018 Issue Deadline:  
June 15, 2018**



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[www.sahp.vcu.edu/vcoa](http://www.sahp.vcu.edu/vcoa)

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## Community Integration for Individuals with Lifelong Disabilities

*The 14th Annual Conference of the Area Planning and Services  
Committee for Aging with Lifelong Disabilities (APSC)*

June 4, 2018

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

**Keynote Address:** *Supporting Successful Aging in People with Lifelong Disabilities*, by Dr. Elizabeth Perkins, Associate Director of the Florida Center for Inclusive Communities (FCIC), the University of South Florida's University Center for Excellence in Developmental Disabilities, President-Elect of the American Association on Intellectual and Developmental Disabilities (AAIDD), and highly published author.

### Session Topics Include:

- Engage me: The how to's of community integration
- Outdoor activities for individuals with lifelong disabilities
- Financial exploitation and lifelong disabilities
- A speech therapist's guide to physiological changes with aging, and issues with swallowing, choking, and special diets
- Outreach to special populations through Live Well Virginia! workshops
- The arts as tools for caregivers
- Social Security benefits for individuals with lifelong disabilities

Registration fee of \$40 includes materials, lunch, and breaks. For information and registration, please go to [www.apsc2018.eventbrite.com](http://www.apsc2018.eventbrite.com) or contact [eansello@vcu.edu](mailto:eansello@vcu.edu).

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