

## Case Study

### Virginia's Money Follows the Person Demonstration

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#### Educational Objectives

1. Describe Virginia's Money Follows the Person Demonstration project, including the new services available to individuals through Virginia's Medicaid-funded home and community-based waiver program.
2. Explain how Virginia's Money Follows the Person Demonstration project, being administered by the Virginia Department of Medical Assistance Services (DMAS), would assist an individual in transitioning from a long-term care facility to the community.
3. Illustrate how someone might experience the MFP processes from pre-transition through post-transition.

#### Background

The Money Follows the Person

Demonstration (MFP) is a national initiative of the federal Centers for Medicare and Medicaid Services (CMS). The MFP Demonstration's vision is to create a system of long-term services and supports that enables available funds to "follow the person" by supporting individuals who choose to transition from long-term care institutions into the community. Nationally, \$1.4 billion was allocated to the 31 states participating in the program, with an estimated 37,000 individuals projected to transition to the community over the four-year demonstration. Virginia's MFP Demonstration went "live" on July 1, 2008 and will operate through September 20, 2011.

#### Activating MFP in Virginia

The MFP Demonstration gives individuals of all ages and all disabilities who currently live in institutions in Virginia options for community living not previously offered. To accomplish this, Virginia's MFP Demonstration will make permanent changes to Virginia's long-term support system, enabling individuals to use one of five Medicaid home and communi-

ty based waivers or one of Virginia's Programs for All-Inclusive Care for the Elderly (PACE). The changes also reflect Virginia's commitment to rebalance further its long term support system and encourage community-based supports in lieu of institutional care.

The MFP Demonstration has three major goals. They are:

Goal 1. To give individuals who live in nursing facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities/Mental Retardation and Related Conditions, and long-stay hospitals more informed choices and options about where they might live and receive services.

Goal 2. To assist individuals in making the transition from these institutions, if they choose to live in the community.

Goal 3. To promote quality care through services that are person-centered, appropriate, and based on individual needs.

The MFP Demonstration Project anticipates achieving these goals by

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adding both new and existing waiver services to select Medicaid home and community-based waivers. Specifically, the MFP Demonstration created the following two new home and community-based waiver services:

**Transition Services:** A one-time, life-time \$5,000 benefit for those individuals transitioning from a qualified institution to a qualified community setting to assist with items and services needed for a successful transition. Examples of transition services include rental deposits, utility deposits, and essential household appliances and furnishings.

**Transition Coordination:** A time-limited service similar to case management that provides needed support for the individual with activities that are associated with transitioning, including the development and implementation of the transition and service plan.

In addition to the new waiver services, DMAS added certain existing waiver services to select home and community-based waivers. The following chart illustrates these additions, as a result of the MFP Demonstration:

Waiver	Waiver Service to be Added
<b>Elderly and Disabled with Consumer Direction (EDCD)</b>	Environmental Modifications Assistive Technology Transition Coordination Transition Services
<b>HIV/AIDS (AIDS)</b>	Environmental Modifications Assistive Technology Transition Services
<b>Technology Assisted (TECH)</b>	Personal Emergency Response System Transition Services
<b>Individual and Family Developmental Disabilities Supports (DD)</b>	Transition Services
<b>Mental Retardation (MR)</b>	Transition Services

DMAS anticipates that 1,041 individuals across Virginia will make the transition from institutions into home and community-based settings during the MFP Demonstration's four-year implementation period.

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#### *Pre-Transition Period: Making the Decision*

Ethel is a 64 year-old woman who receives Medicaid services and has lived in a large, state-run training center for 52 years. The seventh of nine children, she had lived with her family until her needs precipitated admission to this facility. She has a profound intellectual disability and bilateral foot deformities which keep her from walking independently, though she wears custom shoes and inserts. Ethel spends a lot of time in her wheelchair, which she propels using her feet. With assistance, she can stand in order to get in and out of bed, the shower, or her favorite recliner. Ethel does not speak, but sometimes makes vocal sounds when she is especially happy or unhappy. She expresses preferences through her visual gaze, through vocalizations or by wheeling herself away from an area.

