

Case Study

Integrating Geriatrics in Primary Care: Progress and Prospects

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Educational Objectives

1. Demonstrate the need for primary care redesign to better meet the needs of older patients.
2. Identify prospective redesign solutions.
3. Appreciate educational implications that redesign engenders.

Introduction

As readers of *Age in Action* are well-aware, the “Silver Tsunami” is upon us. Nowhere is this realization more acute than in primary care, wherein the vast majority of older adults receive medical services. Unfortunately, there is often a mismatch between the structure of primary care and the needs of older patients. We first identify characteristics of primary care that lead to this mismatch, and then describe

our experiences with an ongoing redesign intervention. We conclude with a brief consideration of the educational implications of this effort.

Background: The Challenges of Primary Care “As Usual”

Primary care of robust older adults can occur with our current system, which relies on short visits of 15-20 minutes and the knowledge the participants gain through on-going follow-up over time. This is not sufficient, however, for vulnerable elders, those afflicted with geriatric syndromes such as falls and dementia, as well as poorly regulated multimorbid chronic illnesses.

Proper care of these complicated issues is extremely challenging in brief encounters wherein the clinician is expected single-handedly to identify and manage multiple, often acute, concerns as well as chronic illnesses. There usually is little time for systematic assessment, education, coordination of care, and attention to psychosocial needs. In other words, primary care as it currently exists is prey to “tyranny of the urgent,” the need to respond to

presenting and often acute concerns, while underlying determinants of these issues go unaddressed (Moore, 2006).

Primary care is also “silo-ized” to a considerable extent. There is often a disconnect between various sites and providers of care, making transitions hazardous. There is no system for communication between primary care and other disciplines with important roles in geriatric care, such as nursing, social work, and pharmacy. Moreover, a divide exists between primary care and the system of community-based services and supports. This divide is especially noteworthy as social and behavioral determinants of health account for about two-thirds of the variance in adverse health outcomes, such as hospitalizations and preventable deaths (Alley et al., 2016).

To understand the difficulties of “primary care as usual” for complex older adults, let’s meet Mr. A.

Case Study 1

Mr. A, 79 years old, is discharged following a hospitalization for heart

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failure. Mr. A does keep his one week follow-up appointment. His clinician updates the medication list, orders some laboratories, reviews the need to follow-up with his cardiologist, and asks him to return in a month. However, Mr. A no-shows for this appointment and is brought by ambulance to the emergency room a few days later with decompensated heart failure, requiring readmission. Mr. A is also delirious, has fallen, and is dehydrated. He is stabilized, but is too deconditioned to return home and is transferred to a skilled nursing facility. He is eventually discharged to live with his daughter, who has had to quit her job to be his caregiver. He is no longer able to live independently.

What went wrong for Mr. A? There is no simple answer. However, several possibilities come to mind: Did Mr. A understand the instructions given him at discharge? Were there sensory impairments that got in the way? Did he have pre-existing cognitive impairment? Could he afford his medications? Did he know the warning signs that his condition was worsening? Did he lack transport to doctors' appointments? Was his home environment safe? Was he drinking? What was the involvement of his caregiver?

Ideally, Mr. A's doctor would have assessed the above questions, realized that he was at high risk and put together a more proactive, targeted plan to avert the readmission and loss of independence. The fact that this did not occur is not an indictment of the individual physician's knowledge and judgement but is instead a system issue. Mr. A's plight vividly underscores the need

for a different primary care approach in which challenges such as those listed above can more readily be identified and addressed.

A Redesign Initiative: Progress to Date

In order to foster redesign, the federal Health Resources and Services Administration (HRSA) initiated Geriatrics Workforce Enhancement Program (GWEP) grants in 2015. The GWEP program represented a major shift from prior HRSA funding in that GWEPs must include clinical patient care activities, such as practice redesign initiatives that integrate geriatrics in primary care and build interprofessional education around this framework.

The Virginia Geriatric Education Center, a consortium of Virginia Commonwealth University (VCU), Eastern Virginia Medical School (EVMS), and the University of Virginia (UVA), led by the Virginia Center on Aging (VCoA) at VCU and partnering with several other organizations, was one of 44 GWEP awardees nationwide. EVMS's Department of Family & Community Medicine addresses required integration of geriatrics in primary care practice and training with a program entitled Excellence in Primary Integrated Care-Geriatric Patients (EPIC-GP).

The workings of EPIC-GP is illustrated by the story of Ms. B.

Case Study 2

Ms. B is also 79 and is seen one week following discharge from a heart failure hospitalization. Her doctor develops a plan like that

devised for Mr. A but suggests Ms. B get a Medicare Wellness Visit (MWV) as her next appointment. The physician introduces Linda, one of the department's RN care managers, to describe the wellness visit and get Ms. B scheduled. Linda finds at the MWV that Ms. B has had several falls and is unsteady getting up. She also notes that Ms. B has limited understanding of how to care for her heart and has questions about the future if her heart failure should worsen. Linda makes sure Ms. B keeps her follow-up with her doctor. In addition, Linda refers Ms. B to fall prevention and chronic illness self-management classes offered at the regional area agency on aging. When seen three months later, Ms. B feels well, has increased confidence in her ability to avoid falls and manage her heart failure, and is actively discussing advance care wishes with her family.

What went right for Ms. B? Several things. First, the MWV identified important unmet needs that were not evident on the first office visit: she was falling, had limited health literacy, and was interested in advance care planning but did not know how to go about it. Second, Linda leveraged her relationship with Ms. B to ensure that she did get needed medical follow-up. Third, Linda referred Ms. B to community-based services to address her issues of falls and limited health literacy. Fourth, Linda facilitated the process of advance care planning by providing information and helping her schedule a visit dedicated to this issue with her primary care clinician.

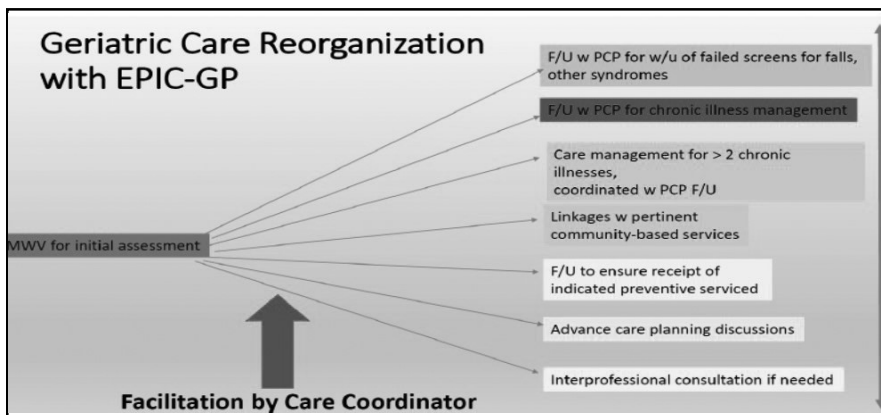
More generally, Ms. B benefitted

from systemic assessment, active care coordination and management, and resource linkage. These principles are the crux of EPIC-GP, which overcomes “tyranny of the urgent” by using the Medicare Wellness Visit (MWV) for assessment, combined with active coordination of follow-up for identified needs and care management for high-risk patients. The approach is summarized in Figure 1.

