

Case Study

Bringing Comfort to People with Advanced Dementia

by Ann Wyatt, MSW
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Educational Objectives

1. Explain the purpose of looking at palliative care through a dementia lens.
2. Define dementia-capable palliative care.
3. Identify and provide examples of specific care practices that can bring comfort to people with advanced dementia.
4. Describe the process that staff use in identifying what brings comfort to individual residents.

Background

In 2012, the Alzheimer's Association, New York City Chapter, undertook a special project focused on palliative care for people with advanced dementia, based on the groundbreaking work at Beatitudes Campus, Phoenix, Arizona, which has invested considerable research

and training into expanding knowledge and practice in residentially-based care for people with advanced dementia.

The Beatitudes Campus of Care, founded in 1962 in Phoenix, now consists of a nursing home, assisted living units, and independent apartment units, as well as a home care program. More than a decade ago, staff members at Beatitudes began to focus more intensively on the care they provided to residents with dementia living in their nursing home. Using a comfort approach and working with their partner, Hospice of the Valley, they have identified a number of interventions specifically for people with advanced dementia living in residential settings. All of these interventions are based on knowing as much as possible about the individual with dementia, with the added dimension that these residents cannot usually articulate their needs, but often express them in other ways. Beatitudes offers specific practice changes that address not the behaviors, but the needs underlying them.

What attracted the New York Chap-

ter to the work done by Beatitudes is the degree to which they have identified the organizational adaptations necessary to support improved care practices for people with advanced dementia. Results of their efforts include the following: 1) liberalized diets contributing to stable weights; 2) increased toileting for reduced incontinence; 3) elimination of physical restraints; 4) almost no anti-psychotic, anxiolytic, and sedative medications; 5) increase in pharmacologic and non-pharmacologic methods for treating pain; 6) decrease in total number of medications prescribed; 7) elimination of "sundowning" symptoms; 8) improved staff knowledge, beliefs, and attitudes about palliative and end-of-life care; 9) residents receiving active comfort and even enjoyment from meaningful engagement; 10) greater family engagement and satisfaction; and 11) much improved staff satisfaction with almost no turnover. In recognition of their work, in 2010 LeadingAge gave them the Excellence in Research and Education Award, and in 2013 they received the LeadingAge Public Trust Award. Beatitudes has now developed an accreditation

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program, *Comfort Matters*TM, which is intended to educate and set the standard for dementia-capable palliative care.

Our project consisted of working with three nursing homes to bring the Beatitudes model to New York City: Cobble Hill Health Center; Isabella Geriatric Center, and The New Jewish Home, Manhattan campus. Also included in the project were the three hospice programs involved with these homes: Calvary Hospice, Metropolitan Jewish Geriatric Services Hospice and Palliative Care Program, and Visiting Nurse Service Hospice. Over a 30-month process of education, piloting, and evaluation, these homes worked to implement the practice changes pioneered by Beatitudes. Our intent was to learn from the process and understand the obstacles, so that our experiences could assist other homes in implementing these practices.

Why Palliative Care?

The purpose of palliative care is the prevention and alleviation of pain and suffering. The earlier that palliative care is involved, the better, when someone has been diagnosed with an acute, chronic, and/or terminal illness. While other specialists are treating the disease(s), palliative care focuses on symptom management, helping to ease stress for the person and for the person's family, including symptoms such as depression, pain, anxiety, or difficulty sleeping or breathing. Some researchers (Temel, Greer, Muzikansky, et al., 2010) suggest that this additional level of support and attention to comfort and quality of life may even prolong life. Further,

a focus on personal priorities with regard to treatment and comfort can help clarify preferences for medical care directives as the disease progresses. This person-centered focus has been shown to reduce the need for crisis hospitalizations (Mitchell, Teno, Kiely, et al., 2009).

The Palliative Care Disconnect for People with Alzheimer's and Other Dementias

Alzheimer's is a progressive, terminal disease, with the average time between diagnosis and death being about eight to 10 years; but it is extremely variable and can last up to 20 years or more. Typically, about 40% of this time is spent in the advanced stages. Palliative care has the potential to offer more over a longer time period for people with dementia; however, unless there are specific modifications in how palliation is offered to people with dementia, there is a strong possibility that it will be ineffective. Far too often, palliation isn't even considered as an option for people with dementia.

As an individual's dementia advances, his or her actions, rather than words, are more likely to communicate distress. Unfortunately, all too often these behavioral expressions are not understood as distress; rather, they are often assumed to be the inevitable consequences of the dementia itself. Palliation cannot occur if the reason or triggers for distress are not known or understood. Anti-psychotic and anti-anxiety medications do not take away pain, nor do they comfort, if someone living with dementia is hungry, cold, too warm, tired, or frightened by noises or activity in their envi-

ronment. Indeed, the medications may mask the continuing discomfort.

Dementia-Capable Palliative Care

In order to respond to the specialized needs of people with advanced dementia, dementia-specific practices and tools are needed to evaluate and to respond appropriately to their needs. In particular, this means: 1) use of a behavior-based pain assessment tool; 2) use of round-the-clock rather than PRN orders for pain medications; 3) offering food in small, manageable amounts, especially finger food, throughout the day and evening; 4) essential flexibility for rising, eating, bedtime, and other routines; and 5) attention to the needs of the person with dementia for a delicate balance of stimulation and rest in the environment throughout the day.

Advance Directives

Dementia-capable care practices aren't the whole story. Significant decisions must be made regarding aggressive medical treatments, traditionally used with the goal of curing, which are more often than not inappropriate for someone with advanced dementia. Specifically for persons with dementia, these treatments include: 1) artificial nutrition through gastric tube feeding; 2) antibiotic therapy; 3) cardio-pulmonary resuscitation (CPR); and 4) hospitalization for infection. These are highly individual decisions that must be made based on the person's values and best interests. People with dementia and their families need information and

understanding about how to weigh the risks and benefits. Palliative care decision points are reached when the person with dementia is beyond understanding, and it is essential that family be involved, and provided with appropriate education and support.

The two case studies that follow illustrate key elements of the Beatitudes model in practice. Guiding principles are interwoven through these cases.

Case Study #1

Sharon C's husband, Anthony, was diagnosed with Alzheimer's disease in 2005. As the disease progressed, Sharon struggled with taking care of her husband at home. During the difficult period when Anthony wandered, he ended up in ERs, private psychiatric facilities, and homes without Alzheimer's units. Some facilities rejected him. Finally, a little over two years ago, Sharon was able to place him in a facility with a floor specifically for people with dementia, at Isabella Geriatric Center, just at the moment when Isabella became a partner in the Chapter's palliative care project.