Ethel eats a pureed diet. She drinks from a cup and can feed herself small amounts, although she prefers for others to feed her. She seems to like upbeat country music, but otherwise shows little interest in her environment and seldom reacts to or reaches for objects around her. The facility has tried to promote greater awareness of herself and her environment, for example, by encouraging Ethel to make eye contact with others for brief periods and to look in a mirror. Ethel depends on others for all aspects of her care, and is generally cooperative with whatever needs to be done.

Interdisciplinary Teams at the training center are responsible for identifying individuals who may wish to participate in this Project. Ethel's Interdisciplinary Team suspected that she might be interested in living in the community, so it contacted her brother to discuss the possibilities, as well as potential risks to community living. When an individual in a Virginia state facility has a legal guardian, or if an Authorized Representative has been appointed, that representative must agree with community placement and give consent for transition planning to begin. Both of Ethel's parents are deceased but she had a brother living in the family's hometown and a sister in California. Ethel's brother had been appointed as her Authorized Representative. When the facility's social worker provided information about services available in the community and about Ethel's ability to participate in this Project, he strongly embraced the prospect of community placement and gave all of the necessary informed consents for discharge

planning to begin. This included his written permission for Ethel to participate in the MFP Demonstration. The facility began coordinating with the Community Services Board serving Ethel's home county in order to obtain a slot on the MR Waiver list for Ethel. Ethel met the criteria for this waiver, for the criteria for residency in the training center (which is an intermediate facility for individuals with intellectual disabilities/mental retardation) are the same as for the MR Waiver. Since Ethel was participating in the Project, she immediately received one of the 110 MR waiver slots reserved for those who need services under the Project's MR Waiver.

### ***The Transition: Careful Coordination***

Ethel's brother requested that community services be located as close to the family home as possible. At the same time, he decided that he did not want to take an active role in setting up Ethel's services but wished to be kept fully informed by the Community Services Board and the facility's social work staff. The Mental Retardation Director of the Community Services Board contacted several residential providers meeting the geographic criteria, both group home and sponsored residential placements, and invited them to the facility to meet Ethel and gather information from the team on her living unit. After considering available providers, their locations, their proximity to activities of interest to Ethel, and populations served by each provider, Ethel selected Apple Valley group home whose owner was eager to develop services for her in the community.

The provider articulated a vision for a small three-bed group home located not far from the family home, which would be configured to meet Ethel's physical needs and which would offer a comfortable, safe environment with a gentle boost in the activities and stimulation available to her. The facility's social worker, who had established a close, trusting working relationship with the family over many years, endorsed this plan. Ethel's brother gave consent for transition planning to begin, and the provider started the process of identifying an appropriate house and appropriate housemates for Ethel. Her case manager administered the first Quality of Life Survey to Ethel, and her brother assisted her in responding. Unfortunately, Ethel's brother passed away soon after this, and there was a short interruption in transition planning. Ethel's sister in California was initially hesitant about Ethel's ability to live in the community. Training center staff connected Ethel's sister with the family of an individual who had moved into a group home several months ago. Ethel's sister spoke several times with the family, learning how many supports are now in the community to address individuals and their safety needs. After learning of these improvements, Ethel's sister was equally in favor of the community placement; it took a couple of weeks for the facility to designate her as an Authorized Representative and obtain the necessary informed consents, which included consent to participate in the Money Follows the Person Project. As can be seen, in the MFP program, any conflict or difficulty that might arise during the stages of the transition is dealt with individu-

ally on a case-by-case basis, involving the person who is transitioning, or the Authorized Representative, and the Case Manager/Transition Coordinator. This is due to the dynamic and unique nature of each transition planning/implementation process. When planning resumed, staff members from the facility and the group home coordinated a series of information-sharing and transitional activities:

- The residential manager and assistant manager from Apple Valley spent an entire evening shift and part of the following day shift on the living unit with Ethel and her staff, observing and learning her care routines. The facility provided on-grounds accommodations for the community group home (provider) staff;
- Staff members from the facility reviewed with provider staff the latter's responsibility to offer staffing in accordance with needs;
- A team of facility staff members who knew Ethel well, including staff from social work, direct care, and physical therapy, visited the prospective group home site to assess the property and provide recommendations for modifications to the physical plant based on Ethel's needs. Following this visit, the group home provider modified the property by installing a front porch ramp and a curb cutout, widening interior doorways, and fitting grab bars and a transfer seat in the bathroom and corner guards on furniture. Facility staff also recommended the correct height for Ethel's bed for the most effective transfers.

