

Case Study

Remembering through Music: Music Therapy and Dementia

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Educational Objectives

1. Define music therapy and its benefits with older adults with dementia and related disorders/diseases.
2. Describe active and passive music therapy interventions and strategies for older adult populations.
3. Identify the ways a non-musician can use music to engage older adults and mitigate some symptoms of dementia.

Background

For centuries, music has been recognized for its powerful effects on mood and emotion and its importance and many uses during celebrations, rituals, holidays, religious rites, cultural events, and the many stages of life. In its various forms, music can be simple or extremely

complex, improvised or highly structured, sophisticated or rudimentary. Whether vocal or instrumental, enjoyed as a performer, listener or audience member, music roots itself deeply within the brain and is retained even when memories begin to fade with time, illness or disease. During the past decade, advances in neuroscience and brain imaging have helped to create better understanding of music's effect on the mind, body, and human condition. The many facets of our functioning as individuals are directed by and engaged within various regions of the brain.

It would likely be easy for most of us to create a list of the songs that mean the most to us, bring us joy, spiritual support, or comfort and serve as a reminder of relationships, who we are as individuals, and our connection to the world through music (Levitin, 2008). Because musical information is stored and travels throughout the brain, rather than being solely a left- or right-brained activity, musical stimuli affect emotion, cognition, and other areas even when disease, injury or disability are present. Most individuals associate particular musical

genres, artists, and specific songs with life events, milestones or experiences in such a way that they serve as a soundtrack for their lives. As the aging population grows, so does the number of older adults needing leisure activities, social engagement, and continued opportunities for participation in enjoyable programs relevant to their cohort. For adults with memory impairment, music may serve as a link to their past, allowing them to recall their youth, life experiences, and loved ones, and may enable them to connect with others in a significant and meaningful way.

An increasing number of healthcare centers, rehabilitation facilities, and adult day programs recognize music therapy as a necessary and beneficial intervention and employ board-certified music therapists to work with their patients and participants to provide goal-oriented programming. The American Music Therapy Association (AMTA) defines music therapy as "The clinical and evidenced-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has com-

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pleted an approved music therapy program. Music therapy interventions can be designed to promote wellness, manage stress, alleviate pain, express feelings, enhance memory, improve communication and promote physical rehabilitation” (AMTA, n.d.). While not all elders have memory impairment, the case studies that follow relate specifically to those who do, and how the use of music therapy interventions may be used to address the needs of impaired elderly. It is not uncommon for those with mild to moderate dementia to sing. This is true even when recall does not occur within the context of conversation. Singing and actively participating in other structured musical activities, such as live music making and movement, lend themselves well to group settings, such as those in which older adults are brought together to encourage and support socialization and physical activity.

Music has the ability to cut across religious and cultural boundaries, creating a connection between individuals and among groups of people who may not otherwise find commonalities with one another. While the manner in which music is created, performed, and delivered continues to evolve, most often our relationship to it is unchanging. Many of us tend to rely on music, have grown to expect it, long for it, and need it in our daily lives. For these reasons, music therapy can uncover lost or forgotten memories, provide an outlet for self-expression, and create environments conducive to maintaining and improving physical and cognitive ability.

Music Therapy Treatment and Interventions

In the early stages of dementia, singing familiar songs can fully engage the older adult population. Although some may have inhibitions about singing in the presence of others, as the dementia process progresses, such concerns fall away and individuals are able to engage more fully in the music-making process (Clair, 2000). Music therapists working with the geriatric population are trained to use the many qualities of music to help those with memory impairment, dementia, Alzheimer’s and related diseases unlock memories, connect with their past, and continue to live with music as part of their lives.

Music therapy interventions enable older adults to be part of the creative process at any level of functioning; these interventions can help them to be present, utilize their existing skills, and use music as a springboard for reminiscence. If through observation and assessment, it is determined that music elicits responses that are not otherwise observed regularly, an individual’s care plan may be written to include music therapy for the implementation of goals related to communication, movement, reduction of anxiety, and other areas of need. One desired outcome of music therapy is to show measurable improvements through participation in individual or group sessions. Other outcomes may include maintaining cognitive functioning, reducing agitation or slowing the progression of symptoms related to dementia (Baker, et al., 2006). Music therapy interventions include singing, listening to live music,

playing drums and other percussion instruments, and movement. No musical skill is required for participants to benefit from music therapy. For this reason, activities within the music therapy session are designed to stimulate participation, regardless of the level of cognitive or physical function. Even in late stage dementia, music can still be enjoyed in a more passive manner through music listening and other interventions focused on reducing stress, agitation, and confusion (Sacks, 2007). This may be especially helpful while staff, family members, or caregivers are administering medication, assisting with bathing and dressing, or other daily routines. During such instances, music can also become a source of comfort and stress-relief for caregivers performing tasks for the adult with dementia, bringing full-circle the experience of music therapy.

Suggestions for Incorporating Music into Caregiving

There are many ways the non-musician can incorporate music into daily routines, creating a more calming environment and using music to create connections with those for whom they provide care. Even so, not all music elicits pleasant recollection. It is important that family members, caregivers, and healthcare providers take the time to learn and understand an individual’s musical preferences and personal history. This can be done simply by observing an individual’s responses to specific music, thereby determining which songs, performers, and genres he/she is most familiar with. This first step to providing meaningful musical experi-

ences will be the foundation in building the relationship between the individual and the music. Being mindful of chronological age, cognitive level, and musical preferences is key to creating positive interaction during participation in musical activities and experiences. Music need not be performed live by a musician to be enjoyed by older adults. Something as a simple as a melody sung by a caregiver may prompt feelings of comfort and familiarity.

Slow and soothing music can reduce feelings of frustration and agitation. Songs with a more stimulative rhythm can be used to facilitate movement and awaken one who may be lost in the isolation of dementia. Providing favorite recorded music for listening throughout the day can help establish routines and be used to reinforce schedules and create a relaxing environment when performing activities of daily living. Being mindful of religious preference and being sensitive to how music is viewed from a person's cultural background are also of utmost importance.

The layperson should remember that it is not necessary to be a skilled musician to reach someone through music. When songs are sung by those with the desire to comfort and meet the needs of those with dementia, the importance of musicality becomes secondary to meeting the basic need for human connection, something which endures regardless of memory impairment.

Case Study #1

Mrs. A is an 82-year old widow with cognitive impairment and depression, attending a center-based community program for older adults. Prior to joining the program, she lived at home with her spouse where she enjoyed working in her garden and socializing with friends and neighbors. Following her husband's very sudden and unexpected death, she moved into her daughter's home, at which time she began attending the center three times a week. After her first few weeks in the program, the director noticed that, when certain types of music were played during the day, Mrs. A would sing along and engage with her peers and staff in conversations about music and musicians.