When Anthony first arrived, staff had difficulties getting him to bed at night, and difficulties getting him up in the morning in time for breakfast. He was very resistive, emphatically pushing staff away. When they explored this with Sharon, they learned that it had been Anthony's habit for many, many years to stay up late (often as late as 4:00 a.m.), then snack before going to bed, often sleeping until noon or later the next day. With Sharon's encouragement, they experimented

with adjusting Anthony's care plan, and now, as Sharon says, *"the staff tells me that Anthony is the poster boy for letting patients sleep late. It is a great example of how to treat a person with dementia and tailor to his needs. So now, they let him sleep in if he doesn't want to get up. They let him have his own routine. They know and provide the food he likes (fruit and salads especially during the day, and sandwiches, yogurt and/or cookies at night). He has good days and bad days, but staff know how to connect with him, and how to work with him."*

She goes on to say, *"Like most people, I didn't get the meaning of palliative care. Most people think it is for people with six months to live. The real meaning of palliative care is relieving and preventing suffering. If anyone thinks an Alzheimer's patient doesn't suffer... they do, in the brain. I am so relieved he is here. Even though it's an hour and a half travel each way for me, I don't care. He has blossomed with the caring people he has now. He has a better life there than he had at home with me. Once they found a way to make him comfortable, and he was no longer on so many drugs, his personality came back, his sense of humor, his pleasure in dancing. I got my husband back! Anthony has a roommate, and he takes care of him. Anthony takes him for a walk down the hall. My heart just bursts with joy when that happens. It brings tears to my eyes."*

This story illustrates the organizational elements that need to be in place in order to support staff to provide appropriate care for Anthony: 1) facility policies and proce-

dures that support flexibility in waking and sleeping; 2) a care plan that both addresses Anthony's particular needs with regard to this flexibility and ensures that all staff, including weekend shifts, holiday replacements, etc., know and understand these needs; 3) food that Anthony likes is available in the middle of the night; 4) food that Anthony likes is available when he awakens in the early- to mid-afternoon; 5) all three daily shifts need to support each other in this adjustment in schedule (rather than asking, for example, why the night shift didn't get him up before they left); 6) interaction with families occurs as soon as someone is admitted to learn about the resident's routines and specific comforts and discomforts; and 7) ongoing conversation with families about what is working and what isn't, as evidenced by the resident's level of comfort, especially as the resident's needs change over time.

Case Study #2

The staff identified a resident, N.D., who usually sat with her peers in the dayroom and tended to yell out repeatedly throughout the day, seemingly without a break. To see if they could determine why she was in distress, the staff used three tools introduced by Beatitudes. Two of these were 'Spotlighting' and 'Road Mapping.' To 'spotlight' means that the team talks each week about the particular behavior the resident displays ("What is the resident trying to tell us?"), and then completes the 'Road Mapping' tool which acts as a guide or map to lead the staff in the direction of finding a solution. These tools help staff identify specifically when the

behavior occurs, what is taking place when the behavior occurs (including possible precipitating factors), and then guide staff in looking for ways to make the resident more comfortable. They help staff consider possible alterations of elements related to the resident's care or environment, and encourage them to try something new in their approach to the resident or in their delivery of care. Sometimes the environment needs to change, while sometimes it's the way care is provided that needs to change. Sometimes, however, behaviors such as yelling, hitting, cursing, or resisting care may be caused by untreated pain the resident is experiencing.

Staff members learned to avoid words such as 'agitated' and 'combative' which tend to label or define a person with dementia, since labeling tends to prevent staff from looking for a reason for the behavior. The Roadmap asks the staff to consider all possible meanings of a resident's actions, what is happening in the environment, what activities are going on, what noises might contribute to resident's behavioral expressions, and lastly, all possible changes in the care plan that might help. In addition, each week the team revisits any changes being tried out in a resident's care, such as letting a resident sleep, singing a song or reducing noise around the resident to reduce the behavior. We utilized these tools at our weekly team meeting to help us with N.D. in order to try to discover the cause of her yelling and discomfort.

Staff started by brain-storming possible reasons for her yelling out. One team member suggested that the Day Room may be over-stimu-

lating for her, with all of the activities being just too much for her to tolerate. The Beatitudes approach teaches that over-stimulating environments can cause someone with dementia distress, so we reasoned that a calmer environment might help to bring her comfort. We decided to change where she sat; thereafter, we sat her in the doorway to her room rather than in the Day Room so that she could still observe the "action" in the hall, but not be so exposed to the over-stimulating noise of the day room. We observed her each week and felt that there was some improvement; but after a while she began to yell again.

The team met and wrote down possible causes. N.D. had a companion privately hired by her family, and one team member suggested that the one-to-one companion might be too much stimulation for her to tolerate. We decided to speak to the family about this and to suggest they discontinue the private companion because her presence might be causing N.D. to be uncomfortable. They listened to our suggestion and the reasons for it and agreed with our plan. When the privately hired companion was no longer coming in to sit by N.D., we observed that N.D. did yell less than before and she did seem more comfortable.

After a period of time, however, her yelling resumed. We met again to write down other possible paths that might bring her the comfort she deserved. One staff member suggested that maybe even sitting in her doorway was too much stimulation for her as she was someone who really wished for and needed a

very quiet environment, especially as her dementia advanced. We tried sitting her in her room near the window where she could see the outdoors and the sky. At the same time, we also began playing her favorite music softly on her radio. We observed this had a calming effect on her. We continued to discuss her comfort level each week over the course of several months. However, her yelling was never fully eliminated, which concerned us.

We continued to brain-storm solutions, and reviewed what we were taught through this project, that people need a balance of stimulation (not too much and not too little), and determined that we still did not have the right balance to make N.D. completely comfortable. We continued to try to find the best balance for her, and decided on a rotation of sitting areas for N.D., periodically moving her from her doorway to inside her room so she can look out her window (and back again). Our Therapeutic Recreation Director suggested creating an opera iPod music program for her as a way to help soothe her. The combination of moving N.D. from an engaging activity to a calming activity really seemed to help N.D., and still does.

During this time, we also thought she might be experiencing untreated pain. To explore the possibility that some of N.D.'s behavior might be the result of untreated pain, all three shifts used a behavior-based pain assessment (the PAINAD). It was important to capture N.D.'s possible experience of pain over a 24-hour period. Based on the results of the assessment, pain medication was prescribed for N.D.,

and, after trials involving different medications and different doses at different times of the day, our team believed that much progress had been made in identifying and treating N.D.'s pain, and that we now had a good system of medication monitoring to meet her pain needs.

Finding the solution to bringing N.D. comfort took many steps and several months. We never gave up and tried various changes to help bring her comfort. We changed her sitting environment, asked the family to discontinue her private companion, which was counterintuitive, as most think a one-on-one companion would help to calm a person with advanced dementia, addressed her untreated pain, and introduced new music.