- Ethel’s annual review fell within this period, and the provider’s admissions coordinator attended her interdisciplinary team meeting. Up-to-date reports from all disciplines were provided, along with substantial anecdotal information. It was clear at the meeting that the facility’s team members (a sizeable group) knew Ethel, cared about her, and were genuinely supportive of her move to the community.

- In late March, facility staff members brought Ethel to her new group home for a day visit that included lunch. Ethel also met the other two individuals who were living in the home; they all seemed to like each other. The visit was a success. The facility later gave glowing feedback on Ethel’s apparent comfort level throughout the day and on how well prepared the group home staff members were. The residential provider had purchased a lounge chair very similar to Ethel’s favorite chair on the facility living unit, as well as a full-length mirror similar to the one facility staff members had been teaching her to use.

- Facility nursing staff coordinated with Ethel’s new community physician to share information and to schedule her first appointment. Nursing staff also coordinated the transfer of medications and physicians’ orders to the group home.

### ***Life after Transitioning into the Community***

Ethel moved into her new home in the spring. In case Ethel needed to return, the facility placed her on “convalescent leave” with her discharge date being not until a month later. This precaution turned out to

be completely unnecessary. Within the first month, Ethel was settled in, attending a Memorial Day picnic and some other events with undisguised pleasure, and even starting to pick out her favorite staff. Clearly, she was “home.”

Although Ethel now lives in a different county from where she grew up, her original Community Services Board continues to provide her case management. This board assigned a case manager for Ethel shortly before her discharge from the facility; the case manager submitted the service authorization request and other required paperwork to the Office of Intellectual Disabilities for approval, and now visits Ethel at least every 90 days, monitors service delivery, maintains contact with her family, and fulfills the other functions required by waiver regulations

During Ethel’s first 60 days in her new home, the group home provider conducted a comprehensive assessment of her skills and interests. Then, staff members met with Ethel and her case manager to develop a person-centered service plan for the coming year. (Ethel’s sister was unable to attend, but was sent copies of all plan materials later.) Although staff had initially considered establishing training objectives like those at the facility (making brief eye contact, looking in a mirror) for the sake of consistency, they discovered that she was not nearly as detached from her surroundings as had been thought. Ethel was already making more and more eye contact with others and watching what people were doing. She laughed out loud during certain TV shows. Staff noticed that she

enjoyed watching birds out the kitchen window from her seat at the breakfast table. Ethel was more ready for her new life than anyone had suspected.

Ethel will continue to receive these services even after her participation in the Money Follows the Project ends because the services she is receiving are a part of the MR Waiver. Staff members from the Department of Medical Assistance Services will visit Ethel at the end of one and two years following her transition to see how Ethel is doing and to complete the Quality of Life Survey as a part of evaluating the success of the MFP Demonstration.

### **Study Questions**

1. What are the new home and community-based Medicaid waiver services created as a result of Virginia’s Money Follows the Person Demonstration project?
2. What are the steps necessary for a successful transition under Virginia’s Money Follows the Person Demonstration project?
3. Who should be involved in the process in order to ensure a positive transition into the community?

### **References**

For more information about Virginia’s Money Follows the Person Demonstration project, including eligibility requirements and a list of Transition Coordination Provider Agencies, visit:  
[www.olmsteadva.com/mfp](http://www.olmsteadva.com/mfp)  
(Virginia’s MFP Website)  
[http://www.cms.hhs.gov/DeficitReductionAct/20\\_MFP.asp](http://www.cms.hhs.gov/DeficitReductionAct/20_MFP.asp)  
(Federal MFP Website)

## Editorials

### About the Authors



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(DMAS). He is responsible for the development, implementation, monitoring, and evaluation of the Money Follows the Person Demonstration Project. Mr. Rachel graduated from Virginia Commonwealth University in December 2000, earning a Master of Science in Gerontology degree with a track of Healthcare Organization and Planning. He has held positions of responsibility in long-term care and in higher education. Currently, he is pursuing a doctorate in Health Related Sciences with a specialization in Gerontology under the direction of the VCU School of Allied Health Professions.