Because of the consistent connections she made with music, the program director requested that music therapy services be provided at the center, with the hope that the music therapist might be able to create interventions that would improve spontaneous communication, encourage reminiscence, create an opportunity for self-expression, and provide an outlet for what appeared to be an untapped or under-utilized talent. Once the center implemented a weekly music therapy group, Mrs. A was one of the first to express her interest. She often would be sitting quietly in a chair when the music therapist entered the room. When Mrs. A saw the female therapist walk toward her with a guitar, she raised her head, sat up tall, and greeted the therapist verbally and with a smile. She often said, "Hello, guitar lady!" or "Music lady is here!" While Mrs. A's peers and their families were

very forthcoming with information about any prior musical experiences or abilities, she appeared somewhat hesitant to discuss her history or interest in music. Although her family had not identified music as one of her interests or abilities when enrolling her in the day support program, she exhibited both musical skill and extensive knowledge about musicians in her preferred genre during each music therapy group session. During the first group, the therapist noticed Mrs. A's beautiful voice and her ability not only to sing, but also to recall lyrics and historical facts about the artists who recorded the music she knew and loved.

After several weeks of music therapy sessions, Mrs. A began to speak more frequently and openly about her love of music and the fact that she regretted not using her musical gifts prior to her participation in groups at the center. As she and the music therapist developed a rapport, she continued to share stories about her life and expressed the sadness that she felt because her family did not support her interest in music or acknowledge her musical ability. At that time, the music therapist and the program director agreed that the most important goal of therapy was to provide Mrs. A with a safe and supportive environment in which to use her voice, both literally and figuratively. With staff and peer encouragement, a transformation began to take place, as the woman who previously exhibited depression and a reluctance to share her gift of music assumed a leading role in the music therapy sessions. She was unable to name her peers or the day program staff; yet she would sing entire

songs with full voice, enthusiasm, and with great emotion appropriate to each song's lyrical content. She often made lists of song requests and presented them to the music therapist prior to a weekly session. As self-confidence in her singing increased with encouragement and praise from her peers and staff at the day center, Mrs. A began to improvise a song about her life. After several weeks of doing so, the inspiration for the lyrical content of her song became clear to the program director. It was a song about her husband, who had died the previous year very suddenly. Through the song, she was able to express not only her continued love and devotion to him, but also to work through the grief process with the music therapist. The words of her song beautifully conveyed both the depth of her loss and her belief that she would one day be reunited with her beloved husband in heaven. Music therapy assisted Mrs. A in moving from depression to self-expression in such a way that her desire and ability to continue to utilize and nurture her musical skills grew and made more precious the relationships with those she loved and shared friendship.

Case Study #2

Mr. K is a 71-year-old medical patient in a hospital where music therapy is provided by referral. He had a diagnosis of moderate memory impairment, but was hospitalized for treatment of a complex cardiac condition. Prior to his admission, he lived at home with his wife, enjoyed regular visits with their children and was a member of his church choir. While hospitalized, he had the continued support of family

members who visited him often but he was restless and exhibited confusion and anxiety. His nurses and care partners reported that he often attempted to get out of his bed or chair and had daily incidents of agitation, which would require significant attention from his nurse and other staff. His agitation made it difficult for staff to attend to his frequent attempts to leave his room. A unit nurse made an initial referral for music therapy, noting that Mr. K constantly sang along with the radio and did not exhibit the same degree of agitation when music was present. The music therapist met Mr. K and performed an informal assessment to gain an understanding of his musical preferences, personality, cognitive ability, communication skills, etc. Based on the assessment, the music therapist determined that the focus of sessions would be to reduce aggression, provide an opportunity for self-expression, and encourage communication. Family members were able to provide the music therapist with a list of his favorite songs and singers; they also committed to helping reduce his agitation by carrying out suggestions for daily music listening when the music therapist was not present. Mr. K received music therapy a minimum of two and a maximum of four times a week. During music therapy sessions, he made and maintained eye-contact with the music therapist as she sang his favorite hymns and sang with her with a smile on his face. After the first three sessions, he began singing words of his favorite hymns, strumming the guitar, and tapping a drum with assistance.

As music therapy became a regular and familiar part of his daily rou-

tine, his nurses and family members learned the importance of using music before the onset of agitation to create a calming environment and reduce his feelings of confusion and anxiety. The patient's wife commented on the considerable difference she saw in her husband's demeanor and said that she and her two adult children felt less stress and worry after seeing his positive responses to music therapy. She also expressed that she felt a sense of relief knowing that she would be able to use music to help bring a sense of calm to her loved one beyond the walls of the hospital. As Mr. K's physical condition improved, his participation in music therapy increased and he began responding musically and verbally. On one such occasion, the music therapist asked him if he would like to hear some music. An enthusiastic "Oh, yes!" followed, with his spontaneous singing of his favorite hymn. The enriching relationship between therapist and patient continued for four months until Mr. K's discharge from the hospital.

Conclusion

When faces and places are no longer familiar and the names of loved ones are long forgotten, music has the ability to remain as a familiar friend, source of comfort, and trigger of beloved memories. Regardless of the level of one's cognitive functioning, music therapy can be useful for a number of beneficial outcomes, such as encouraging communication, facilitating movement, initiating interpersonal interaction, stimulating memory, and reducing agitation, anxiety, and confusion. As the population ages, music will continue to

serve as a familiar source of comfort, one that may help carry older adults through the processes of growing older and the changes that may occur cognitively, physically and emotionally. Music therapy can be a valuable agent. The more familiar family caregivers and healthcare staff become with the benefits of music with the aged, the more meaningful will be the interpersonal connections they establish with their participants and patients.

Study Questions

1. When an individual is unable to communicate his/her musical preferences, what actions might help to determine the most potentially beneficial or enjoyable musical experiences?
2. How can caregivers use music to calm, engage, and create relationships with older adults?
3. How does music provided by a family member, staff person or musician differ from music therapy interventions provided by a board-certified music therapist?
4. How can music be used throughout the day to create structure?

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About the Author



Melissa L. Owens, MT-BC, manages music therapy services for the Virginia Commonwealth University Medical Center's Department of Arts in Healthcare. In addition to her work in medical music therapy, she provides contractual music therapy for individual students in public and private school systems and individuals throughout the greater Richmond area. A frequent presenter of workshops on the benefits of music therapy with various age groups and populations, Melissa is active in her local and national music therapy community. For more information about music therapy, visit www.musictherapy.org. For professional consultation, contact Melissa at (804) 827-9962 or mowens@mcvh.vcu.edu.

From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

Older Prisoners

Tougher sentencing guidelines and a wave across the country of life without parole legislation in the 1990s have produced a growing number of older inmates. While individual states define "older" differently (e.g., 55, 60, 65), the trend among those incarcerated is clear. The number of Americans in prison who are 55 years old or older is substantial and growing at a much faster rate than others, according to a report by Human Rights Watch in 2012. The impact of more gray within the walls is causing consternation and concern, for varying reasons, among different stakeholders, including prison officials, legislative bodies, clergy, and some gerontologists.