Sometimes finding the solution to a resident's distress can be fast, but at other times it can take a lot of time. We have learned that we must keep searching for the reason because there is always a reason for a resident's discomfort. N.D. is calmer now and her plan of care is to keep her in a quiet environment most of the day, recognizing, however, that she also needs the stimulation of some activities like music and visits from the staff. She still occasionally calls out, but we do not think that this is caused by pain because we assess her pain regularly. We continue our rotation of activities for N.D. and try to anticipate when she needs a change of pace, knowing all the time that she, like all of us, needs a balance of stimulation and peace and quiet.

Conclusion

Palliative care does not mean giv-

ing up. It does mean taking active steps to discover what comforts someone and what gives pleasure, as well as taking active steps to prevent or avoid unnecessary pain and suffering before they take hold. For people with dementia and their families, comfort is an essential point of focus every step of the way, not only at the end of life.

Study Questions

1. Why is it important to adapt policies and practices in palliative care to the needs of people with dementia?
2. Why might some aggressive medical procedures be inappropriate for people with advanced dementia?
3. Why is comfort an important concept in caring for people with dementia, and how might comfort principles be important in caring for frail elderly people who do not have dementia?

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Related Resources

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About the Author



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Editorials

From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

Remembering Our Friends

Eulogies are often filled with superlatives and absolutes. “He was the most...” or “She never...” These are appropriate to the occasion. Of course, life lived just isn’t like that. We each have our faults, or at least the euphemistic “peccadilloes” or minor sins. Occasionally, if we’re lucky, we encounter people who truly are exceptional, people for whom the superlatives and absolutes are not *pro forma* and not too far from reality. The recent death of our friend Frank Hall, former Delegate in the Virginia General Assembly, church elder, long-term member of our VCoA Advisory Committee, friend to so many, has caused me to reflect on his gifts to others. While doing so, it dawned on me that in three consecutive spring times we have lost men whose caring for others was, indeed, exceptional: Bill Egelhoff in 2013, Benny Lambert in 2014, and Frank Hall in 2015.

William (Bill) Egelhoff preceded me as Director of the Virginia Center on Aging and recruited me as his replacement. He was then, and throughout his long life, a quietly fascinating man, an MBA, Episcopal priest, World War II veteran, entrepreneur, family man, bureaucrat, lifelong learner, outdoorsman, traveler, and low-keyed champion for others. He had an impressive range of experiences that he called upon without boast or pretense,

unfolding knowledge and personal connections like compartments in a suitcase. Bill lived a full and meaningful life, touching so many lives with his gentle yet can-do attitude and slowly became a symbol of what a good old age can be.

It wasn't that he was age-less, but age was just not relevant when meeting him. Because of his selflessness, five Virginia Governors sought his counsel by appointing him a member of the Governor's Advisory Board on Aging. Bill helped to inaugurate and to guide the Interfaith Coalition for Older Virginians, as a means to assist clergy and lay leaders to respond to the diverse challenges and opportunities that congregants might face as they grow older. He was concerned with the spiritual as well as the social and economic well-being of older adults.

We write the book of our life one page at a time. Each year, each month, each day is fresh and blank. It's up to us what gets put on these pages. For some, the pages are few, for others there are many pages with little written on them. Bill's book of life was long and full, with many chapters, themes, and characters. Most importantly, his book is a good read. "Amazing" comes to mind

Benjamin (Benny) Lambert lived a life whose days were filled with caring for others, from his loving family to his patients, to his constituents and fellow advocates for others. It ran through more than 50 years as a New England College of Optometry-trained practitioner in Jackson Ward, a champion for almost 30 years in the Virginia

House and Senate, consecutively, of people in need, a catalyst for the growth of his beloved alma mater Virginia Union University, and a stakeholder in many other agencies for the betterment of those who were economically or educationally disadvantaged. He could be counted on for honesty and faced challenges with grace of spirit.

Benny was the first African-American in the 20th century to serve on the Virginia Senate Finance Committee, and also served on the Education and Health, General Laws, General Government, and Health and Human Resources Committees. He used these positions to champion others, not for self-aggrandizement. When our budget was jeopardized despite a record of meaningful work, when the Alzheimer's and Related Diseases Research Award Fund seed grant program was threatened or needed greater funding because of rising laboratory costs, colleagues and I would visit his corner office in the General Assembly building where he'd listen carefully and suggest strategies. He seemed to make time for these conversations, no matter his grueling schedule. He brought these qualities of caring professionalism to such important positions as Secretary of the Board of Trustees of Virginia Union University and member of Virginia Commonwealth University's Health Systems Authority Board. In 1993 he received, deservedly, the Humanitarian Award from the National Conference of Christians and Jews.

Franklin (Frank) Hall's recent death prompted an outpouring of laudatory comments, but whatever and wherever one read an account, it

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couldn't capture the generosity of spirit and genuine regard that Frank had for older Virginians and issues of aging. Frank, like Benny, served on our Advisory Committee about as long as I've been here at VCoA. (Bill Egelhoff was the common link, for one of Bill's first acts when I succeeded him as Director was to introduce me to members of the General Assembly who both cared about aging issues and older Virginians and would act to do something accordingly.)

We honored Frank and Benny in a special ceremony at the Valentine Museum on the occasion of our Center's 15th anniversary in 1993. Frank and Benny were our "go to" guys in the House and Senate, respectively, whenever we had questions about strategy, funding, outreach, partnerships, promotion. Just about anything. Frank's office, Room 529 in the General Assembly Building, staffed by Nancy Bolio, was welcoming. His face could light up from inside in a way that communicated genuine caring for others.

Frank helped me greatly over the course of two dozen years, always with kindness. He'd say "tell me about it" before offering his careful appraisal. He counseled me through the four Assembly sessions that it took to get the "Caregivers Investment Bill" enrolled, starting as his HB 1519 in 1996 and ending, with the great support of Senator Walter Stosch, in 1999 as S910, the Virginia Caregivers Grant Program. Frank didn't care who got "credit" so long as the need for supporting family caregivers was realized.

Frank had been this way since

before our beginning, so to speak. In January 1978 he was a co-patron of House Bill 503 to create the Virginia Center on Aging. VCoA Advisory Committee chairman Bob Schneider and I have a shared perspective on Frank Hall: charming, intelligent, savvy, and wise. But, of course, he was more.

One of the last long conversations that I had with Frank, after last fall's Advisory Committee meeting, was about relationships. Then, as always, he counseled that the only real way to get things done is through relationships. "Build trust, build rapport with members. That's how you help seniors," he said. It applies to the General Assembly and it applies to life.

I hope that people like Bill Egelhoff, Benny Lambert, and Frank Hall are not the last of their kind but that regard for others and for causes beyond "self" thrives in the hearts of elected officials and community leaders here and elsewhere. In fact, I know that there are individuals who fit these criteria, some experienced and some new in their positions. Delegate Ken Plum, the sole still-serving co-patron of House Bill 503 in 1978, has attained seniority in the House, while some younger colleagues there and elsewhere share the gift of commitment to others.