needs (e.g., failed screens for geriatric syndromes; inadequately treated chronic illness) with subsequent care. A care manager facilitates scheduled follow-up with continuity clinicians, entry into non-face-to-face case management for high risk patients, linkages with pertinent community resources, appointments dedicated to discussion of advance care preferences, follow-up on preventive care, and interprofessional geriatric consultation if

MWV and the fact that it is a fully covered benefit with no additional co-pays (although there may be co-pays for other services like immunizations, lab draws, or evaluation and management of other clinical issues during the wellness visit), the MWV benefit is surprisingly underutilized nationally and at our EVMS practices. In 2015, only 153 of some 4,000 EVMS Medicare patients ages 65 and above completed a MWV.

Figure 1: Structure of EPIC-GP



The MWV, an annual benefit for Medicare enrollees, is an hour-long visit to review and update medical histories, the status of chronic conditions, medication reconciliation, attention to preventive service needs, screening for geriatric syndromes, and discussion of advanced directives. In addition, the MWV also includes a health risk assessment to help clinicians identify and address adverse health behaviors. In other words, the MWV is a geriatric assessment geared to primary care.

It is widely recognized that geriatric assessment must be linked to subsequent management to be effective. Accordingly, there is actively guided follow-up of MWV-identified

needed. Care management in EPIC-GP goes beyond coordination and includes functions of monitoring, self-management support, caregiver care, resource linkages, and care plan development (Aliotta, et al., 2008).

The sections to follow detail our progress to date in implementing this clinical model, as well as prospects and future directions. Similarly, we discuss current status and future plans for educational programs based on this clinical framework.

Progress to Date: An Exercise in “PDSA”

Despite the face validity of the

Thus, low MWV recruitment was a “rate-limiting” barrier that would have to be addressed if EPIC-GP was to get off the ground. We responded to this challenge using a PDSA approach. PDSA stands for Plan, Do, Study, Act, a model for testing quality improvement ideas quickly and easily (Leis & Shojaania, 2016). In contrast to research, PDSA methods do not require formal design, sample size calculations, or statistical methods.

Results are pragmatic and measures are simple. The goal is programmatic improvement rather than new or generalizable knowledge. PDSA methods are prominently featured in GWEP projects to foster rapid development and refinement.

The “P” in PDSA stands for Planning. As we had little idea why MWVs were so under-used, we needed planning information and so began with a survey based on scant extant literature and some guesses based on experience. Our aim was to understand barriers. We first surveyed patients (those who had [N=29] and had not [N=70] had a MWV) at our two clinics during January and February of 2016.

Patients were 50.4% female, 33.4%

African-American, 53.2% white, and 13.4% percent “other”. Mean age was 74.2 years. Demographic findings did not vary by practice site and hence are pooled. Demographics did not vary between MWV recipients and non-recipients. Response rates for survey items were between 85% and 100%. Results are summarized in Table 1.

wanted to get scheduled for one. Several noted that being asked to fill out the survey by a staff member who clearly believed in the value of the MWV had encouraged them.

We also surveyed our providers and received responses from 38 of 64 (59%). Most thought the MWV was valuable, but were deterred by

recruitment from approximately 10 per month to 30. Based on this initial success, we expanded the approach by engaging other nursing staff as recruiters (the “S” [Study] and “A” [Act] of PDSA).

At present, we are a year into our implementation. We have completed 489 MWVs from April 1, 2016 through March 31, 2017, a 320% increase over the 153 completed in 2015. Details of our intervention (Bluestein, et al., 2017) and an accompanying editorial (Adler, 2017) have just appeared in *Family Practice Management*, a refereed journal sponsored by the American Academy of Family Physicians that is widely read by practicing primary care clinicians.

Table 1: Perceptions of the MWV by Recipients and Non-Recipients

	<i>Had MWV (N = 29)</i>	<i>Did not have MWV (N = 70)</i>
*Heard of MWV	N/A	37%
*Heard negative things about MWV	N/A	13%
*Concern for unexpected costs	3.4%	15%
*MWV suggested by your doctor?	89.7%	18.6%
**Importance of history & medication review	96.6%	95.7%
**Importance of preventive care	96.6%	92.9%
**Importance of screening for community-based service needs	96.6%	84.3%
**Importance of screening for geriatric syndromes	89.7%	87.1%
**Importance of advance care planning	96.6%	82.9%

* Yes ** Important or very important

Challenges and Future Directions

Getting patients to undergo MWVs is necessary, but not sufficient. This is underscored by our quality metrics, comparing patients who had MWVs to those who had not. We did relatively well with preventive care. MWV recipients were about 6% more likely to have gotten a colonoscopy and 12% more likely to have gotten a mammogram. MWV recipients were more than twice as likely to have completed an advance directive and other advance care planning documents (11.5% vs. 5.3%), though overall numbers are still low.

These findings indicated little to support “bad press,” concern about hidden costs, or unmet needs as reasons for underusing the MWV. Most respondents felt that various items in the MWV were important or very important. Most who had an MWV did so at the recommendation of their physician. Most who had not had an MWV had not heard of it, and, unexpectedly,

its complexity and time demands.

Together, these findings suggested our “D” (Do) in PDSA, an intervention leveraging the weight of the physician’s recommendation, combined with enthusiastic recruitment by an RN care manager who would conduct the visit, thereby unburdening the physician. A one-month observation period increased MWV

Some of these positive differences may have been due to counselling received during the wellness visit. However, it is also possible that persons who got MWVs had a more positive orientation to health to begin with, motivating both greater use of preventive care and advance

care planning, as well as obtaining the wellness visit.

It is also noteworthy that chronic illness metrics do not vary by group. Approximately 39% of hypertensive patients are not at goal and about 16% have poorly controlled diabetes, regardless of MWV status. This lack of difference suggests that, even though the majority of our MWVs were conducted by experienced RN care managers, we are not leveraging their expertise to improve quality metrics through education, self-management support, and coordination.

An important process metric in regard to chronic illness outcomes is improving “health confidence.” Health confidence is a proxy for patient self-efficacy, self-care, and self-management, all of which pertain to patient engagement, which in turn is highly correlated with better health behaviors and health outcomes (Wasson & Coleman, 2017). Health confidence is assessed as a single question: “How confident are you that you can control and manage most of your health problems?” Responses are on a scale from 1 (totally unconfident) to 10 (absolutely certain). Responses in the range of 4-7 indicate patients are preparing to take action and perhaps most likely to benefit from information and support. Ratings over 7 imply successful enactment of behavioral change.