The Human Rights Watch report, "Old Behind Bars," the first of two planned, reflected the group's visits and interviews with people at 20 federal and state prisons in nine states; these included officials, corrections officers, prisoners, and gerontologists. The report found that the number of prisoners who are 65 years of age and older grew by more than 90 times the rate of the total prison population from 2007 to 2010. Specifically, the number of these older inmates increased by 63 percent during this time, while the total prison population rose by just 0.7 percent. One in 10 state prisoners is serving a life sentence. These people and others

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with lengthy sentences are not likely to be released before they have become frail or infirm, physically or mentally. Prison officials are "scrambling" to accommodate the numbers and needs of older inmates but they are confounded by constrained budgets, inappropriate prison architecture, lack of gerontologically and geriatrically trained staff members, indifferent legislative bodies, and a general lack of awareness among the public of these problems.

Prison architecture that reflected the physical abilities and agility of younger prisoners, such as flights of stairs and distances to work sites and common areas within the prison, pose difficulties for older prisoners with disabilities. Tiered bunks may be daily obstacles.

Arthritis and movement-related disabilities may make older prisoners vulnerable to exploitation by other inmates. Add to these the fact that more older inmates are expressing signs of cognitive impairment, Alzheimer's disease or other dementias and there's figuratively a "time" bomb that's ticking.

To accommodate increases in older prisoners, prisons have to initiate far ranging changes, from adopting structural modifications in building designs and housing, to making allowances for those with Alzheimer's or dementia, to finding sufficient ground-floor cells for inmates in wheelchairs, and ensuring that older prisoners are not exploited or robbed by younger inmates.

The report notes that, between 1995 and 2010, the number of state and federal prisoners ages 55 and older

nearly quadrupled, to about 124,400 inmates, with some 26,200 of them being 65 years old and older. The growth in numbers of prisoners ages 55 and above is six times that of the rest of the prison population. While most of the older inmates have been in prison for years, the numbers of older adults just entering have also been increasing. Together, these raise the cost of incarceration.

"Age should not be a get-out-of-jail-free card, but when prisoners are so old and infirm that they are not a threat to public safety, they should be released under supervision," said Jamie Fellner, the author of the study. "Failing that, legislatures are going to have to pony up a lot more money to pay for proper care for them behind bars."

"Prison officials," the report states, "are hard-pressed to provide conditions of confinement that meet the needs and respect the rights of their elderly prisoners." These officials see that the projected increase in aging prisoners in their systems means that in the very near future they will have to operate special geriatric facilities. Some states already do. As for costs, the report notes that, in Michigan, the annual cost of health care for the average inmate was \$5,800, which increased to \$11,000 for prisoners ages 55 to 59; costs rose steadily with age, reaching \$40,000 a year for inmates 80 years and older, more than seven times the average cost.

There are many who will die incarcerated. Between 2001 and 2007, 8,486 prisoners ages 55 and above died in prison. Numbers will

increase as younger offenders sentenced to 30 or 40 years grow old, likely showing what some have called an accelerated presentation of the chronic conditions that affect many in the outside older population. As California's prison population has aged, so has the incidence of chronic and highly complex health conditions. Having only three hospitals for prisoners, totaling some 120 beds, California has had to contract with private operators for inpatient care, with the cost of a hospitalized inmate in such a facility being about \$850,000 a year.

In Virginia today, about 1,000 of its 33,000 prisoners are older. While the average age of Virginia's prisoners today is about 37 and the average length of stay is five years, tougher sentences and life without parole spell increasing amounts of age-related problems for the corrections system. It pursued legislation in the 2007 session of the General Assembly to establish a memory care unit at Deerfield, its *de facto* geriatric prison. Legislation never advanced.

Aged inmates share many of the same needs as the general older population, not just the need to have adequate health care. These include interpersonal and spiritual needs. My gerontologist colleague Joe Hendricks, then at the University of Kentucky, published perhaps 20 years ago a paper anticipating the manifold implications of sentences of life without parole. It's now apparent that he called it right: our states need not only retrofitted and newly designed physical facilities but also staffs and providers with gerontological and geriatric

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training, from corrections personnel to health care providers to clergy and mental health workers. At the same time, our legislative bodies should become aware of the consequences of the graying behind the walls.

To read the report, go to:
www.hrw.org/reports/2012/01/27/old-behind-bars-0

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From the Commissioner, Virginia Department for Aging and Rehabilitative Services

Jim Rothrock

The Importance of Planning

I recently read an interesting article on a research project conducted by the NORC Center for Public Affairs Research. It was an extensive study of public attitudes related to long-term care in the United States. Their major finding noted that few Americans ages 40 or older are prepared for long-term care, care that they expect to need in the future, and even fewer understand the financial costs involved.

I was shocked, but I guess not surprised to see that Americans 40 or older are counting on their families to provide assistance for them as they age, and that a majority support a variety of policy options for financing long-term care.

Critical elements or findings from the NORC study are as follows:

- Many Americans ages 40 or older rely on their families for long-term care, and caregivers provide ongoing living assistance to a variety of family members; four in 10 caregivers have provided care to their mothers.
- Caregivers' experiences with providing care are mostly positive, though perceptions are shaped by demographics and specific family relationships between the caregiver and the recipient.

• Americans ages 40 or older who have personal experiences with long-term care are more likely to be concerned about planning for long-term care and less likely to think they can rely on family as they age.

• One-third of Americans ages 40 or older are deeply concerned that they won't plan enough for the care they might need when they get older, yet two-thirds report having done little or no planning so far for such assistance.

• Among Americans ages 40 or older who expect to be a caregiver for family or friends in the next five years, just three in 10 say they feel prepared to take on the job.

• Compared to one year ago, Americans are currently more supportive of a government-administered long-term care insurance program, similar to Medicare, and think that a number of measures would be helpful for improving the quality of ongoing living assistance.

• Americans lack information about ongoing living assistance. When they do get such information, they tend to hear about it from friends, family or co-workers, although they have more trust in long-term care information they receive from experts.

• Six in 10 Americans ages 40 or older have some experience with long-term care, either as caregivers, recipients of care or financial providers of care. Those who have experienced long-term care tend to be female, lower-income, and in the Baby Boomer generation.

I would encourage our readers to

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gain more information, including the survey's complete findings, by searching the website at www.apnorc.org.

When our agency worked with Dr. Bill Hazel on Virginia's *Blueprint for Livable Communities*, we cited information from Governor McDonnell which noted that:

Virginians spend an estimated 739 million hours each year serving informally as caregivers to their adult family and friends, at an average lifespan cost to each caregiver of \$635,000 in lost wages and pension. With an estimated 700,000 Virginians serving as informal caregivers at any one time, the lifetime opportunity cost to family caregivers will total at least \$400 billion in lost wages, pension, and Social Security in Virginia alone, not including the state tax revenue that those earnings would have produced. Furthermore, these statistics refer only to caregivers of older adults and do not include the tens of thousands of Virginians who care for children with temporary or lifelong disabilities and special needs.