We remember the good that Bill, Benny, and Frank did with their lives. May it be an inspiration.

From the Commissioner, Virginia Department for Aging and Rehabilitative Services

Guest Editorial by Bob Brink,
Deputy Commissioner for
Aging Services, and
Amy Marschean,
Senior Policy Analyst

At 50, A Look Back and a Look Forward

There's a lot for us to celebrate in July. This month marks the 50th anniversary of two of the most important components of our nation's social safety net: Medicare and Medicaid. In addition, 50 years ago, on July 14, 1965, President Lyndon Johnson signed Public Law 89-73, the Older Americans Act, the first comprehensive effort to provide services for the nation's older adults. This momentous month is a good time to take stock of the Commonwealth's older adults and the services they require to live independent, fulfilling lives.

Virginia's population is becoming older and more racially and ethnically diverse. Today, there are an estimated 1.5 million adults in the Commonwealth who are 60 years old or more, and this population will expand to more than two million by 2030. Just as older adults show great variations in their skills and abilities, e.g., one 80-year old might play tennis, while another might live in a nursing home, the internal process of aging differs in all of us. But it is a fact that that older adults will likely live longer because of advances in technology

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and medicine, and that older Virginians with chronic conditions may need more assistance for longer periods of time.

With the restructuring of Department for Aging and Rehabilitative Services (DARS) in 2012, the agency's mission has evolved to promote security and independence, while providing the right care to empower older adults and persons with disabilities to have and make choices about their lives. DARS includes the Virginia Division for the Aging (VDA) whose role is to plan, coordinate, fund, and evaluate programs for older Virginians made possible through funding from the Older Americans Act, discretionary grants, and state general funds appropriated by the General Assembly. VDA oversees fiscal management of, serves in an advisory capacity to, and monitors implementation of quality standards for a full range of nutrition, transportation, health promotion, in-home supports, education, socialization and recreation services, and family caregiver services provided by Virginia's 25 area agencies on aging, (AAAs).

AAAs offer, directly or through contracts, a common set of core OAA programs that include: home-delivered meals and meals at congregate sites, transportation, legal assistance, elder abuse prevention, in-home and family caregiver support services, and information and referral to community resources. Each AAA has considerable flexibility to develop and provide additional services, often reflecting local needs, including care coordination, care transitions, older adult volunteer programs, and tax coun-

seling, to name just a few. As OAA turns 50, DARS has been working with stakeholders and the older adults we serve on one of the OAA's most important requirements, one that also appears in our Code of Virginia (§ 51.5- 136), namely, Virginia's State Plan for Aging Services, October 1, 2015-September 30, 2019 (State Plan). The State Plan reflects feedback from a public listening session held in Fishersville in February 2015, before members of the Commonwealth Council on Aging, with statewide input from videoconference sites in Roanoke, Abingdon, Fairfax, and Norfolk. DARS staff also worked with a multi-member stakeholder group, the Commonwealth Four-Year Plan Work Group (Work Group), to establish the State Plan's goals and vision statement in early March. The Work Group provided comment on an exposure draft of the State Plan at its meeting in mid-April. The final draft State Plan was sent out to all members of three DARS advisory boards for aging and to interested parties and posted on the agency website for a public comment period in early May. The Work Group chose as the overarching vision for Virginia's State Plan: *Age-friendly livable communities that foster independence for all Virginians.*

The State Plan describes the agency's goals and strategies to achieve its mission, emphasizing the common themes that will enhance the lives of older Virginians moving forward. Utilizing demographic and service data, state agency reports on the impact of the aging population, and input from older adults and caregivers during the Council listening sessions and

from aging network stakeholder meetings, DARS adopted the following service goals:

1. Assess and facilitate statewide community readiness for an aging population, recognizing both the untapped resources and the unmet needs of this population;
2. Empower older adults and their families to make person-centered and informed decisions about personal health and well-being, long-term services and supports (LTSSs), and end-of-life care options;
3. Enable people to live in the community, as appropriate, through the availability of formal and informal high-quality LTSSs, including supports for families and caregivers;
4. Strengthen statewide systems that protect the rights and prevent the abuse, neglect, or exploitation of older adults; and
5. Enhance effective and responsive management of programs serving older adults to ensure the fiscal and programmatic accountability of those programs.

These service goals support the State Plan's overarching vision of creating livable communities that are age-friendly and foster independence, and they form the framework for the State Plan's strategic goals for 2015-2019. The full plan is available on the agency website: www.vda.virginia.gov/boards.asp.

Achieving a person-centered, statewide, comprehensive and coordinated system of programs and services for all, regardless of age or disability, has required DARS and

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the AAAs to partner with public and private organizations, including various state agencies and educational institutions, to advocate for and develop the necessary LTSSs, in addition to finding ways to address the critical issues of housing and transportation. While Virginia has made great strides in aligning service delivery to older adults and adults with disabilities since the creation of DARS in 2012, this State Plan is primarily focused on aging services and supports. Virginia believes that livable communities have the ability to bring together enhanced partnerships among providers of aging services, housing, health care services, and transportation so that all Virginians can age successfully.

2015 DARS Meeting Calendar

Commonwealth Council on Aging
September 23

Alzheimer's Disease and Related Disorders Commission
August 25, December 1

Public Guardian and Conservator Advisory Board
September 10, November 19

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

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. This just-concluded FDP cohort of 16 health-related professionals included two scholars from Kazakhstan whose intention is to apply what they learned with us in developing the first-ever gerontology curriculum for their country's undergraduate medical students. Our 2014-15 FDP Scholars celebrated the conclusion of their training year on June 19, 2015.

Askar Chukmaitov, MD, PhD, MPA, and Michael Halvachs, both of the Department of Healthcare Policy and Research, School of Medicine, VCU, had hosted the Kazakhstan Scholars for their stay at VCU and attended their graduation, which occurred earlier because the Scholars had travel arrangements to return to their country.



Top Picture: (Front, l-r) Ethlyn Gibson, MSN, RN, BC; Marian Coiley, MS, ANP-BC, AACC; Brenda Miller, MSW; Angela Gentili, MD. **(Back, l-r)** Brenda Exum, MSW, ACSW; Travonia Hughes, PhD, MCH; Rachel Comer, PharmD, MS; Linda Copeland, BSN, ENP, MBA; Anita Ramsey, MSW, ACSW; Kimberly Davis, MS, RN; Suzanne Taylor, PhD, MBA/HCM, OTR/L.