What is the health confidence of our patients? An audit of 50 charts indicated mean confidence levels of 8, mostly around healthy eating and exercise. A subsequent review, however, showed no evidence of

behavioral change. These unrealistically high levels have several potential explanations: a) Social desirability bias, a desire to please an important “other,” in this case the care manager; b) Not knowing what you don’t know about barriers; c) Simple fatigue and lack of attention, as Health Confidence is assessed in an action plan at the end of an hour-plus visit.

The results of this audit are the “P” in our second PDSA cycle; we know we have a problem. As this is written, we are engaged in “Ds” (Dos) to test various alternatives, such as use of visual scales, different wording of the health confidence question, and differences in when the question is asked.

Getting a better gauge on health confidence brings to mind the aphorism from the movie “Field of Dreams”: “If you build it, they will come.” In other words, identifying a larger number of patients needing help with behavioral change implies a need for resources to accomplish this. Our care managers can help with this, to be sure. However, the increased volume will necessitate additional resources to support behavioral change that ultimately affects quality metrics. This can most likely occur through outreach and partnerships, with an area of future endeavor being to seek “win-win” relationships with our area agencies on aging and other community-service organizations that offer support services and disease self-management programs. This approach also has the benefit of working to address social determinants of health, an approach that is not widely possible in “primary care as usual.”

Educational Implications

EPIC-GP is first and foremost a clinical innovation. However, GWEP programs have important educational mandates and any innovation is bound to “wither on the vine” unless it is understood and valued by upcoming generations of learners in health care professions. Accordingly, EPIC-GP incorporates three educational initiatives: training in clinical geriatrics, the social model of care, and advance care planning in the non-acute, ambulatory setting. To date, we have addressed these through lecture format and creation of resources (clinical templates). A 2016 “visiting professorship” showcased the import of social services and the social model of care through a two-day visit by Dr. Dick Lindsay, a retired geriatrician from UVA, and Adrienne Johnson, CEO of Virginia Navigator. They spoke to multiple audiences through grand rounds presentations and informal discussions. We have also used a series of didactic (lecture) sessions to foster learning about basic topics in advance care planning.

While we have expended considerable effort in providing various presentations at EVMS, especially on topics that lie outside “medicine” such as understanding/leveraging community-based services and supports, and advance care planning, these interventions have not led to practice change. This is not surprising, however, given the complexity of the topics and the limits of traditional classroom/lecture activities.

On the other hand, the success of academic detailing has been a very

positive surprise. This is a recent undertaking wherein patients who have failed geriatric screens, such as the Mini-Cog or the Up & Go test for falls, are being scheduled for follow-up evaluations by their primary care clinicians, most often resident physicians. These appointments are actively tracked, enabling Dr. Blustein and other EPIC-GP team members to touch base beforehand, review evaluation approaches, provide resources, and be available to answer further questions. As most clinicians learn and internalize information in the context of patient care experiences, the success of this individualized approach was to be hoped for. We were not prepared, however, for the extent of the enthusiasm academic detailing has generated, suggesting that this approach be expanded to address not just core clinical topics but also use of social services and advance care planning.

Conclusion

EPIC-GP has achieved notable initial successes, leveraging PDSA methods to understand obstacles and test successful interventions. Challenges remain, most notably using care management to improve quality metrics and developing creative approaches to increase health profession learners' self-confidence in translating what they learn to practice change in working with the human services system and advance care planning. PDSA methods will be vital to moving these initiatives forward.

These approaches will be important to primary care practice in the new world of value based reimbursement under the new CMS programs

“MACRA” and “MIPS,” the Medicare Access and CHIP Reauthorization Act and the Merit-based Incentive Payment System, respectively (Mullens, 2016). Going forward, Medicare Part B payments will be adjusted based on scores from performance categories which include quality, practice improvement activities, 30-day readmissions, and eventually lower costs. Higher performance will result in bonuses, below average performance with penalties. MWV completion, follow-up of positive MWV findings, and application of PDSA methods can all contribute to higher scores in these parameters.

Despite the “face validity” of linking MWV assessment with subsequent care management, it is imperative to document that this model improves outcomes. Showing the value of these services will allow their continuance, to the benefit of patients, families, and new cohorts of learners.

Study Questions

1. What are common barriers to primary care of older adults?
2. How can the Medicare Wellness Visit be used to improve the primary care of older adults?
3. Why is teaching geriatrics in primary care best done by supporting learners at the point of care?

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Editorials

About the Authors



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From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

Laughter and Well Being as We Age

The cynic might say that there's little to laugh about in growing older. Aging brings its challenges and losses, so what's funny about this? Of course, life can be tough, but even in the awful there can be the funny. Like, what else could go wrong?

Robert Frost said it (and Jimmy Buffet put it to song): "If we couldn't laugh, we would all go insane."

I met a veteran recently over dinner at a shelter where I volunteer. He had lost an eye to bullet fragments and had irreparable damage to the other during a clandestine Black Ops mission in Central America almost 40 years ago. He said that things could have been worse, as it was for others on that mission. He expressed his gratitude for life with a grin and a laugh. As we talked, he discussed his grown children and his grandchildren. One son had joined the military, the other had not. He accepted their decisions and stated that we each have to live our own lives. We exchanged ideas about politics, religion, families, and so on, and I realized he wasn't an act; he was the real thing. He accepted his life and laughed. He said that maybe he'll develop keener hearing once he loses sight in the deteriorating eye.

Laughing at life, at ourselves, falls under the hackneyed category of Laughter as the Best Medicine. It's an area replete with quotes from famous and unknown figures in history, from Roman philosopher Seneca's observation that it's "more fitting ... to laugh at life than to lament about it" to the contemporary Mel Brooks' comment that "life abounds in comedy if you just look around you." But what supports laughter as a medicine? Is there research?

Turns out, there's a fair amount of it. First, we should distinguish between humor and laughter. The first may or may not produce the latter. There can be humor without laughter. And laughter can be produced without causal humor. Humor involves cognitive, social, and behavioral elements. Laughter is a physical response, a psychophysiological reaction. This physical response does, in fact, seem to be associated with well-being in later life.

As for humor, Houston, McKee, Carroll & Marsh (2010) found humor effective in reducing anxiety among nursing home residents. Crawford & Caltabiano (2011) found, with 55 community-dwelling adults in Australia who were randomly assigned to experimental or control groups, that an eight-step program to teach humor skills improved measures of emotional well-being, such as positive affect and self-efficacy; they conjectured that humor helped reframe adverse events by increasing positive thinking and perceptions of control, while decreasing negative thinking, perceptions of stress, and anxiety.