Clearly, family caregiver is both widespread and costly, in human and economic terms. During the past year, our agency also was successful in garnering and managing **The Virginia Lifespan Respite Voucher Program**, funded through a grant of over \$200,000 to the Virginia Department for Aging and Rehabilitative Services (DARS) from the federal Department of Health and Human Services, Administration on Aging, Office of Home and Community Based Services. This was a productive project where our agency worked col-

laboratively with the Virginia Caregivers Coalition.

The Virginia Lifespan Respite Voucher Program provided reimbursement vouchers to home-based caregivers for the cost of temporary, short-term respite care provided to individuals of any age with a disability or special need. Program characteristics included:

- Voucher funding was limited to a total of \$400 a family.
- 503 families were served.
- Age range of the individuals served by the respite care recipients was 1-102 years old.
- Respite care recipients represented 80 different disabilities or health-related issues; many had multiple disabilities.
- Caregivers requesting respite included parents, adult children, siblings, grandparents, and legal guardians.

DARS hopes to receive additional funding to continue offering this service that family caregivers so desperately need. It's a small measure to support the familial and uncompensated care network that the Commonwealth relies upon.

Each of us should plan for our future. We should consider contacting our local Area Agency on Aging and other resources to gain information about available resources and should take action. If you do so, you will be in an informed minority and, hopefully, be well prepared for the future.

2014 DARS Meeting Calendar

Commonwealth Council on Aging
(Wednesdays)
September 24, 2014

Alzheimer's Disease and Related Disorders Commission
(Tuesdays)
August 5, 2014
December 2, 2014

Public Guardian and Conservator Advisory Board
(Thursdays)
September 18, 2014
November 20, 2014

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

Visit Our Websites

The website for the Virginia Center on Aging is www.sahp.vcu.edu/vcoa. Visit to learn about programs from lifelong learning to geriatrics training, to access the archives of issues of *Age in Action*, ARDRAF reports, and more. The website of the Virginia Department for Aging and Rehabilitative Services is www.dars.virginia.gov. Visit to learn about services, commissions, boards, and councils on adult protective services, aging, Alzheimer's, guardianship, independent living, and more.

Focus on The Virginia Center on Aging

Ruth Anne Young



Ruth Anne Young is the newest member of the VCoA's team focusing on abuse in later life, joining in February 2013. She serves as the Project Coordinator for the Virginia Elder Justice Training and Services Grant Project (VEJTS), one of nine funded for the 2012-2015 grant cycle by the US Department of Justice Office on Violence Against Women.

This project concentrates on the communities of Bristol City and Washington County in Southwest Virginia. It seeks to enhance the safety of victims aged 50 and older and to hold offenders accountable by providing training for criminal justice professionals, victim advocates, and governmental agency staff, and opportunities to strengthen collaboration across the organizations that serve older victims.

Before coming to VCoA, Ruth Anne already had built a career of accomplishments in community-based non-profit organizations. She served as the Program Manager for the ElderFriends Program at Family Lifeline, Inc. ElderFriends is a friendly visiting program in which volunteers visit lonely and/or isolated older adults weekly and advocate on their behalf. Ruth Anne greatly enjoyed meeting the clients, listening to their stories, and hearing of the positive benefits the regular visits produced for both the volunteers and the clients.

Ruth Anne attended James Madison University, graduating in 1986 with a Bachelor Degree in Communication Arts. After graduating, she moved to Richmond to join the volunteer staff community at Freedom House, which served the homeless and hungry with a community soup kitchen, clothing closet, and case management. Ruth Anne was the first full-time volunteer coordinator for Freedom House.

She has since worked for a variety of other non-profit and governmental agencies, including the Virginia Interfaith Center for Public Policy, the YWCA, the Chesterfield Fire Department, and the Richmond Peace Education Center. All the while, Ruth Anne has been an active volunteer in the Richmond community. She volunteered with the Richmond Public Schools while her children were enrolled there and served for two years as the Chair of the RPS Gifted Advisory Committee. Prior to serving on the staff of the Richmond Peace Education Center, she volunteered with their Conflict Resolution Team, leading workshops on conflict resolution with local community groups and inmates in the Virginia Correctional Center for Women.

Ruth Anne earned her M.Ed. from VCU in 1991, with a focus on Adult Education and Human Resource Development. Drawing on her experiences in working with and training volunteers for community work, she sought through this VCU degree program to strengthen her skills in working with groups and helping others to learn and grow as well.

In 2006, Ruth Anne was accepted into the Connecting Communities Fellowship Program (CCFP) sponsored by Hope in the Cities/Initiatives of Change. CCFP is a program that increases the capacity of communities to overcome divisions of race, culture, economics and politics by creating a network of skilled facilitators, capable team builders, and credible role models. It does this by selecting a diverse group of 25 participants to take part in five intensive monthly weekend training sessions focusing on the skills needed to become catalysts for change; promote honest, inclusive dialogue; heal history; and build and sustain teams from diverse sectors of the community. She completed this program in 2007 having gained a greater appreciation for the impact of Richmond history on the lives of those who live here and stronger skills in facilitating groups through challenging processes.

She has had many role models for successful aging in her life from whom she draws great inspiration as she enters her own "later life." Ruth Anne's Great-Aunt Marge was regularly roller skating into her 80s when her doctor told her she needed to stop out of fear that she would break a hip if she fell. Aunt Marge lived independently until the very last couple of years of her life, passing away at age 103. Ruth Anne's grandfather worked many years in physical education, and he exercised daily until the day he died at age 87. He spent his last day swimming at a lake and enjoying the company of family and friends. While Ruth Anne was at JMU, she

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COMMONWEALTH OF VIRGINIA

Alzheimer's and Related Diseases Research Award Fund

2014-2015 ALZHEIMER'S RESEARCH AWARD FUND RECIPIENTS ANNOUNCED

The Alzheimer's and Related Diseases Research Award Fund (ARDRAF) was established by the Virginia General Assembly in 1982 to stimulate innovative investigations into Alzheimer's disease and related disorders along a variety of avenues, such as the causes, epidemiology, diagnosis, and treatment of the disorder; public policy and the financing of care, and the social and psychological impacts of the disease upon the individual, family, and community. The ARDRAF competition is administered by the Virginia Center on Aging at Virginia Commonwealth University. Questions about the projects may be directed to the investigators or the ARDRAF administrator, Dr. Constance Google (ccoogle@vcu.edu).