Karen Lawson is the Policy and Research Manager at DMAS, Division of Policy and

Research. She is responsible for managing and completing large-scale research projects, policy and program development, grant development and monitoring, and policy analysis support for the Medicaid program. Ms. Lawson graduated from James Madison University in 1993 with a Bachelor in Social Work degree, and from VCU in 1996 with a Master in Social Work and a Certificate in Aging Studies. Ms. Lawson has been employed with DMAS since 1996, specializing in long-term care services provided to Medicaid populations.

### From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

#### *Sold a Bill of Goods*

My father used a phrase to describe when someone has been duped. He would say that the person was “sold a bill of goods.” I guess it had its origins in buying or accepting something without checking it. With regard to Boomers, elders, and all of us growing older, we have been sold a bill of goods here in America on a couple of things. The first is independence.

We have internalized the myth of Americans as fiercely independent and autonomous. “Rugged individualism” is the supreme value. Lewis and Clark and other solitary adventurers explored the unknown America. Homesteaders braved the elements and much more to settle isolated sections of the country. And having the “big pond” separate us from Europe cultivated and set in place a go-it-alone mentality for ourselves and our nation. We came to buy into and to enshrine this mindset of individualism. So it comes as no surprise that we so frequently hear people who are clearly in need of help saying, “I don’t want to be a burden” or “I can get along just fine.”

The truth is that we have long since stopped being a nation of wilderness explorers and farmers and ranchers and recluses eking out a solitary subsistence or working in small pockets of communities to produce the food that others need.

Now we as a nation live in population sprawls whose margins between city and suburb are blurred. We rely on others for services as they do on us. And when in our personal lives have we ever truly been independent or autonomous? Did we birth ourselves? Did we dress and school and socialize ourselves as children? Did we raise and launch our children without interactions with others? Can we get along solely by ourselves without using any resources from our employers, our family, or our community? Clearly, for the overwhelming majority of us the answer is “No.” We have needed others since before grade school to become and to be the persons we are. Why, then, do we assume that all of this is turned on its head when we develop an incapacity or when we become frail?

I have been proposing and writing about “*assisted autonomy*” for about 20 years, in part in response to the heavy toll taken by the artificial ideal of rugged independence. By assisted autonomy I mean assistance from others with the intention being to help make a person more interdependent and connected, because with these connections the person will more likely realize his or her goals. “Independence” is seldom achievable at any point in the life course, and may be even less so with age or impairments. This says nothing about whether or not achieving “independence” should even be a goal in the first place. Interdependence more truly describes one who is engaged with community and others. Interdependence more likely contributes to achieving one’s personal goals. Yet independence and autonomy are

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often blindly championed as goals for people with needs or impairments.

It seems that the mantra of autonomy or independence has sometimes had a hollow ring, justifying inaction by others and policies and practices of non-intervention and benign neglect. *“Leave them alone. They want to be independent.”*

The 17th century English poet John Donne wrote that “No man is an island.” Nor should he or she be. As my gerontologist friend Harry R. (Rick) Moody noted in his 1992 book *Ethics in an Aging Society*, too often autonomy-as-independence fails to consider the deeper human need for respect and social connections, for “dignity is far more bound up with the interpersonal and social fabric than with isolated acts of rational deliberation or consent” Moreover, in order for the exercise of choice by individuals with needs or disabilities to have any meaning, that is, for there to be true selection among options and true steps to activate the options that are selected, there must be some negotiation with and assistance from others. Therefore, assisted autonomy rather than independence is a means to empowerment and inclusion.