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As for laughter, some time ago Martin & Kuiper (1995) reported that daily laughter decreased the negative emotions associated with daily stressors.

Some of our colleagues in the Southern Gerontological Society recently published their pilot (preliminary) research in *The Gerontologist* (August 2016 online) on the effects of simulated laughter on various measures of well-being, including participation in physical exercise, indices of mental health, and aerobic endurance. Celeste Greene, Jennifer Craft Morgan, and Chivon Mingo (Georgia State University) and LaVona Traywick (University of Central Arkansas) began by acknowledging that many people don't enjoy exercise, so perhaps a laughter intervention might induce people to begin or continue to exercise.

In their pilot study with 27 assisted living facility residents, they combined brief (30-60 seconds) simulated laughter exercises with a 45-minute, moderate-intensity physical activity program on strength, balance, and flexibility. Their 12-week, twice weekly, exercise program used a wait list control design so that everyone eventually participated in the six-week *LaughActive* exercise regimen. The average age of the participants was 82 years. The researchers found statistically significant improvements among participants in mental health (using the SF-36v.2 scale), aerobic endurance (using the two-minute step test), and self-efficacy for exercise (using the Outcome Expectation for Exercise scale).

So, participants faked laughing, but

the results were nonetheless impressive. As the Georgia State information office summarized, *"Because the laughter exercises were combined with playful behavior and eye contact, and because laughter is 'contagious,' it usually transitioned to genuine laughter; the researchers noted. In any case, 'the body cannot distinguish between genuine and self-initiated laughter,' they said. (Similarly, other research has found that fake smiling can improve mood and reduce stress.) In addition, 'when laughter is self-initiated as bodily exercise, older adults do not need to rely on cognitive skills to 'get the joke,' or a positive mood state to reap the benefits of laughter."*

The latter points warrant emphasis. Faked or simulated laughter helped produce physical and mental health benefits, at least in this pilot study. And simulated laughter apparently works without the cognitive engagement associated with humor, an important point when one may be concerned about the well-being of individuals with dementia.

Coming full circle to the veteran at the shelter, being able to laugh, even faked laughter can be therapeutic. I can vividly remember one of my most embarrassing incidents as a child. When I was nine years old, we spent a summer week on vacation in Maine with my cousins. Returning home, we drove South along the Maine Turnpike. My mother was driving and my aunt was up front with her. I was behind the driver's seat, wearing my newly acquired tee shirt emblazoned with a huge, green pine tree and the motto *Maine: The Pine Tree State*.

When we stopped to pay the toll, the man looked in the back seat at me and asked, "Did you have fun?" I nodded. "What kind of trees did you see?" I hesitated, being caught off guard in the spotlight, then replied, "Oh, maples, and oaks, I guess." He looked at me strangely. As soon as we drove on, both turned to me and said something about me looking at my shirt and the state's motto. I was mortified. That embarrassment stayed with me for decades, and I couldn't think of the incident without cringing.

Later, as a 30-something adult, it was my task one Thanksgiving to carve the roasted turkey. I started, hit bone, and quietly sidled up to my wife to whisper that we were in trouble, having an apartment full of guests and no turkey meat to share. She went back with me to the kitchen and saw at once what I'd done: I had the turkey upside down and had been carving the back. This time, with added years, we both saw the silliness and burst out laughing.

As for The Pine State fiasco, it's only been recently that I have learned to put it in context: I was only nine years old! I can now balance the cringe factor with "Was I ever so young and so clueless?" Yes, now I'm older and clueless.

Laughing at mistakes, laughing at stressors, is demonstrably healthy. We all make mistakes and we all have circumstances and events that can be serious, damaging, or harmful. As we get older, we have accumulated a lifetime of them. Humor and laughter, laughing at ourselves or our circumstances, can indeed be therapeutic.

Editorials

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

Jim Rothrock with
Marcia C. DuBois
Director, Division for the Aging
Virginia Department for Aging
and Rehabilitative Services

Leadership, Learning, and Legacies

A busy and bustling spring culminated with the celebration of Older Americans Month and the 2017 Virginia Governor's Conference on Aging in May. As promised, this year's conference was better than ever, following an extremely successful 2016 predecessor and increased demand for an expanded, more inclusive conference. This demand was met through a change in location to the Hotel Roanoke in order to improve access for participants from Southwest Virginia and to make room for a wide array of accomplished presenters, exhibitors, and engaged advocates. Approximately 400 attendees enjoyed presentations on topics related to the four focus areas: Culture Change in Long Term Support Services, Livable Communities, Safety and Financial Security, and Volunteer and Community Engagement. We are sincerely grateful to all of the generous sponsors that made this conference possible, including our Presenting Sponsor, Dominion Energy; our Platinum Sponsor, AARP Virginia; and the Virginia Association of Area Agencies on Aging; who partnered with the Department for Aging and

Rehabilitative Service to host the conference.

In keeping with the Age Out Loud theme for Older Virginians Month, Governor McAuliffe provided the luncheon address with the same title and highlighted how the Commonwealth's innovative aging network is creating and implementing culture change in long term services and supports and livable communities. McAuliffe said that he reestablished the conference last year because, in three years, two million Virginians will be older than 60, representing 20 % of the Commonwealth's population and the percentage will continue to grow over the next decade. He noted the need to cultivate resources that allow Virginians over 60 to live independently and stressed the importance of strengthening laws to spot and prosecute financial exploitation against older adults.

Other keynotes featured Dr. Bill Thomas, a nationally recognized expert geriatrician, who provided the opening plenary session and invited participants to reframe their perceptions of age and aging; Dr. Richard Lindsay, who led a panel discussion on caregiver leave policies that explored workplace solutions to support family caregivers; and John W. Martin of SIR, who offered the policy wrap up and outlined ten steps that needed to be taken over the next few months in order to truly move forward in meeting our policy goals.

In addition to the Governor's Conference, we have celebrated two very exciting launches over the past few months. The Virginia Poverty

Law Center recently announced inauguration of the new statewide Senior Legal Helpline that is up and running. The helpline is made possible through a contract between Virginia Poverty Law Center and the Department for Aging and Rehabilitative Services, with funding from a three-year Model Approaches to Statewide Legal Assistance Systems grant from the federal Administration on Community Living.

The Senior Legal Helpline toll-free number (844-802-5910) is now available for Virginians aged 60 and older and for those calling on their behalf. Advice may be sought on the following topics: long term care issues, public benefits (including Medicaid, SSI and Social Security, Medicare), guardianship and alternatives to guardianship, financial exploitation, adult abuse and neglect, age discrimination, and a limited number of consumer issues.