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

A radically different therapeutic approach for the treatment of Alzheimer's disease, known as neuroprotection, involves the use of therapeutic agents to defend nerve cells from death. One of the best neuroprotection agents is nerve growth factor (NGF), a protein that is naturally produced in the brain. Nerve growth factor not only prevents cognitive decline, it also delays the progression of Alzheimer's disease by keeping the neurons alive. However, because it can't enter into the brain from the bloodstream, nerve growth factor therapy requires direct administration to the brain. To circumvent this problem, this research group has identified protein kinase C (PKC) and several of its specific downstream cell signaling partners as promising targets for drug-induced upregulation of NGF secretion. They will further this investigation by using a series of protein specific agonists and antagonists to validate select members of the PKC signal transduction pathway, thereby highlighting them as promising targets for the development of therapeutics. (*Dr. Couch may be contacted at (703) 993-4770, rcouch@gmu.edu.*)

ODU Gianluca De Leo, PhD and Scott Sautter, PhD, ABN

Improving Quality of Life of Alzheimer's Family Caregivers: Creating a Reminiscence Slideshow through a Smartphone Application

Previous research has determined that engaging family caregivers in meaningful activities can improve their quality of life. This study aims to determine if a reminiscence slideshow of meaningful events, captured by using smartphones, can improve the quality of life of families of patients with Alzheimer's disease. An easy to use smartphone application will allow family members to take pictures and/or video clips of pleasant moments experienced with the patient and rate the patient's level of happiness experienced during each event. The slideshow will be available on a secure Cloud space accessible by using smartphones, tablets or computers. It is hypothesized that reviewing the slideshow will improve the mood of family caregivers and increase their quality of life. This study will also evaluate the use of this application from usability and satisfaction points of view. (*Dr. De Leo may be contacted at (757) 683-6733, gdeleo@odu.edu: Dr. Sautter may be contacted at (757) 498-9585, drsautter@thememoryclinic.com.*)

UVA Roberto Fernandez-Romero MD, MPH, PhD

The Neurophysiology of Driving Impairments in Early Alzheimer's Disease

Getting lost in familiar surroundings, wandering and unsafe driving have been associated with a decreased capacity to perceive and process optic flow, i.e., the patterns of visual motion observed by individuals during common tasks like ambulation or vehicular driving. Cortical responses from the brain areas responsible for optic flow can be measured by using event related potentials (ERP), a common electroencephalographic technique. The investigator has previously linked real-world navigation capacity to visual motion ERPs, and demonstrated that ERP response magnitude is significantly decreased in early Alzheimer's disease. This study will combine ERPs and a virtual-reality driving simulator to explore the links between cortical dysfunction and measures of driving performance in patients with early Alzheimer's disease. This novel approach may provide a better understanding of such deficits and potentially lead to the development of screening methods that are safe, highly objective, and cost effective. (*Dr. Fernandez-Romero may be contacted at (434) 243-5611, r6u@virginia.edu.*)

UVA Erin Pennock Foff, MD, PhD and Benjamin Purow, MD

Investigating the Role of miR-762 in Mediating Disease in C9ORF72-Based Frontotemporal Degeneration

Frontotemporal Degeneration (FTD) is a common cause of neurodegenerative dementia, particularly in the early-onset population (prior to age 65). This ultimately fatal disease is biologically linked to Amyotrophic Lateral Sclerosis (Lou Gehrig's disease), and the familial forms and some sporadic cases have been shown to share underlying genetic defects. The most common known cause of such familial cases is the expansion of the 6-nucleotide repeat in the gene, C9ORF72, whose normal biologic function remains unknown. The investigators have identified a regulatory molecule, known as microRNA-762 (miR-762), that is predicted to bind tightly to the expanded repeat. They have pilot data to support their hypothesis that this effectively "sponges" the miR, rendering it unable to perform its normal biologic function, but crucial experiments are needed to define the role that this mechanism may play in causing disease. This study will use human cell lines obtained from C9ORF72-positive patients to demonstrate the sponging effect in vitro, and compare the cellular expression profile to patients with the disease, but without the repeat expansion. Future experiments will investigate whether a common and safe anti-seizure medication can alter available miR-762 levels in an attempt to develop a disease-modifying therapy in FTD patients. (*Dr. Foff may be contacted at (434) 243-1006, epf4b@virginia.edu; Dr. Purow may be contacted at (434) 982-4415, bwp5g@virginia.edu.*)

Warren Jonathan Winter, MD and J. William Kerns, MD

Memorial *Pharmacologic and non-pharmacologic management of Behavioral and Psychological Hospital Symptoms of Dementia (BPSD): A Mixed-Method Pilot*

The behavioral and psychological symptoms of dementia (BPSD) are frequently treated with antipsychotic medications which have the potential for dangerous health side effects. For this reason, the Centers for Medicaid and Medicare Services have been purposeful in trying to curb their use in patients with dementia, but with little effect. The potential for severe risks was highlighted by Food and Drug Administration's 'black box warnings' in patients over age 65 with dementia, yet they continue to be prescribed for over 20% of nursing home patients in Virginia. This study will evaluate behavioral health diagnoses and prescribing trends for BPSD over the last decade among nursing home and community dwelling patients in Virginia insured by Medicaid. These data will inform interviews with patients' families and nursing caregivers about their experiences and perceptions regarding the treatments for BPSD. A better understanding of the perspectives of all stakeholders will be critical in identifying and increasing family, nursing, and physician engagement in shared decision-making regarding treatment options, including non-pharmacologic approaches with or without medication use. (*The investigators may be contacted at (540) 631-3700, jwinter@valleyhealthlink.com, bkerns@valleyhealthlink.com.*)

GMU Joseph J. Pancrazio, PhD

Analysis of Amyloid Beta Effects with Living Neuronal Networks

A hallmark feature of Alzheimer's disease is the manifestation of amyloid plaques which are largely comprised of amyloid beta (A β). There are conflicting reports concerning the neurotoxicity of soluble A β oligomer, monomer, and fiber forms. In addition, various receptors have been identified that may mediate functional neurotoxicity or cytotoxicity in neurons. The principal approach of this research group involves the use of cultured murine cortical neuronal networks on microelectrode arrays. This well-established technique allows noninvasive, long-term measurement of physiologically relevant bioelectrical activity. They aim to: 1) compare the relative potency of the oligomer, monomer, and fiber forms of A β on spontaneous bioelectrical activity and cytotoxicity in neuronal networks; 2) determine the role of excitatory receptor modulation in A β neurotoxicity effects; and 3) examine the capacity of a custom peptide that binds A β to interfere with neurotoxicity effects. If successful, this work will lead to a new in vitro cell-based strategy for therapeutic screening. (Dr. Pancrazio may be contacted at (703) 993-1605, jpancraz@gmu.edu.)

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

The genetic revolution in medicine is making it possible for individuals to have genetic testing to determine their risk for diseases that can occur later in their lives. For example, the e4 form of the apolipoprotein-E (APOE) gene has been associated with an increased risk for late-onset Alzheimer's disease. Decisions about genetic testing were originally made in consultation with genetic counselors. The tests are now widely offered in situations where there is little time or opportunity to provide counseling, e.g., through physicians' offices and on the internet. Many people thus have genetic testing with inadequate information or preparedness. The investigators have developed an online decision-aid prototype designed for people considering APOE gene testing. The prototype is based on over 150 interviews, in which the factors that consumers regard as most important when deciding about genetic testing were identified. The decision aid includes a novel values-clarification component: dramatized vignettes that present the pros and cons of genetic testing. This study will rigorously test this decision aid. Survey methodologies will be used to determine its effectiveness in communicating relevant knowledge, improving understanding of risk, and eliciting the value components of genetic testing. The findings will be used to enhance the utility and robustness of the decision aid and make it available online to the wider community.