The second item in our bill of goods, that is, another thing about which we have been duped or misled is uniformity in later life. Researchers and educators would call it homogeneity. The popular wisdom is that somehow we become more and more alike as we grow older. Aging is pictured as like a big blob that absorbs us and makes us all the same, so that our

characteristics, our needs, and our value become more similar with advancing time. So, certain programs are tied to chronological age and we are eligible for them whether they fit us or not and whether we need them or not. The message is “You’ve reached this threshold age, you must fit the mold.” At the same time, many of us start making pronouncements as if older people are all alike. This sometimes becomes mythologized, as when people assume they can speak for all or most older citizens or when they purport to summarize who Boomers are or what Boomers want. You even hear older adults saying, “Well, older people don’t like this” or “Seniors want that.” Again, there’s this one size fits all mentality when nothing could be further from the truth. In fact, as we grow older, we grow less and less like our age mates. Dissimilarity or heterogeneity increases. The defining element of growing older is how wonderfully difficult it is to encapsulate what it is and who we are. As mentioned, however, this does not stop those who wish to make pronouncements.

Research on various characteristics of older adults as they age shows greater “within-group variance,” more spread in scores or observed measures, whether one is studying physical abilities, problem solving, organ functions, stamina, economic status, sexuality, responses to a medication or a number of other characteristics. For 20 years or so I have been calling this reality the process of *individuation*. More recently, Harvard researchers Lisa Berkman and Maria Glymour have been writing about “the centrality of variability” to describe aging.

While there may be similarities in appearances, the core of aging is its dissimilarities. Comparing several age groups at a given point in time will show that there is more variance within the older groups than the younger groups, in almost anything being measured. This does not speak to whether the function or characteristic being measured is better or worse with older groups but to the range being found. The thrust of human development seems to be greater variability within a birth group as it grows older. It’s as if Mother Nature didn’t have a script for us once we had ensured the survival of the species. In other words, with increasing time we become more a birth group of individuals. Why, then, should we agree to be treated or to treat ourselves or to treat our age-mates as a herd of similarities. The truth is, “When you’ve seen one older adult, you’ve seen one older adult.”

### Did You Know?

The Virginia Center on Aging’s website features a list of videos available at no cost from its extensive lending library, links to aging-related resources, staff profiles, annual reports, *Age in Action* current and back issues, ARDRAF archives, and much more.

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

## Editorials

### From the Virginia Department for the Aging

Linda Nablo

What do the homeless woman rummaging through the restaurant dumpster and your local Sheriff have in common? In years past, both may have been subject to a decision by their local Circuit Court judge, a decision which may have found the homeless woman to be incapacitated and the Sheriff to be her “guardian of last resort.” After years of study, however, the 1998 session of the Virginia General Assembly created the *Virginia Public Guardianship and Conservator Program* (§ 2.2-711 thru 2.2-713 of the Virginia Code). Since then, the public guardianship program has provided a public guardian or conservator for those Virginians ages 18 and older who are incapable of making decisions, whose finances are insufficient to compensate a private guardian, and for whom there is no willing or responsible person to serve as their guardian.

The Virginia Public Guardianship and Conservator program is truly a program of last resort. When absolutely no other options exist, only then can a public guardian or conservator be appointed by law. Virginia’s law is unique (and one of the best in the nation) and provides important safeguards to insure that the wishes of incapacitated persons are respected and that they are allowed to participate in decisions affecting their life whenever possible. Effective January 1, 2009, new regulations clarify the General Assembly’s strong intent that an incapacitated person’s wishes be

considered. For example, part of the new regulation explicitly states that “The guardian or conservator shall encourage the incapacitated person to participate in decisions, to act on his own behalf, and to develop or regain the capacity to manage his personal affairs, to the extent possible” (Virginia Administrative Code, 22VAC5-30-30, The Virginia Public Guardianship and Conservator Program, “Services” at section (F)(2)).

As with many publicly-funded services, however, Virginia’s public guardianship program does not have sufficient funding to meet the real need for public guardians. Two research studies authorized by the General Assembly in 2003 and 2007 identified a substantial need for increased statewide coverage and the capacity to serve even more vulnerable adults. Beginning in fiscal years 2005 and 2006, the program received additional funding from the General Assembly to expand public guardianship services to target more adults with mental illness or mental retardation. In Fiscal Year 2007, the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) provided funding to provide public guardianship services to individuals residing in, or at risk of placement in, a state mental retardation training center.