(Not pictured) Karma Lapacek, PT, DPT, GCS; Natalie Penaranda, MD; Kacie Powers, PharmD, BCPS



Bottom Picture: Kazakhstan Bolashak Scholars (l-r) Gulmira Yermakhanova, MD, MPH, and Karlygash Absattarova, MD, PhD

COMMONWEALTH OF VIRGINIA

Alzheimer's and Related Diseases Research Award Fund

2015-2016 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 awards this year have been 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 (*). The ARDRAF competition is administered by the Virginia Center on Aging in the School of Allied Health Professions at Virginia Commonwealth University. Questions about the projects may be directed to the investigators or the ARDRAF administrator, Dr. Constance Coogle (ccoogle@vcu.edu).

EVMS Frank J. Castora, PhD and Randolph Coleman, PhD
Biochemical Systems Theory Modeling of Alzheimer's Disease Using Mitochondrial Genes Involved in Amyloid Precursor Protein and Tau Processing

Mitochondria, the energy-producing structures inside nerve cells, have been reported to function abnormally in a number of neurodegenerative diseases including Alzheimer's Disease (AD). The investigators aim to help delay the onset and slow the progression of AD by identifying specific genes for mitochondrial proteins that are linked to AD. Using polymerase chain reaction (PCR) arrays to assess gene expression, they have recently found abnormal expression of several genes essential to mitochondrial function in AD brains. These genes interact with critical components of the AD disease process, namely protein tau and the amyloid precursor protein. This study will use state of the art bioinformatics and biochemical data to develop a functional model of these interactions in order to better understand the role that mitochondria play in the onset and progression of AD, and to identify and assess new targets for therapeutic interventions. (*Dr. Castora may be contacted at (757) 446-5657, castorfj@evms.edu; Dr. Coleman may be contacted at (757) 221-2679, racole@wm.edu.)*

UVA Alev Erisir, MD, PhD*
Ultrastructural Neuropathology in Transgenic Models of Alzheimer's Disease

The electron microscopy approach is a powerful technique that allows identification of the cellular compartments at which neuropathological changes occur. Using structural morphometry and immunolabeling techniques, the investigator will conduct an extensive electron microscopy study of a transgenic mouse model to reveal the localization of different neuropathological signs of AD, including amyloid plaques; vascular amyloid deposits; intracellular amyloid fractions and accumulation; tau bundles; multivesicular bodies; dystrophic dendrites and axons; nuclear, mitochondrial or endoplasmic reticulum pathology; and cellular degeneration fragments. Brains from early adult ages will be examined to reveal selective neuropathologies that may correlate with preclinical and clinical stages of AD, particularly those that correlate with the emergence of early behavioral deficits. The project will establish a standardized procedure modeled after the Alzheimer Association guide for scoring spatiotemporal progression of neuropathology in postmortem diagnosis of AD. The results obtained will provide insights into mechanisms of amyloid pathogenesis and guide future investigations of neuropathology in human AD brain. (*Dr. Erisir may be contacted at (434) 243-3549, ae4h@virginia.edu.)*

ODU Karen A. Karlowicz, EdD, RN and colleagues
An Examination of Policy Application and Education Needs of Working Dementia Caregivers

Critical information regarding the unique factors impacting work-life balance for dementia caregivers is scarce. It is also unclear how many employers are using EEOC policy, or recommendations from the Alzheimer's Workplace Alliance (AWA) or the AARP Respect a Caregiver's Time (ReACT) program. This research will identify: 1) the factors that are impacting work-life balance for dementia caregivers, and 2) the gaps, barriers, and facilitators in the application of EEOC policy, as well as the AWA and ReACT guidelines. A mixed method, multi-level assessment of policy guideline implementation will use qualitative and quantitative procedures to enhance implementation of available policies and guidelines and facilitate identification of strategies that contribute to a sustainable infrastructure in workplaces to support dementia caregivers. This study will inform a larger, systematic study across the Commonwealth of Virginia to: 1) determine how existing dementia caregiver support policy is implemented in the workplace, and 2) identify the educational needs of dementia caregivers and workplace managers about these policies. *(Dr. Karlowicz may be contacted at (757) 683-5262, kkarlowi@odu.edu.)*

VCU MaryPeace McRae, PharmD, PhD and Patricia Slattum, PharmD, PhD*
Investigating the Relationship between Benzodiazepine Medications and the Development of Blood Brain Barrier Dysfunction as Risk Factors for Alzheimer's Disease

The blood brain barrier (BBB) is a selective permeability barrier separating the brain from circulating blood. Surgery and general anesthesia may exert neurocognitive damage via an inflammatory response and/or by damaging the BBB. Insults leading to the dysfunction of the BBB may allow the passage of amyloid beta across the BBB and may cause, or aggravate, AD. Recent data from this group and others suggest that the chronic use of benzodiazepine medications is associated with the development of AD. This project will utilize an in vitro human BBB model, already established in the investigator's lab, to examine the effects of benzodiazepine medications on the integrity and barrier properties of the BBB. Understanding the effects of these medications on the BBB may help to elucidate another risk factor for the development of AD. *(Dr. McRae may be contacted at (804) 628-5076, mpmcrac@vcu.edu; Dr. Slattum may be contacted at (804) 828-6355, pwslatt@vcu.edu.)*

VPI & SU Webster L. Santos, PhD and Gregorio Valdez, PhD*
Controlling Neuronal Sphingosine-1-Phosphate as Alzheimer's Disease Therapy

Although there are FDA-approved drugs to treat AD, none of these treatments slow or stop damage to neurons. Drugs with a new mode of action are urgently needed. Sphingosine-1-phosphate (S1P) has been shown to be a potent lipid signaling molecule that protects neurons from dying as a result of biological insults. This molecule is synthesized by two proteins that control S1P levels. The investigators have developed specific inhibitors that can increase or decrease S1P levels. They have also established primary neuronal cultures and *in vivo* assays, using mice and rats, to determine the impact of these inhibitors on neurons known to be directly involved in AD. This study aims to determine the effects of increasing or decreasing S1P levels (via inhibition) on neuroprotection and AD. *(Dr. Santos may be contacted at (540) 231-5742, santosw@vt.edu; Dr. Valdez may be contacted at (540) 526-2076, gvaldez1@vtc.vt.edu.)*

GMU

Catherine J. Tompkins, PhD and colleagues*

Individuals with Dementia at Adult Day Health Care Centers: Examining the Effects of Individualized Music on Mood and Agitation

The Music and Memory Program is an international program that brings personalized music selections into the lives of people with dementia. This study will examine the effect of linking individualized treatment goals to strategic music implementation on behavioral and emotional functioning in a sample of older adults with dementia participating in six different adult day health care centers. A mixed methods study will employ an 8-week experimental two-group design, with 5-10 older adults participating in the iPod intervention (treatment) and 5-10 older adults participating in a control condition at each center (30-60 participants total in each condition). Ultimately, it is hoped that this research will increase understanding of a non-pharmacological, situation-specific individualized music intervention that can be used by formal and informal caregivers to impact the behavior of individuals with AD. *(Dr. Tompkins may be contacted at (703) 993-2838, ctompkin@gmu.edu.)*