(Dr. Zallen may be contacted at (540) 231-4216, dtzallen@vt.edu; Dr. Holtzman may be contacted at (540) 239-2949, holtzman@vt.edu; Dr. Kim may be contacted at (540) 981-8025, KYKim@carilionclinic.org.)

UVA **Zhiyi Zuo, PhD**
Environmental enrichment reduces postoperative cognitive dysfunction

Postoperative cognitive dysfunction (POCD) is a relatively new, but well-documented, syndrome affecting patients after heart and non-heart surgeries. About 10% elderly patients (age 60 years or older) have POCD three months after non-heart surgery. Currently, effective and clinically practical methods to reduce POCD are not established. Recent studies indicate that inflammation in the brain, an abnormal process for many chronic brain diseases including Alzheimer's disease, may be involved in POCD. The investigator has preliminary data showing that environmental enrichment reduced post-surgery learning and memory impairment and enhanced brain cell regeneration in young adult mice. This new study will determine whether environmental enrichment after surgery can attenuate learning and memory impairment, reduce inflammation in the brain, and improve brain cell regeneration in aged mice. These studies will provide pre-clinical evidence for potentially using this non-pharmacological intervention to reduce POCD. (Dr. Zuo may be contacted at (434) 924-2283, zz3c@virginia.edu.)

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2014 ARDRAF Reviewers

The Alzheimer's and Related Diseases Research Award Fund (ARDRAF) has been enabling promising lines of research into dementing illnesses since 1982 and has emerged as the most productive and cost-effective state-funded pilot grant program for research on dementia in the country. Its success depends in large measure on the careful scrutiny that the ARDRAF review panel gives each grant application. Experts in bio-chemical, physiological, and psycho-social aspects of dementia, family caregiving, clinical practice, and other relevant areas volunteer their time and talent to the review process.



Pictured clockwise from top are the members of this year's review panel in session: Drs. Constance Coogle (ARDRAF Administrator), Hu Yang, Myra Owens, Annemarie Conlon, Kathleen Fuchs, Patrick Zou (VCoA recorder), Christopher Deppmann, Christine Jensen, Jorge Cortina, Paul Aravich, Linda Phillips, Shirley Taylor, Shijun Zhang, Jenni Mathews (VCoA recorder), Leslie Davidson, Pamela VandVord, and Pablo Sobrado.

VGEC Faculty Development Program June Graduates

The Virginia Geriatric Education Center (VGEC), a consortium of faculty from VCU, Eastern Virginia Medical School, and the University of Virginia, annually conducts a 160-hour Faculty Development Program (FDP), September through June. FDP Scholars commit to this interprofessional geriatrics training program with the expectation of passing their training to colleagues in order to maximize the impact of their training. Our 2013-14 FDP Scholars celebrated the conclusion of their training year on June 20, 2014.



Pictured are: (Standing) Annemarie Conlon, PhD, MSW; Ryan LeBlanc, PharmD, MBA; Marcy Boclair, DPT; Deborah Kahrs, MS, OT/L; Rebecca Cowan, PhD; Marie Coad, BSN, MBA; Larry Anderegg, RPh, BS; and Patricia Bonwell, BSDH, PhD; (Seated) Kathy Dial, MSW, PhD; Helen Lamberta, NP; Lendoria Riddick, MSW; and Monique Sessler, MD.

Not pictured: Colleen Kenny, NP and Kyong Chong, PharmD, MD.

You're Never Too Old to Be Studied

(Researchers Donna Zulman, a physician in internal medicine, and Keith Humphreys, a psychologist, both at the Stanford University School of Medicine, were published in the Op-Ed pages of the *New York Times* on May 22nd this year, commenting on the relative scarcity of older adults in medical research.

The under-representation of older adults in clinical trials often results in best guesses ["extrapolation"] about the research's application to them. Reasons for exclusion are many, including the convenience of access that academic researchers may have to younger people as subjects and the prevalence of co-morbidities (concurrent illnesses or conditions) among elders that may muddy the waters when trying to measure the effect of a treatment upon a specific condition, such as diabetes. Therefore, some recommended "evidence based practices" may not be relevant or even recommended for older patients. The Zulman and Humphreys opinion piece follows.)

When older patients seek health care, they are unwittingly enrolling in an experiment: Will medical procedures that have been proved effective mainly on the young also help the elderly?

Doctors are often in the dark about whether certain drugs, procedures, and tests will benefit older adults, because these patients are routinely excluded from medical research. A systematic review in *The Journal of the American Medical Association* in 2007 looked at randomized con-

trolled trials published in high-impact medical journals between 1994 and 2006, and found that close to 40 percent excluded individuals over the age of 65. Clinicians consequently have to extrapolate findings about diseases as diverse as cancer, heart attacks, and mental illness from studies of younger and often healthier people, potentially putting their older patients at risk.

A patient's age affects all sorts of treatment decisions. For example, as people get older, they generally experience a decline in kidney and liver function, which can affect the way their bodies process medications. This can lead to increased drug levels in the body, resulting in more side effects like dizziness, drowsiness, and depression. As a result, older people often need to take smaller doses than studies of younger adults suggest.

Another important example involves diabetes. Early diabetes studies conducted mainly with younger patients suggested that maintaining low blood sugar levels might decrease the risk of heart attack and stroke. But when researchers studied a population that included older adults and patients with longstanding diabetes, they found that intensive blood sugar treatment did not have this benefit, and actually increased the risk of dangerous outcomes, including hypoglycemia. Many clinicians are now recommending less stringent blood sugar goals for their older diabetic patients.

Researchers often impose age limits in clinical trials because they are concerned that elderly patients will

have complicated health issues that pose practical or ethical challenges to their participation. However, advanced age is not a reliable proxy for poor health. If researchers are worried that studying people with certain health conditions will increase the risk of side effects or complicate the interpretation of the results, then they should exclude participants based on those health conditions, not on their age alone.

Today, around 13 percent of Americans are 65 or older, and this proportion is expected to grow to more than 20 percent by 2030. The Agency for Healthcare Research and Quality reports that older adults, who tend to have more chronic medical conditions and a greater risk for functional and cognitive decline, accounted for more than \$333 billion in health care expenses in 2006. As clinicians who care for older patients ourselves, we want to make sure that we're giving them the best treatment possible. But we can't do that if we don't have evidence for what works and what doesn't.

Older people aren't the only ones who have been underrepresented in medical research. The National Institutes of Health started requiring studies to include women only in 1993. Last week, it called for researchers to start testing new drugs and treatments on more female lab animals. This is a welcome trend. Ending the exclusion of older patients should be the next step. (It would also have a major impact on female patients, because the majority of older adults are women.)

The N.I.H. and other public funding

agencies should prohibit the exclusion of study subjects solely on the basis of age, just as they prohibit the exclusion of women and minorities. And the Food and Drug Administration should require that new drugs and medical devices be tested on older adults before approval, when appropriate. Finally, medical journals and reviewers should insist that researchers who left out older participants explain why they did so, and include a discussion about what that might mean for the results.