DARS and our partners also celebrated a terrific public launch of our No Wrong Door (NWD) network, the public-private effort which helps Virginians gain streamlined access to needed services through a virtual network of resources. The Library of Virginia hosted the launch with many people attending. Senator Mark Warner spoke at the event, attended by Secretary Hazel as well as many of NWD's 100 partners.

Over the past few years, several of our efforts have received national acclaim for innovation. However, recognition of our No Wrong Door (NWD) System, begun almost a decade ago, has been significant. A constant behind this system change

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initiative has been our DARS colleague, Katie Roeper. After much thought and consideration, Katie has decided to conclude her career with the state and join an exciting business venture with her husband, Ken.

All system-change projects encounter occasional speed bumps, and NWD has withstood its share. But Katie's commitment, creativity, and entrepreneurial expertise have helped to bring solutions to these challenges and identify and secure federal, state, and private funds. New partners ranging from small, private non-profits to major health care systems and health plans have emerged with growing interest. An array of agencies, many of which were once "siloeed" and incapable of information-sharing, are now connected through common goals and electronic tools, linking Virginians with the supports they need to maintain independence and the quality of life they desire. All of this is being accomplished through NWD, in large part due to her vision, passion, and focus.

Virginia's NWD just celebrated its 100th partner and Katie has been called on again to share her wisdom and best practices we have established in the Commonwealth, with a national audience. Her leadership will surely be missed.

We are working on a plan to fill the void created by her retirement. Thankfully, Katie has helped Virginia build an incredible network of NWD champions, supported by an accomplished NWD Team. Together, they will be developing strategies to assure that the great momentum that NWD has experienced will

endure, as we strengthen the NWD network of communities across the Commonwealth.

Katie will be continuing her leadership of NWD through August 11th. We know you all will join us in thanking Katie for her dedicated efforts and wishing her the very best in all she does.

2017 DARS Meeting Calendar

Commonwealth Council on Aging
July 12, September 20

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

Public Guardian and Conservator Advisory Board
September 14, November 9

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

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Tri-Cities Area Support Groups, Social Engagement, and Educational Programs

The Alzheimer's Association offers many programs in the Tri-Cities area (Petersburg, Colonial Heights, Hopewell).

Support Groups

Hopewell: First Baptist Church, Hopewell. First Tuesday of each month at 3:00 p.m.

Petersburg: Petersburg Public Library, 1st Floor Conference Room, Petersburg. Second Wednesday of each month at 4:00 p.m.

Petersburg Memory Café

Perks Coffee Shop, Petersburg. Fourth Wednesday of each month at 3:00 p.m. Come join us for free coffee or tea provided by Care Advantage and fellowship with other persons with Dementia and their caregivers.

There are also many educational programs offered in the Tri-Cities area. Pre-registration is required for all programs. For more information, or to register, please call Cindy Hamlin at (804) 446-5860 or email chamlin@alz.org.

Visit Our Websites

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

Virginia Department for Aging and Rehabilitative Services
<https://www.vadars.org/>

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 200-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 2016-17 FDP Scholars celebrated the conclusion of their training year on June 16, 2017.



Pictured (Back Row): Deborah Clarkston, MSN, RN; Christianne Fowler, DNP, GNP-B; Amy Bodman, MBA, OTR-L; Karen Kott, PT, PhD; Georganne Poole, MSN, RN; Annette Greer, PhD, MSN; Terry Wright, RN, MS; Tonia Parker, MSN, RN; Milena Staykova, EdD, FNP-BC

Front Row: Sunny Alperson, PhD, FNP-C; Laurie Daigle, PT, MA; Rachana Patel, RPH; Jaisri Thoppay, DDS, MBA; Jenna Clemons, PharmD

Not Pictured: Dorolyn Alper, MSN, RN; Jillian Dur, DO; Dorothy Harriman, MSW; Keiko Kuykendall, DNP; Elise Sideris, MD

Hearing Health Care: Priorities for Improving Access and Affordability

The National Academies of Sciences, Engineering, and Medicine has compiled a list of online resources for adults with hearing loss. A small portion of these resources is listed below. For the complete list, visit www.nas.edu/hearing.

Consumer and Patient Organizations

American Cochlear Implant Alliance

www.acialliance.org

Association of Late-Deafened Adults

www.alda.org

Hearing Link

www.hearinglink.org

Hearing Loss Association of America

www.hearingloss.org

U.S. Federal Government Agencies

Americans with Disabilities Act information

www.ada.gov

Centers for Disease Control and Prevention

www.cdc.gov/niosh/topics/noise

Department of Defense Hearing Center of Excellence

www.hearing.health.mil

Department of Education Rehabilitation Services

Administration, <https://rsa.ed.gov/>

Professional Associations

Academy of Doctors of Audiology

www.audiologist.org/patient-resources

American Academy of Audiology

www.howsyourhearing.org

American Academy of Otolaryngology-Head & Neck

Surgery, www.entnet.org/content/patient-health

American Speech-Language-Hearing Association

www.asha.org/public/hearing/hearing-loss

COMMONWEALTH OF VIRGINIA

Alzheimer's and Related Diseases Research Award Fund

2017-2018 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).

VCU

Heather Lucas, PhD

Developing an Expression Platform for Tetrameric Alpha-Synuclein to Advance Systemic Biochemical Studies

The aggregation-prone protein α -synuclein (α S) has been linked to neurodegenerative diseases such as Alzheimer's disease (AD) and, more commonly, to Parkinson's disease and Lewy Body Dementia. This protein has been suggested as a modulator of cognitive function, yet its native function and disease-related conformation remain ill-defined. New findings have indicated the presence of a native tetrameric alpha-helical conformation that is stable to aggregation. A convenient method to isolate tetrameric α S for biochemical studies has yet to be reported, even though stabilization of this aggregation-resistant conformer may represent a viable therapeutic approach. Moreover, metal dyshomeostasis has long been linked to PD, but the influence of biometals on the aggregation propensity of tetrameric α S cannot be studied systematically until a robust method of accessing the tetramer is identified. Accordingly, an expression and purification platform will be developed for tetrameric α S that exploits fusion protein technology and relies on mild isolation techniques available through affinity chromatography, rather than conventional ion exchange chromatography methods that require high salt and dilute protein conditions. This platform will extend the reach of biochemical and biophysical investigations of α S, yielding valuable insight into a key protein that lies at the crossroads of several neurodegenerative diseases and setting the stage for the identification of new targets for drug development. (*Dr. Lucas may be contacted at (804) 828-7512, hrlucas@vcu.edu.*)

VA Tech

Harald Sontheimer, PhD*

Is Amyloid Toxic for Glial Cells?