After more than 10 years of operation, Virginia’s public guardianship program consists of 16 local/regional programs and has the capacity to serve and protect 637 of the most vulnerable low-income citizens of the Commonwealth. However, there are still persons

who are not being served and localities within the Commonwealth that are not covered by a public guardianship program. In these localities, the local Sheriff may often once again be tasked with being the guardian of last resort.

What do public guardians do? The primary focus of the program is social/human services rather than legal counseling or intervention, although these services also are within the scope of the duties provided under the statute. The complexity of the public guardianship cases requires that the public guardian invest a great deal of time as well as possess an in-depth knowledge of social services, health care, and public benefits. As specified in the law, “guardian” means a person appointed by the court who is responsible for the personal affairs of an incapacitated person, including responsibility for making decisions regarding the person’s support, care, health, safety, habilitation, education, therapeutic treatment, and, if not inconsistent with an order of involuntary admission, where the incapacitated person will live. Local/regional public guardianship programs use multi-disciplinary panels to help the court-appointed guardians make complex decisions that represent the best interests of their clients, including end of life decisions for those individuals who have a terminal illness. The public guardianship program provides a full range of services and supports for clients. Some practical program examples may include:

- Assist individuals in getting connected to benefits and services that enable them to become more self-

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sufficient.

- Give individuals a voice when they are unable to communicate due to mental illness or other disability.
- Intervene to reduce incidents of abuse, neglect, and exploitation.
- Assist individuals in finding a safe and secure place to live.
- Assist individuals in moving out of a nursing home or other facility and into a monitored independent-living situation.
- Monitor personal finances, assist in creating and managing a budget, and help with paying bills (if the guardian is also appointed as a Conservator by the court).
- Coordinate visits with family members and work to re-establish and support a relationship with family, friends, and community.
- Assure that individuals receive adequate medical care and psychological care if needed.
- Monitor health status and help individuals make informed health care decisions.
- Make pre-need funeral arrangements and follow up with funeral plans after an individual dies (this service is not mandatory but authority is permitted in the law).

Who is served by the public guardianship program? Sometimes the phrase “most vulnerable citizen” gets overused. However, if one is poor, incapable of making decisions about life, may have been abused or exploited, and has no family or friends to help, the label, unfortunately, fits. These are the individuals for whom the public guardianship program was created.

Consider Mr. A, an older man with Alzheimer’s disease who is unable to meet his own basic care needs and is without family or other per-

sons to serve as his guardian. Symptoms of his disease include his physical and verbal abuse of those around him and inappropriate sexual acting out behavior. Because of these behaviors, the various assisted living facilities and nursing homes in which he had lived were unwilling for him to stay. He seemed destined for a state mental health facility. After an extensive work-up by the local public guardianship program, Mr. A’s medications were effectively modified, resulting in more control of his anti-social behavior. He now lives in an assisted living facility. The public guardian also established Mr. A’s eligibility for the military veterans insurance program: TriCare-for-Life. Now his medications and his care in the assisted living facility are paid for by TriCare. A volunteer with the public guardianship program helps to engage Mr. A in social activities, such as checkers, a baseball game, a concert, and other social events. These activities have helped to reduce Mr. A’s acting-out behaviors and allowed him to remain stable in the assisted living facility. His story is an example of the effectiveness of Virginia’s Public Guardianship and Conservator Program.

Although the public guardianship program is operated through the Virginia Department for the Aging (VDA), the General Assembly also created a *Public Guardianship Program Advisory Board* to work with VDA in providing guidance to and oversight of the program. The Board provides these and technical assistance to the 16 local public guardianship programs and has helped develop regulations that guide the program’s operations.

More information about the public guardianship program can be obtained from Mrs. Janet James, Esq., the program director, at the Virginia Department for the Aging, 1610 Forest Avenue, Suite 100, Richmond, VA 23228. Her phone number is (804) 662-7049 and her e-mail address is

[janet.james@vda.virginia.gov](mailto:janet.james@vda.virginia.gov).