Addressing the underrepresentation of older adults in medical research won't be easy; researchers will have to work to ensure that recruited patients reflect the spectrum of health issues common among older individuals, and many older patients will have to volunteer to participate in clinical trials. But continuing the current exclusionary practices will only create more scientific evidence that cannot be generalized to a growing, complex and costly cohort of aging patients. Medical researchers have become increasingly committed over the past half-century to allowing all citizens to participate in studies, in order to benefit all citizens. Older Americans are our patients, too. We can't leave them out.

A Father's Day Goodbye

by Pete Earley

This essay appeared in The Washington Post, June 20, 2014.

Father's Day found me with a man who often doesn't remember who I am, although we have spent much of his 93 years together. My father has dementia.

Five years ago, I persuaded my parents to move from Spearfish, S.D., into a second house that my wife and I own that doubles as my office. Leaving a community where they were well-established was difficult. But they enjoyed seeing grandchildren, spent Saturdays at garage sales and played Upwords with me at lunch time. It was good.

I first noticed little things. Forgetfulness, confusing names. It's part of aging, I thought.

A year ago, my parents' world narrowed. A retired minister, my father began hurrying from church, afraid he might say something foolish. No more garage sales, no more word games. In October, my mom felt severe back pain. Cancer. My father slept next to the hospital bed that hospice delivered. They celebrated their 70th wedding anniversary in November. Three weeks later, she died. I learned then that she had been covering for him. At her funeral, he asked if I was enjoying "the party" and said he was sorry that my mother had missed it.

I'd promised I'd take care of my parents at home. They were terri-

fied of nursing homes. Round-the-clock caregivers were hired. When my father began wandering, child-proof locks and alarms were installed. One night I found him sitting on his bed, sobbing. "What's wrong, Dad?" I asked. "I want my mommy and daddy." In his mind, he was 5.

The third time he fell, I broke my promise. We moved him into a "memory unit" in Fairfax. Outside each bedroom are photographs. They help residents identify their rooms. A bank executive at his desk, a diplomat enjoying a retirement party, a grandmother embraced by children. I have learned each of his neighbor's names and studied their photos. Memories sealed behind Plexiglas.

Some traits have deep roots. Ask and my father can still offer a beautiful, extemporaneous prayer. He refused to eat at first, not because he wasn't hungry but because he didn't have any money and always had paid his own way. The home's director printed meal tickets for him marked "paid." Problem solved. Some traits have vanished, such as his quick temper and his insistence on always being in charge.

We've always been close. I'm named after him. About every minute, someone develops Alzheimer's or some form of dementia. I'm 62. Am I walking down his path?

He used to wait eagerly for me. Now I visit for me, knowing that, an hour after I leave, he will have forgotten I was there. I have watched the thoughtful man who offered me advice become

confused, frightened and unable to express the simplest thought. Before he became ill, he wrote a short autobiography for his grandchildren. I read him passages, but most days he thinks I'm describing my life.

Two-thirds of dementia patients die from pneumonia. My father has had it twice since January. Because he is tired, he refuses to do much. Inactivity brings on pneumonia. We are in a vicious circle that I've been warned will eventually kill him. Last week, we replaced his walker with a wheelchair. If left alone, he would use neither and stay in bed.

Everyone tells me I'm lucky and should feel grateful I still have him. Should I? I feel ashamed even thinking such a question, and yet I know he would understand exactly why I think them.

I was angry at first. I couldn't save him. Diapers. Confusion. Indignity. He was a proud man. Respected. I didn't like deciding whether he needed medication that I knew would knock him out. The resentment is gone now, replaced by abiding sadness.

In a cruel twist, the hardest visits are when he is the most lucid. "How did I end up like this?" he asks. "Let me die."

Yet during those moments, at least I have him back — if only for a moment. He tells me I am a good son. Minutes later, I am a stranger. He needs a ride to a baseball field where he is meeting his younger brother, Harry. I've not been born yet and Harry, who died decades ago, is waiting.

On Father's Day, I took him hot chocolate and we sat outside. Even though he was wearing three shirts, he complained about being cold. He didn't want me to read his autobiography. He wanted to sit and hold hands. The two of us. Father and son saying a long goodbye.

The writer is the author of Crazy: A Father's Search Through America's Mental Health Madness.

VCoA Focus, continued

enjoyed visiting Great-Aunt Jack, walking through gardens, learning the names of plants and hearing stories from earlier in her life. In addition, Ruth Anne's mother, now 75, has been RVing around the country with her husband and 90-year-old mother-in-law for the last several years. Experiencing the love and care of these older adults in her life has taught Ruth Anne how much we have to learn from those who have lived more than we have and that there can be much to look forward to as we age! Ruth Anne and her husband hope to be role models in healthy aging for their two sons who are just becoming adults at ages 18 and 20.

As for other interests, Ruth Anne is also an artist. She is a juried member of the Artisans Center of Virginia for her work in pysanky (sometimes referred to as Ukrainian Eggs). She enjoys knitting, pottery, creating works from the plants in her yard and garden, and exploring new art forms.

Shepherd's Center Welcomes New Executive Director



The Shepherd's Center of Richmond is pleased to announce the appointment of Julie Adams-Buchanan as its new Executive Director.

For the past six years, Adams-Buchanan served as the Center's coordinator of volunteer services.

Adams-Buchanan received her bachelor and master degrees in sociology from Virginia Commonwealth University, where she was a member of Alpha Kappa Delta, the international sociology honor society. She earned a certificate in volunteer administration in 2013 from the Council for the Certification of Volunteer Administration and is a member of the Board of the Greater Richmond Association of Volunteer Administration. At First Baptist Church, where her grandfather, the Rev. Theodore Adams, was long-time pastor, Adams-Buchanan is a volunteer in the area of community outreach, and she serves on the board of the church's pre-school.

In addition to her experience with The Shepherd's Center, Adams-Buchanan has coordinated services in the business office of a senior living facility and has served as an office manager for a family construction firm.

She becomes the fifth executive director of the Shepherd's Center, as it celebrates its 30th anniversary this year. She succeeds Linda Frank, who served for ten years.

Eight Are Recognized at Shepherd's Center Anniversary Program

As part of its 30th anniversary celebration in April, The Shepherd's Center of Richmond recognized eight persons whose work and support have been invaluable to the development and successful operation of the Center over the years. Receiving the Distinguished Service Awards were William (Bill) and Miriam Blake, Betty and James "Buddy" Harlan, Gene Harrison Knoop, and Betty Ann Dillon. Recognized for their generosity to the Center were Carole and Marcus Weinstein, who also sponsored the celebration on April 4.

President Arthur Gunlicks described the contributions of each recipient in making the awards. Of **Bill and Miriam Blake**, he noted, "They are a dynamic duo, bringing many talents to the Open University through their entertaining and informative courses." Bill Blake also served as president of the Board of The Shepherd's Center and is the Center's resident songwriter.