It is commonly assumed that amyloid contributes to functional impairment of neurons, albeit how amyloid is toxic to brain remains unclear. While plaques are found near neurons, they are often close to brain support cells called astrocytes as well as along blood vessels. The astrocytes touch blood vessels throughout the brain and have been shown to support the integrity of the blood brain barrier (BBB) that prevents entry of blood born molecules into the brain. Astrocytes also regulate blood flow by releasing vasoactive molecules. The investigator has demonstrated that vascular amyloid separates the astrocytic attachments on blood vessels called endfeet. By forming a rigid cast around arterioles and penetrating arteries, the amyloid deposits hinder the release of vasoactive molecules and impair the regulation of blood flow. This study will explore whether amyloid deposits also cause local impairment of blood flow and BBB integrity. The over-arching hypothesis is that amyloid impairs astrocyte function and, therefore, vessel health and local regulation of blood flow. Obviously, impairments of blood flow will starve neurons of energy and could hasten their demise, thereby explaining the progressive dementia. These studies may show a completely unexplored pharmacological target. (*Dr. Sontheimer may be contacted at (540) 526-2229, sontheimer@vt.edu.*)

VCU **Xuejun Wen, MD, PhD**
An In Vitro Model for Alzheimer's Disease Based upon 3D Self-Assembled Neurovascular Microtissues

Conventional model systems that rely on in vivo transgenic/lesion and cell line studies are unable to capture the complexity and biology of the human system. As a result, therapeutic strategies that are efficacious in animal models fail in pre-clinical and clinical human trials. In order to improve the translational potential of experimental studies, establishing an in vitro humanized model for AD is imperative. The investigator previously fabricated an in vitro AD tissue model based upon 3D self-assembled neurovascular microtissues of primary AD cortical neurons and glia cells that are associated with microvasculatures. This project aims to validate the model through testing of neurovasculature-delivered drugs in comparison to 2D co-culture model and in vivo profile. Once validated, the in vitro AD tissue model would offer a stable experimental framework to facilitate AD modeling, and drug discovery and testing in a dynamic, high-throughput manner. The project would also define guidelines for the development of in vitro models of the specialized neurovascular tissue environment to advance understanding of healthy states and pathologies, identifying therapeutic targets, and drug testing. *(Dr. Wen may be contacted at (804) 828-5353, xwen@vcu.edu.)*

VCU-Shenandoah **Jonathan Winter, MD***
Family Practice **Changes in Physician Approaches to Behavioral and Psychological Symptoms of**
Residency **Dementia Since CMS's National Partnership to Improve Dementia Care**

After CMS's 2012 initiative to reduce 'inappropriate' antipsychotic use in nursing homes, such prescribing decreased 27% in four years. Excluded from this calculation, however, were antipsychotics 'appropriately' prescribed for schizophrenia, Tourette's, and Huntington's. Over this same period, CMS described a greater than 20 percent increase in the reporting of these diagnoses. In addition, since the initiative's debut, CMS has been careful to trend the prescribing of other psychiatric medications commonly used for dementia symptoms including anxiolytics, antidepressants, and sedative-hypnotics to ensure that medication substitution is not occurring as the use of anti-psychotics decreases. The investigator's previously funded ARDRAF study hinted that the use of other risky medications also used off-label for dementia symptoms in nursing homes (i.e., lithium and anticonvulsant mood stabilizers) have increased since 2012. Because utilization of these is not being trended by CMS, this study will retrospectively query de-identified data from the VA Department of Medical Assistance Service for rates of these diagnoses and medications since 2011. The objective is to better clarify how reactionary changes in diagnosing and prescribing distort the apparent reduction in pharmacologic solutions to dementia symptoms since CMS's 2012 National Initiative. *(Dr. Winter may be contacted at (540) 631-3700, jwinter@valleyhealthlink.com.)*

VA Tech **Ling Wu, MD, PhD and Bin Xu, PhD***
Drug Repurposing for Tau Aggregation Inhibitors as Neuroprotective Agents for
Alzheimer's Disease

AD is characterized by the accumulation of two types of abnormal structures, extracellular amyloid plaques and intraneuronal neurofibrillary tangles in brain. Small, soluble oligomers of the neuron-specific, axon-enriched, microtubule-associated protein, tau, the building blocks of the tangles, represent the most toxic molecular species in AD pathogenesis. Moreover, toxic, misfolded oligomers of both A β and tau self-propagate by prion-like processes, whereby their direct contact with normally folded counterparts catalyzes the latter's conversion into toxic, misfolded forms. This project will screen repurposed drugs from an NIH Clinical Collection library of 700 small molecules and identify compounds that can block tau oligomer formation and protect neurons from tau-induced cytotoxicity. Further tests will establish whether validated lead compounds from the screens and additional in vitro assays can protect cultured neurons from the adverse effects of extracellular tau oligomers. *(Dr. Wu may be contacted at (540) 231-8442, wul3@vt.edu; Dr. Xu may be contacted at (540) 231-1449, binxu@vt.edu.)*

VCU

Shijun Zhang, PhD*

Development of NLRP3 Inflammation Inhibitors for AD

Neuroinflammation has been recognized as an essential player in the pathogenesis of AD, especially for the late-onset AD. Inflammasomes have been recently identified as multi protein complexes that tightly regulate the innate immune response and the production of pro-inflammatory cytokines, and the NLRP3 inflammasome is the most extensively studied and widely implicated. The NLRP3 inflammasome regulates the production of interleukins (IL-1 β and IL-18) and has been indicated as having a critical role in the pathogenesis of AD. The investigator recently developed small molecule NLRP3 inhibitors and one lead compound was identified with in vivo efficacy to reduce AD pathology and to improve memory functions. The goal of this study is to develop more potent analogs based on the newly identified lead structure. The results will significantly facilitate development of more potent inflammasome inhibitors as potential disease-modifying agents for AD. (*Dr. Zhang may be contacted at (804) 628-8266, szhang2@vcu.edu.*)

UVA

Zhiyi Zuo, MD, PhD*

Empathic Transfer of Postoperative Cognitive Dysfunction

Caregiving spouses of patients with dementia have an increased chance of suffering from dementia. Although the mechanism of this phenomenon is not clear, increased stress due to caregiving and similar living environments are thought to contribute to it. Postoperative cognitive dysfunction (POCD) is a relatively new but well-documented clinical entity that affects patients after heart and non-heart surgeries. POCD not only affects patients' daily activity but also predicts high mortality. Recent studies from the investigator's laboratory and others have indicated that inflammation in the brain, an abnormal process for many chronic brain diseases including Alzheimer's disease, may be involved in POCD. Preliminary data showed that mice living in the same cage with mice that have surgery also develop neuroinflammation and POCD. In this project, the investigator will determine how this empathic transfer works and which brain regions are activated in the cage-mates of the mice with surgery. These studies have a significant implication for bystander health and will help us understand how caregiving spouses of patients with dementia may develop dementia as well. (*Dr. Zuo may be contacted at (434) 924-2283, zz3c@virginia.edu.*)

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Wondrous and Wild: The Paradox of Aging

by Carol Orsborn

(Excerpted from *LPNQ: The Quarterly Journal of the Life Planning Network*, Spring 2017, by permission.)