VPI & SU

Bin Xu, PhD, David Bevan, PhD and Ling Wu, MD, PhD*

Molecular Mechanisms of Amylin as a Novel Contributor to Alzheimer's Disease

Epidemiological studies have shown a link between type 2 diabetes (T2D) and the risk for AD. A feature common to both diseases is the formation of amyloid peptide aggregates. The peptide associated with AD is amyloid beta (Abeta), and for T2D, it is amylin. Very recent studies have demonstrated that amylin peptides, typically formed in the pancreas, can possibly travel to the brain, and aggregate themselves, termed amylin amyloids, or with Abeta, to form amylin/Abeta-crossed amyloids. The investigators hypothesize that metabolic disorders and aging promote this accumulation of toxic amylin and mixed amylin/A β amyloids in the cerebrovascular system, thus contributing to the etiology of AD. They will apply an interdisciplinary approach involving cellular, biochemical, biophysical, and computational methods to address the molecular mechanisms of how amylin induces neurotoxicity, and how amylin and A β may interact to have a synergistic effect on neurons. *(Dr. Xu may be contacted at (540) 231-1449, binxu@vt.edu; Dr. Bevan may be contacted at (540) 231-5040, drbevan@vt.edu; Dr. Wu may be contacted at (540) 231-8442, wul3@vt.edu.)*

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Virginia Geriatric Education Center Secures Major Geriatrics Training Award

The Virginia Geriatric Education Center, administered by VCoA, has successfully competed to obtain a three-year award of nearly \$2.6M to support interprofessional geriatrics training from pre-clinical to practice levels across Virginia. The Health Resources and Services Administration, USDHHS, announced the award of this 2015-2018 project. The VCoA leads a consortium of Virginia Commonwealth University, University of Virginia, and Eastern Virginia Medical School (EVMS) that together comprise the Virginia Geriatric Education Center. The VGEC competed against some 200 top-flight applicants to secure one of the 44 awards under the Geriatrics Workforce Enhancement Program announcement. VCU internal partners include Medicine, Nursing, Occupational Therapy, Pharmacy, Physical Therapy, Social Work, and, of course, the Virginia Center on Aging.

The project has a special focus on Medically Underserved Areas (MUAs) and will have a broad geographic impact, from Virginia's Eastern Shore to far Southwest Virginia, and from Southside to the National Capital area. Besides working to train aspiring and practicing professionals, it will prepare family caregivers for dementia care by partnering with Senior Navigator, which maintains web-based resources and training sites at over

700 community settings across the Commonwealth. The project will harness the expertise of the VGEC's Plenary (core staff) of committed educators and practitioners to develop and evaluate interprofessional geriatrics training experiences. These include: a) the Excellence in Primary Integrated Care-Geriatric Patients (EPIC-GP) at EVMS to train physicians, medical students, physician assistants, behavioral health and nursing trainees, and other health professionals; b) a web-based, team-learning, required geriatrics course at VCU for pre-clinical students in medicine, nursing, pharmacy, and social work; c) a 200-hour statewide Faculty Development Program for health care professionals with academic appointments (tenure track to affiliate) that includes a 40-hour rotation at an economically disadvantaged community site; d) a 40-hour Train the Trainer program for direct care and preceptor health professionals; e) a 24-hour Evidence Based Practice program on falls, dementia, delirium, depression, and palliative care for health care practitioners in community-based settings, such as the Program for All-inclusive Care for the Elderly (PACE); f) innovative continuing education and Continuing Medical Education programs for professionals and community college training sessions for health career students. The dementia focus includes five annual conferences for providers, direct care workers, families, and older adults. The project will adapt evidence-based training resource modules on dementia care to make them understandable for family caregivers and accessible through Senior Navigator's vast network; it will also

maintain an interprofessional dementia track in the annual meetings of the Virginia Geriatrics Society.

Collaborating partners include: Community Memorial Hospital, Richmond Health and Wellness Program, Riverside Health System, Sentara Health, Virginia Health Quality Center (QIO), Mountain Empire Older Citizens PACE, Senior Navigator (SN), Southside Community College; for the dementia focus: George Mason University, Norfolk State University, all four chapters of the Alzheimer's Association in Virginia, and the Alzheimer's Association, Massachusetts and New Hampshire; and at least seven Area Agencies on Aging across Virginia.

Overall, the VGEC Geriatrics Workforce Enhancement Project intends to accomplish four goals. Highlights within each follow:

1. Clinical Training of some 300 medical students at EVMS and 600 pre-clinical health professions students at VCU; health professions practitioners at a primary care extension in an economically disadvantaged urban site; nurses, pharmacists, and social workers from Community Memorial Hospital in South Hill and community-based primary care providers in its region; nursing and health care students from Southside Virginia Community College; and more.

2. Professional development of providers in geriatrics assessment and treatment, especially in MUAs, through an array of training programs, including the Faculty Development Program, the Train

the Trainer program, the Evidence Based Practice program focused on preventing the recurrence of falls, a sentinel event in the well-being of older adults. It will also develop a NICHE (Nursing Improving Care for Healthsystem Elders) program at VCU.

3. Community-based programs for patients, families, and caregivers to increase their knowledge and skills necessary to improve health outcomes and quality of care for older adults. This project will train multidisciplinary direct care workers and supervisors, personal care assistants (CNAs), and family caregivers associated with the Mountain Empire Older Citizens PACE site; and, through Senior Navigator, annually provide community based workshops on site in MUAs for older adults, families, and family caregivers; and other workshops for aging services providers, including case managers/discharge planners, with case-based scenarios on medication management, transitions in care, and falls prevention, and other needs-identified local topics.

4. Training on Alzheimer's disease and related dementias (ADRD) for families, caregivers, direct care workers, and health professions students, faculty, and providers. This project will work with community-based co-sponsors to deliver needed interprofessional education on screening, referrals, available clinical trials, community resources, and more, while also highlighting the tested habilitation theory approach to caregiving as an understandable framework for family care; and will collaborate with the Memory Disorders Clinic at UVA.

Avoiding Problems in Selecting an Agent for Your Medical Decisions

by Stephan J. Lipskis, Esq.,
Hook Law Center, Virginia
Beach and Suffolk
(Hooklawcenter.com)

The following first appeared in Hook Law Center News, June 9, 2015, and is reprinted with permission.

Who makes medical decisions for you when you are unconscious or incapable of making them on your own? Frequently, an alternative decision-maker or "Medical Agent" is needed for those with diminishing mental capacity or individuals under anesthesia. Determining your preferred Medical Agent and the scope of authority given to that agent are of critical importance to ensure your healthcare wishes are followed. This article discusses three steps to effectively plan for Medical Agent succession and common mistakes to be avoided.

Step #1. Consider Who You Want as Your Medical Agent and How Much Discretion to Give Your Agent.