Gene Knoop has given 23 years of service as office volunteer, driver of seniors to the grocery store and to medical appointments, member of the public relations committee, library liaison, and contributor wherever help has been needed. Said Gunlicks, "Her kindness, patience, and generosity have enriched the lives of many people: clients, staff, and especially her fellow volunteers."

Buddy Harlan, also a past president of the Board, currently is a greeter at the Open University site at First Presbyterian Church. He has been instrumental in recruiting other volunteers and has been a financial adviser for many years. **Betty Harlan** has been a mainstay on the hospitality committee, and together the couple chaired the 25th anniversary celebration.

"**Betty Ann Dillon** has done it all," said Gunlicks. "She is a past president of the Board, current chairman of the Financial Committee, chief volunteer fundraiser, driver, and all-around cheerleader for the work of the Shepherd's Center in the Richmond metropolitan area."

He called on Ms Dillon to recognize the contributions of **Marcus and Carole Weinstein**. In describing their philanthropy, she remarked, "They have significantly reduced budget deficits in several years, funded the establishment of the Open University Coordinator, and helped secure a consultant to assist with strategic planning for our future. Their gracious and generous support has made a significant difference in our day-to-day operation."

Ralph H. Graner, acting executive director for the Center, also recognized the hundreds of volunteers present at the celebration who have provided services to seniors in need, staffed the Center's office, worked on committees, and taught courses or lectured at lunch for the Open University.

VCU Gerontology Alumni in the News

Janina Bognar, gerontologist, is the new PACE Program Specialist with the Department of Medical Assistance Services (DMAS). PACE is the Program of All-inclusive Care for the Elderly, a community-based initiative for frail older adults. The chief objective and purpose of the position is to provide leadership, management, and administrative expertise in the development of PACE throughout the Commonwealth and to serve as a technical expert to PACE sites.

Janina now has many responsibilities. She will conduct quality management and technical advisory reviews, as well as participant satisfaction and quality assurance surveys, to determine that the criteria for reimbursement and for the health, safety, and welfare of program participants are met according to federal and state regulations. Janina will conduct quality management reviews and investigate complaints. She will participate in all developmental and operational processes with PACE providers and process PACE providers' applications for PACE program development and expansions. Janina will also ensure compliance with the Centers for Medicare and Medicaid Services by monitoring and taking action to address determinations of inappropriate level of care for enrolled Medicaid individuals in the EDCD Waiver, HIV/AIDS Waiver, and other waiver programs.

Congratulations, Janina!

Calendar of Events

July 24, 2014

2014 Joint Conference on Adult Guardianship and Elder Rights. Presented by the Virginia Guardianship Association and the Virginia Elder Rights Coalition. The Westin Richmond. For information, visit www.vgavirginia.org.

August 5, 2014

Caregiver Connection. A support group for caregivers, most of whom are caring for a parent or spouse. 4:00 p.m. - 5:15 p.m. (Group meets each month on the 1st Tuesday.) Lucy Corr Village, Chesterfield. For information, call (804) 768-7878 or e-mail Leidheiserd@chesterfield.gov.

August 19, 2014

Church Ambassador Program. 9:00 a.m.-12:30 p.m. Chesterfield Community Development Building, Chesterfield. The program is offered to leaders and laymen of the faith community in Chesterfield who work with seniors. It is designed to provide information on resources to help the older adults in the congregation. For information, all (804) 768-7878 or e-mail Leidheiserd@chesterfield.gov.

August 21, 2014

Grandparent Connection. A support group for grandparents raising grandchildren or other kin raising a child. 4:30 p.m. - 6:00 p.m. (Group meets each month on the 3rd Thursday.) Chesterfield Community Development Building, Chesterfield. Free child care available. For information, call (804) 768-7878 or e-mail Leidheiserd@chesterfield.gov.

October 5-8, 2014

65th Annual Convention and Expo of the American Health Care Association and the National Center for Assisted Living. Gaylord National Resort and Convention Center, National Harbor, MD. For information, visit www.eventscribe.com/2014/ahcancal.

October 8, 2014

11th Annual Empty Plate Luncheon and Awards Ceremony. Benefit for Senior Connections: The Capital Area Agency on Aging. Richmond. For information or sponsorship, call (804) 343-3023 or email mjames@youraaa.org.

October 14-15, 2014

Virginia Assisted Living Annual Fall Conference. Presented by the Virginia Assisted Living Association. The Inn at Virginia Tech, Blacksburg. For information visit www.valainfo.org.

October 19-22, 2014

LeadingAge Annual Meeting and Expo. Nashville, TN. www.leadingage.org/ Annual_Meeting_2014

November 5-9, 2014

Making Connections: From Cells to Societies. 67th Annual Scientific Meeting of the Gerontological Society of America. Washington, DC. For information visit www.geron.org/annual-meeting.

November 11-12, 2014

Annual Conference and Trade Show of the Virginia Association for Home Care and Hospice. The Westin, Richmond. For information, visit www.vahc.org.

January 28, 2015

Virginia Center on Aging's 29th Annual Legislative Breakfast. St. Paul's Episcopal Church, Richmond. 7:30 a.m. - 9:00 a.m. For information, call (804) 828-1525.

February 26 - March 1, 2015

The Changing Face of Aging Around the World. AGHE's 41st Annual Meeting and Educational Leadership Conference of the Association for Gerontology in Higher Education. Sheraton Nashville Downtown, Nashville, TN. For information, visit www.aghe.org/am.

March 23-27, 2015

Aging in America. Annual conference of the American Society on Aging. Chicago, IL. For information, visit www.asaging.org/aia.

Age in Action

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2014 Walk to End Alzheimer's

Walk to End Alzheimer's is the Alzheimer's Association's signature nationwide fundraising event. Each fall, tens of thousands of people walk together to help make a difference in the lives of people affected by Alzheimer's and to increase awareness of the disease. Become part of the group of individuals, corporations, and organizations that are proud to lead the fight against Alzheimer's disease!

Central and Western Virginia Chapter
Register for walks in this area at www.alz.org/cwva.

Roanoke, September 6
Greater Augusta (Waynesboro), September 13
Tri-County (Orange, Madison, Culpeper), September 20
Danville, September 27
New River Valley (Blacksburg), October 10
Lynchburg, October 11
Charlottesville, October 18
Harrisonburg, October 25

Greater Richmond Chapter
Register for walks in this area at www.alz.org/grva.

Middle Peninsula (Urbanna), September 20
Fredericksburg, September 27
Petersburg, October 18
Richmond (Glen Allen), October 18

National Capital Area Chapter
Register for walks in this area at www.alz.org/nca.

Northern Virginia (Reston), September 28
Winchester-Shenandoah Valley (Winchester), October 11
Virginia Tri-Counties (Manassas), October 18

Southeastern Virginia Chapter
Register for walks in this area at www.alz.org/seva.

Suffolk, September 20 Virginia Beach, October 12
Farmville, October 2 Newport News, October 18
Nassawadox, October 4 Williamsburg, October 25

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