“We who are old know that age is more than a disability. It is an intense and varied experience, almost beyond our capacity at times, but something to be carried high.” Florida Scott-Maxwell, The Measure of My Days.

What is age to those of us living it? Poised on the eve of my seventieth year, I am filled with equal portions of wonder and dread. The young cannot possibly fathom what it means to live with one’s cheek pressed hard against the shadows. Earlier in our lives, we had expected either to continue on as is forever, punctuated by a hard stop at the end, or to fade away gently into the dark night. We did not expect to be facing a new threshold, feeling more alive than ever. The irony nearly breaks us, as we leapfrog through the mystery of age one paradox at a time.

Aging is a time full of irony. We find ourselves brimming with unexpected passion, but frequently lack the energy to see things through. We experience ourselves to be at the peak of our knowledge and abilities, only to realize that we are masters of a world that no longer exists. We who are old discover untapped reservoirs of compassion for humanity, while having less patience for individuals than ever

before. We crave to be included while yearning to be left alone. We worry we won’t have enough for the demands of a cavernous future while fearing that tomorrow may be our last. It seems just yesterday, we found our own aging parents’ crankiness to be irritating. Today, we realize that insisting we be allowed to do things our own way, no matter how inconvenient for others, is not only our hard-earned right, but the essence of what we want most: the freedom to make our own choices to the very end.

There is nothing quiescent or serene about any of this, even should there be moments or even long stretches of indescribable peace and joy. But in their place, we can discover that we have become somehow transformed by aging to become not only older and wiser but something wondrous. More and more I feel myself to have a numinous beauty, not what the young refer to as pretty, but expressive: a natural wonder eroded by time into something wonderful. It is as if with every lightning strike, every assault endured and paradox accepted, God has been saying: “Now do you understand?”

This transformation cannot be forced, only allowed. And it is only by dint of how we formulate our answer to the question that we become something to behold rather than a pile of rubble.

Love is the answer, bursting inside of me, begging for expression yet often confined to the page. For in real life, sharing everything I am is often too much for others. Especially the young. They need their energy for their own lives while I blaze

secretly beneath as serene a facade as I can manage. When my heart burns clean, remembering that I have chosen to temper the full expression of myself out of love, I gaze clear-eyed at the whole of life, every act of the human drama, feeling a peace that goes beyond mere acceptance.

Ah, the privilege of life, something I’ve longed to experience through my achievements, by doing. With a love this big, I now feel as if I could conquer the world, it feels endless, infinite. And yet, how ironic, I write one page and feel worn out. Anything that requires effort lifts me up then drops me back down again, but it is to a place new to me, where the love is not conditional nor exhaustible, back to where I can simply be.

This is a newfound ability, a gift of age: newly able to detach from the fray of life, and my own ambition, to descend,—or is it elevate?—into solitude. In this place of being, I grow deeper and I grow wilder. After years of having to channel the essence of my vitality to make a living, to be part of the world, my spirit has found sanctuary. I am, in this place, not only fierce with age, but with life.

Carol Orsborn is the author of more than 25 books including *The Spirituality of Age: A Seeker’s Guide to Growing Older*, coauthored with Robert L. Weber. It was the 2015 Nautilus Book Awards gold winner in the category of Consciously Aging.

Age Wave Showcases Transportation Innovation, Education, and Future Planning

The Greater Richmond Age Wave hosted *Transportation and Accessibility: Future Vision and Innovation in Our Region* on May 10th at Triple Crossing's Fulton location. The group posed the questions: "Why do 7.5 million rides go unfulfilled in our region each year? Who are the changemakers creating and planning to push the needle on this number as need rises?"

The audience first heard from the personal experiences of residents who use public transportation, with varying degrees of satisfaction. Age Wave Neighborhood Livability Chair Ken Lantz, Principal Planner with the Richmond Regional Planning District Commission, provided an overview of general transportation needs. He was joined by Charles Rasnick of Hanover Senior Rides with a breakdown of how his service operates.

GRTC's Carrie Rose Pace, Director of Communications, and Adrienne Chargois, Planning Manager, shared upcoming developments in GRTC's Bus Rapid Transit system. These changes have already begun to reshape the landscape in Richmond.

Marshall Contino, director of the Center for Vehicle Safety with the nonprofit Altarum, addressed the ways autonomous vehicles could dramatically, if not completely, eliminate traffic deaths. His most impactful statistics: 110 people in

the U.S. die each day in an automobile accident, 94 percent of accidents are caused by a human driver, and our cars sit unused 96 percent of the time.

The final presenters were an Innovation Panel from UZURV, a Richmond-based TNC app startup; Perone Robotics, a Charlottesville-based company that creates software for autonomous vehicles; and RoundTrip, a local startup favorite that provides innovative medical transportation software.

The event included an audience brainstorm session. The full list of their ideas can be viewed at agewellva.com/trending.

The Fall tour will cap off a year of events organized by the group. In February, Age Wave joined forces with the United Way Young Leaders Society to host a networking event that included a brainstorming and sharing session about innovative ways to promote social connectedness in our communities. In March, the Age Wave organized an Aging2.0 Global Startup Search competition, where seven startups and small businesses delivered four minute pitches. Richmond Winner OnGuardian, an app designed to enhance the family care experience, hopes to head to the final round of the global competition this fall in San Francisco.

The Age Wave is jointly managed by VCU Department of Gerontology and Senior Connections, the Capital Area Agency on Aging. For more information about past and upcoming Age Wave projects, visit agewellva.com or contact macdonaldcs@vcu.edu.

Resource for Dementia Caregivers

Oftentimes, caregivers of persons with dementia can feel overwhelmed. They are in a new world of changes, dealing with a variety of medical, behavioral, and other issues; plus health and medical issues come with their own jargon. There's a new resource for caregivers of individuals with dementia who are also beginning to experience non-memory-related medical problems. With help from a grant from the National Institute of Nursing Research, faculty at the University of North Carolina at Chapel Hill and Duke University have written *The Alzheimer's Medical Advisor: A Caregivers Guide to Common Medical and Behavioral Signs and Symptoms in Persons with Dementia*.

This is an easy-to-read guide on 54 common medical and behavioral signs and symptoms experienced by older adults with dementia, such as cough, agitation or not eating or drinking, that can give caregivers more confidence in evaluating, talking with providers about, and managing possible medical issues. This guide includes instruction on taking vital signs, recognizing pain and dehydration, basics of medication safety and management, guidance when conferring with health care providers, advice for navigating the health system, and more.