Planning who you want to make medical decisions on your behalf is not as simple as it may appear. A spouse or child may be ill-equipped emotionally to deal with end-of-life decisions. Alternatively, a proposed agent may be difficult to reach in the event of a crisis. Thorough discussion of your options and concerns with an attorney who understands the implications of this

authority will help sort through available options and determine which agent or agents are preferred.

Medical decisions are, by their very nature, the most personal decisions that can be made. They address the integrity of your body and your very life. Accordingly, a thorough discussion with your physician and an attorney should identify what restrictions you want placed on your Medical Agent's authority. Absent effective instructions, your Medical Agent may end up making a decision that is not what you desire. The instructions given to Medical Agents may address religious objections to certain treatments, personal beliefs regarding end-of-life care, and an array of other matters that need to be discussed in depth with spiritual, medical, and legal advisors (in that order).

Step #2. Execute Planning Documents!

In order to have an effective Medical Agent, an individual must execute a document that will be recognized under state law. Hospitals and medical facilities are increasingly working with admitted patients to execute documents, when possible. In executing these documents at the hospital, individuals are often left with insufficient time to consider options and ask appropriate questions of legal and spiritual counsel, and may not fully understand the repercussions of naming a Medical Agent.

Furthermore, the individual may feel pressured to name someone who is with him or her at the hospital rather than a more appropriate

individual. Planning ahead and executing the documents removes mistakes that are made due to urgency and also prevents further procrastination.

An “Advance Medical Directive” is the preferred document for naming your Medical Agent, because it is a combination of two important documents, a “Living Will” and a “Healthcare Power of Attorney.” The Living Will portion of the Advance Medical Directive gives specific direction as to care that should be made available or should be specifically withheld. These decisions are effective, even if your Medical Agent is not able to act. Accordingly, the Living Will portion directs medical professionals caring for the individual as well as the Medical Agent. The Healthcare Power of Attorney portion of the Advance Medical Directive names the Medical Agent (or Agents) empowered to make decisions under specified conditions and may even provide for standby Medical Agents, if the first choice is unavailable. Also, contact information is provided so that the medical staff can reach the individual’s agent. The additional clarity provided by Advance Medical Directives allows for a Medical Agent to better understand the scope of his or her authority and prevents unnecessary delays in care or undesired treatments because treating medical staff know whom to contact.

Step #3. Communicate Your Wishes.

Occasionally, individuals mistake completing documents with completing their planning. An Advance Medical Directive should be

discussed with the chosen agents and should always be recorded at your primary care physician’s office and in the local hospital system. Modern technology allows for an individual’s Advance Medical Directive to be accessed whenever and wherever it is needed, so long as it has been recorded in the appropriate registries. Registries are now even available to store Advance Medical Directives via smartphone app.

Conclusion

Our office has recently seen complications arise from do-it-yourself Advance Medical Directives and those done at the hospital. While completing medical agency documents in those situations is not always the wrong choice, it sometimes can lead to unintended complications. Furthermore, the need for thorough thought in this type of planning requires not only time (which is unavailable in the hospital setting) but also expertise (which is unavailable in the do-it-yourself setting). Should you be concerned about whether your documents appointing your Medical Agent read as you believe them to, please contact our office to arrange a meeting to review your documents.

Visit Our Websites

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

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

Bones and Balance Introductory Workshop

Osteoporosis or “porous bones” affects about 55% of Americans aged 50 and over. It’s a condition where decreased bone strength increases the risk of a broken bone. Here’s help: a five-week evidence-based workshop that begins Wednesday, August 5th, at 10:30 a.m. To reserve your spot, call the Senior Center in Charlottesville at (434) 974-7756.

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You can subscribe to our publication at no cost. Simply e-mail us (eansello@vcu.edu) and include your first and last names and your best e-mail address. We do not sell or exploit the addresses of our readers and simply need your full name because our mailing lists are organized by names of recipients.

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Virginia Lifespan Respite Voucher Program

The Virginia Lifespan Respite Voucher Program provides 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 (children and adults, including elderly persons). It is funded through a federal grant awarded to the Virginia Department for Aging and Rehabilitative Services (DARS) from the federal Department of Health and Human Services, Administration on Aging, Administration for Community Living.

Individuals eligible to apply for voucher funding through the Virginia Lifespan Respite Voucher Program include Virginia caregivers of children or adults who reside in the same household as the person receiving care. Voucher funding is limited to a total of \$400 per family. Voucher funding will continue until August 31, 2015, or when funds are expended.

Respite funds must be requested by the primary caregiver who resides full time in the same household. Funds may not be used to reimburse household expenses or day-care (to go to work or other day-care). Due to limited funds, not all eligible applications will be approved.

How do I apply for funds for short-term respite care?

1. Complete the two-part Virginia Lifespan Respite Voucher Applica-

tion Form and attach proof of the individual's disability/special need (see Application Form for a list of acceptable documents). Your application will not be reviewed until both are received. The application form can be found at <http://vda.virginia.gov/respiteservices.asp>.

2. You may apply for voucher funding up to \$400 for reimbursement of respite care services, which must be used within 90 days of the date the application is approved. You do not have to use the \$400 all at one time; it can be spread out over several periods of respite care (e.g., two or three weekends). For example, you may choose to use \$200 to offset the cost of a week-long respite care program, and \$200 to reimburse the cost of an individual providing in-home respite for a weekend while you travel out of town. Note that you will only be reimbursed for actual expenses that are documented and submitted to DARS.

3. The Application Form will be reviewed by DARS staff. You will be contacted within four weeks to inform you of the status of your application. You may be notified by e-mail, phone, or regular U.S. mail.

4. If you have questions about the Application Form, please contact Mary Strawderman at (800) 552-5019, (804) 662-7505 or mary.strawderman@dars.virginia.gov.

Age in Action Honored

The Southern Gerontological Society (SGS) recognized *Age in Action* at its 2015 annual meeting in Williamsburg, VA, in April. SGS honored *Age in Action* with its Media Award, "In recognition of an outstanding media product promoting awareness of aging activities in the Southern region." SGS, representing aging-related academics, researchers, and practitioners across more than a dozen states in the South, annually screens and selects the best "media product" from among digital, video, print, and broadcast media, including newsletters, newspapers, DVDs, and more. Ed Ansello gratefully accepted on behalf of the Virginia Center on Aging.

Ed had the opportunity to co-celebrate with long-time SGS friends during the award ceremony. Pictured below are (l-r) Graham Rowles, Vic Marshall, Wiley Mangum, Ed, Len Poon, and Erdman Palmore.



Interprofessional Excellence at VCU: Senior Mentoring and VoicingElder

The VCU Department of Gerontology and Dr. Tracey Gendron have been active in interprofessional engagement throughout 2014 and 2015. The VCU Senior Mentoring Program, launched in the Fall 2014 semester, partnered first-year medical students and students from pharmacy and nursing in teams of two or three students with older adults living in the Richmond area. Students and elders met four times and discussed various topics from quality of life to living environments. After each meeting, medical students either blogged or tweeted about their experience. After a vote, there was a tie for the winning tweets (shown below). Congratulations to the two winners Nicholas Schmedding and Michelle Vy.

It isn't physical space that matters for happiness, but "human space." Today I was surprised at how much "human space" can fit into such a small physical space. #VCUSeniormentoring

What is life without good company? #liveandlaugh #behappyandcheerful #writeabook #haveaboyfriend that is how you maintain quality of life #VCUseniormentoring

Another interprofessional activity in which Dr. Gendron is involved is VoicingElder. VCU's VoicingElder project is partnering with a local continuing care retirement community to pilot cutting-edge electronic arts research that aids in life review

for older adults as a therapeutic technique. As participants speak about their lives, facial-recognition cameras and voice-signal technology automatically process facial feature interaction and lip movement. The data are then mapped in real time on the face of an on-screen virtual puppet, also known as an avatar. The project strives to increase quality of life for the seniors by accessing their emotional engagement and hidden memories through a life review process. The virtual puppetry format also actively involves family members with the senior's life review process, promoting intergenerational knowledge.

Congratulations to Dr. Gendron for her efforts toward supporting the professional identity development of emerging physicians and for marrying technology and optimal aging.

Conference on Dementia

The Alzheimer's Association Greater Richmond's Conference on Dementia will be held **October 19, 2015**, at the Short Pump Hilton from 8:30 a.m. – 4:30 p.m. Marilyn Albert, PhD, Professor of Neurology at Johns Hopkins, Director of the Division of Cognitive Neuroscience, will discuss "The Dementia Diseases and What is New in Research?" Two workshops will be offered for professional caregivers: "Offering Good Customer Service" and "The Secret Prescription for Alzheimer's Caregivers." Two workshops for family caregivers will cover: "Bringing the Family Together" and "The Reality of Denial." Sponsorship opportunities are available.

For information or to register, visit www.alz.org/grva or call (804) 967-2580.

Greater Richmond Senior Safety Day August 19, 2015

**First Baptist Church
Monument and Boulevard, Richmond
9:00 a.m. - 4:00 p.m.**

Sponsored by the Senior Center of Greater Richmond, the Office of the Attorney General, and the First Baptist Church. The Day will be filled with resources on how to be a savvy and safe senior. Meet with local officials, attend workshops, visit vendor tables, and network with others from across the region and Commonwealth. Register for this free event and lunch at <https://rvasafetyday.eventbrite.com>. For more information, call (804) 839-6846. Vendor table information available at <http://rvaseniorsafetyvendor.eventbrite.com>.

Calendar of Events

August 10, 2015

Come Together: Eliminating Social Isolation in Older Adults. Presented by United Way of Greater Richmond and Petersburg. 8:30 a.m. - 5:00 p.m. Registration and light breakfast starting at 8:00 a.m. MeadWestvaco Conference Center, Richmond. For information, call (804) 771-5865.

August 21, 2015

Alzheimer's Disease and Dementia Care Seminar. If you want to increase your knowledge or pursue Certified Dementia Practitioner (CDP) certification, this is the ideal training. Sponsored by the VCU Department of Gerontology and featuring Denise Scruggs, ADC, CDP, CADDCT. \$185/person. 9:30 am - 6:00 pm. Mariners Landing Resort Community and Conference Center, Smith Mountain Lake. Lunch included. For information visit https://training.vcu.edu/course_detail.asp?ID=14038.

September 8, 2015

Diabetes Workshops Series. Presented by the Senior Center of Greater Richmond and the American Diabetes Association. Open to the community by reservation, this program will focus on activity with "How to Limit the DAMAGE that Diabetes Can Do." This is part one of a two part class (second part to be held on October 13th, same place and time). Battery Park Christian Church, Richmond. 10:30 a.m. - 12:00 p.m. Reservations include a light lunch. For information and to register, call (804) 353-3171 or visit www.SeniorCenterOfGreaterRichmond.org.

October 4-7, 2015

66th Annual Convention and Expo of the American Health Care Association and the National Center for Assisted Living. The Henry B. Gonzalez Convention Center, San Antonio, TX. For information, visit www.ahcaconvention.org or www.ncalconvention.org.

October 7, 2015

Senior Connections' 12th Annual Empty Plate Luncheon and Awards Ceremony. 11:30 a.m. - 1:00 p.m. Trinity Family Life Center, Richmond. For information about the event or sponsorships, contact Martina James at (804) 343-3023 or mjames@youraaa.org.

October 13-14, 2015

Virginia Assisted Living Association's Annual Fall Conference and Tradeshow. Renaissance Portsmouth - Norfolk Waterfront Hotel, Portsmouth. For information, visit www.valainfo.org.

November 1-4, 2015

Be the Voice. 2015 LeadingAge Annual Meeting and Expo. Boston, MA. For information, visit www.leadingage.org/annualmeetingexpo.

November 17-18, 2015

Virginia Association for Home Care and Hospice Annual Conference and Trade Show. The Doubletree by Hilton, Charlottesville. For information, visit www.va hc.org.

November 18-22, 2015

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

January 27, 2016

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

March 3-6, 2016

Developing Educational Leadership in Gerontology Worldwide. AGHE's 42nd Annual Meeting and Educational Leadership Conference. The Westin Long Beach, Long Beach, CA. For information, visit www.aghe.org/events/annual-meeting#sthash.HK9KFkI1.dpuf.

Age in Action

Volume 30 Number 3
Summer 2015

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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. E-mail kivey220@yahoo.com.

**Fall 2015 Issue Deadline:
September 15, 2015**



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2015 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!

<p>Central and Western Virginia Chapter Register for walks in this area at www.alz.org/cwva.</p>	<p>Tri-County (Culpeper), September 19 Danville, September 19 New River Valley (Blacksburg), September 25 Greater Augusta (Waynesboro), September 26 Lynchburg, October 3 Roanoke, October 17 Charlottesville, October 24 Harrisonburg, October 31</p>
<p>Greater Richmond Chapter Register for walks in this area at www.alz.org/grva.</p>	<p>Middle Peninsula/Northern Neck, September 19 Fredericksburg (Mary Washington Univ.), September 26 Richmond (Innsbrook), November 7</p>
<p>National Capital Area Chapter Register for walks in this area at www.alz.org/nca.</p>	<p>Reston, September 26 Winchester, October 2 Manassas, October 17</p>
<p>Southeastern Virginia Chapter Register for walks in this area at www.alz.org/seva.</p>	<p>Suffolk, September 19 Virginia Beach, October 11 Farmville, October 1 Newport News, October 17 Nassawadox, October 3 Williamsburg, October 24</p>

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