The *Alzheimer's Medical Advisor* is published by Sunriseriverpress.com.

VCU Gerontology Assisted Living Program on Track to Offer Spring Classes

The Department of Gerontology in VCU's School of Allied Health Professions will begin its first official academic year of accreditation for Assisted Living Administration this Fall and offer new courses in the subject beginning in Spring 2018.

The Assisted Living Concentration has received academic accreditation from the National Association of Long Term Care Administrator Boards (NAB).

"This accreditation has opened VCU Gerontology's door to students across the country who want to become licensed assisted living administrators, by providing them a quality educational experience that has been endorsed by those who create the national standards," said Co-Program Director of the Assisted Living Administration Concentration Jennifer Pryor.

The final accreditation makes VCU Gerontology the only NAB accredited program in Virginia, and the first-ever accredited program in Assisted Living Administration. The NAB is the nation's leading authority on licensing, credentialing, and regulating administrators of organizations along the continuum of long term care.

The accreditation journey began in 2014, led by Pryor. She and VCU Gerontology Professor Jennifer Inker appeared at the June NAB meeting to review the final steps

taken by VCU during the accreditation process. These include three new courses within the specialty area added within the department.

"We're eager to continue the important work of preparing students for this dynamic field," Pryor added.

For more information about the Assisted Living Administration Specialty Area and VCU Gerontology, visit www.sahp.vcu.edu.



VCU Gerontology Professor Jennifer Inker, Karen Skaff, and Jennifer Pryor, Co-Program Director of the Assisted Living Administration Concentration, just after receiving final approval at the NAB's June meeting in Salt Lake City.

Shepherd's Center Fall Open University

The Shepherd's Center of Richmond, serving older adults 50 and above, has announced the fall schedule for its Open University. Offerings are available at three locations around the city, beginning September 18th.

The eight-week session of courses features topics in literature, geography of the Great Plains; history of art and architecture, opera, musical theatre, faith of the founding fathers, genealogy, topics in religion, politics, and current events; yoga, Feldenkrais, and French, Spanish, German, Latin, and Japanese.

In addition, the Open University sponsors lunch-time speakers on a variety of topics. Richmond and Virginia's past and present are the focus of many of the talks, including: "Richmond and World War I"; "Mansions and Monuments and Southern Identity in Richmond"; "Richmond's Civil War Legacy"; "The Dooleys of Richmond"; "Lewis Ginter Botanical Gardens: Unearthing Potential"; "The Red Cross in Richmond"; "Tobacco in Virginia"; "Jamestown Women and Children"; "The Virginia Governor's Race"; and the digital collection of the Virginia State Library. Other topics include North Korea's threat; Haiti; Cuba; money laundering; and coin collecting.

A full schedule with names of teachers or speakers, dates, times, location, and cost is available at www.TSCOR.org or by calling (804) 355-7282.

Calendar of Events

July 20, 2017

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

July 29-August 2, 2017

42nd Annual Conference & Tradeshow of the National Association of Area Agencies on Aging. Savannah International Trade & Convention Center. Savannah, GA. For information, visit www.n4aconference.org.

August 18, 2017

Lifelong Learning Institute's Fall Catalog. The Fall Catalog of the Lifelong Learning Institute in Chesterfield will be available on site and online. For information, visit www.LLIChesterfield.org or email info@LLIChesterfield.org.

August 28-30, 2017

Justice for All: Protecting Vulnerable Adults. 28th Annual National Adult Protective Services Association Conference. Hilton Milwaukee City Center, Milwaukee, WI. For information, visit www.napsa-now.org/about-napsa/annual-conference/.

September 6 – October 11, 2017 *Diabetes Self-Management Program.* Sponsored by Senior Connections and St. Barnabas Episcopal Church. St. Barnabas Church, Chesterfield. Wednesdays only, 10:00 a.m. – 12:00 p.m. For information, call (804) 343-3004. For information, visit [www.stbarnabasrichmond.org/18 health--wellness.html](http://www.stbarnabasrichmond.org/18-health--wellness.html).

September 11-15, 2017

Virginia Health Care Association-Virginia Center for Assisted Living Convention and Trade Show. Richmond Marriott and Greater Richmond Convention Center. For information, visit www.vhca.org/2017convention.

September 12, 2017

Living with Alzheimer's for Caregivers: Conversations About Alzheimer's and Dementia. Presented by the Alzheimer's Association. 6:30 p.m. - 7:30 p.m. Petersburg Public Library. For information, call (804) 446-5860 or visit www.alz.org/.

September 24-30, 2017

International Active Aging Week. Initiated in 2003 by the International Council on Active Aging. For information, visit www.activeagingweek.com.

September 25, 2017

Aging and the Arts. 3rd Annual Bon Secours Richmond Successful Aging Forum. West End Assembly of God, Richmond. For information, visit www.bsvaf.org/successfulagingforum.

October 10-11, 2017

Navigating the Waters of Leadership. Virginia Assisted Living Annual Fall Conference. Hilton Norfolk The Main, Norfolk. For information, visit www.valainfo.org.

October 15-18, 2017

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

October 19, 2017

Legal and Financial Planning. Presenter: Fletcher Cooke, Esquire. Presented by the Alzheimer's Association. Dinwiddie Public Library. 5:30 p.m. - 6:30 p.m. For information, call (804) 446-5860 or visit www.colonialheightschamber.com/.

November 14, 2017

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

January 24, 2018

Virginia Center on Aging's 32nd Annual Legislative Breakfast. St. Paul's Episcopal Church, Richmond. 7:30 a.m. - 9:00 a.m. For information, call (804) 828-1525 or email eansello@vcu.edu.

Age in Action

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Director, VCoA

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Commissioner, DARS

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Editor

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

**Fall 2017 Issue Deadline:
September 15, 2017**



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2017 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.

Culpeper, September 9
 Danville, September 16
 Waynesboro, September 30
 Blacksburg, October 7
 Roanoke, October 14
 Harrisonburg, October 21
 Charlottesville, October 28
 Lynchburg, November 4

Greater Richmond Chapter

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

Middle Peninsula-Northern Neck, Urbanna, October 7
 Fredericksburg, October 14
 Richmond (Glen Allen), November 4

National Capital Area Chapter

Register for walks in this area at
www.alz.org/nca.

Solomons, MD, September 16 Washington, DC, October 14
 Oxon Hill, MD, September 23 Manassas, VA, October 21
 Reston, VA, September 24 Winchester, VA, October 28
 La Plata, MD, September 30

Southeastern Virginia Chapter

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

Suffolk, September 16 Newport News, October 7
 Virginia Beach, September 23 Onancock, October 14
 Farmville, October 5 Williamsburg, October 28

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