### ***The Hidden Epidemic* 2008 Conference DVD Available**

The Virginia Department of Alcoholic Beverage Control created the Alcohol and Aging Awareness Group (AAAG) in March 2007. The mission of the AAAG is to educate older adult consumers, their family members, and their service providers about the issues related to alcohol misuse and possible interactions between alcohol and medications in the aging population.

To accomplish its mission, the AAAG presented *The Hidden Epidemic, Alcohol, Medication and the Older Adult* conference on April 29, 2008. This conference was professionally recorded and is now available on a four disc DVD set. If you wish to purchase the DVD set as an educational resource for clients or a training tool for staff, please submit a check for \$35 made payable to: VA ABC, Education Section, 2901 Hermitage Road, Richmond, VA 23220, with DVD referenced in the memo section of the check. All proceeds from the DVD sales will be used for future educational trainings on the topic of alcohol, medication, and the older adult.



## Focus on the Virginia Center on Aging

Monica Hughes



Monica Hughes joined VCoA in September 2007 as Executive Director of the Lifelong Learning Institute in Chesterfield (LLI), which we co-sponsor with Chesterfield County Public Schools and Chesterfield County government. As the LLI's primary resource, she is responsible for managing the operation, developing course curricula and events, recruiting faculty, and coordinating volunteers.

Monica helped the LLI to mark its fifth anniversary in December 2008, with a special celebration after the holidays attended by charter and current members, county officials, directors, faculty and supporting individuals and organizations. This was, happily, no small feat, as the LLI has grown to a membership of 450 older adults and has, so far, offered over 700 'course' selections such as one-day and multiple-day classes, special events, guest speakers, and more.

The LLI is fundamentally both member-driven and member-taught, providing opportunities for mental, physical, and social stimulation for everyone involved. And so, besides the tremendous growth in membership, the LLI has been honored by over 300 faculty members who have contributed their time and knowledge in the classrooms. Moreover, several organizations have contributed substantially to

the success of the Institute by partnering in projects, information sharing, and fund-raising.

Working with the Board of Directors and volunteers, one of the primary responsibilities of the Executive Director is to develop the constantly evolving educational curriculum. Supporting these courses with qualified instructors, managing the daily operations, and promoting the program are also critical functions. With her rich work and volunteer history, Monica brings a well matched resume of experience to this position, presenting a balance of business acumen, education formation, and interpersonal skills. She has worked successfully in office management, master scheduling, accounting, human resources, curriculum formation, teaching, and church ministry.

Growing up in a family with ten siblings and raising four children of her own, she is no stranger to an active, dynamic environment. Monica has spent most of her life in Overland Park, Kansas, "second to the bottom" in a family with six older brothers, three older sisters, and one younger sister. This is where she experienced and learned that "there is always room for one more," whether it was a foreign exchange student, an unexpected guest at the dinner table, another stray cat or an extra friend climbing into a car already packed with 13 occupants (sometimes three deep to the seat) for the nine hour drive to see grandparents in Texas. One of the best things about growing up in a large family, Monica believes, becomes most apparent in times of great joy and celebration and in times of sadness. No matter the

occasion, there is always someone to share in it. "Of course," she adds, "most of the time the occasion was as simple as a weeknight family dinner, but there was definitely laughter and joy." She looks forward to any opportunity she gets to go back home to spend time with them.

Of course, it is not only her parents, siblings, and their families that draw her back home. Her oldest son, Marcus, brings her the delight of being a grandmother to two granddaughters, Karsyn (4) and Avery (2). They and their mom, Megan, currently live close to Monica's parents and siblings in Kansas City. She also boasts about and looks for chances to spend time with her two 'Hokie' daughters, Melissa and Lauren, who are studying at Virginia Tech. Knowing how quickly time passes, she, and her husband, Tim, enjoy every minute they can of their youngest daughter, Morgan, a freshman in high school.

When you spend any time with Monica, you quickly realize that she is a woman of many passions. She has a deep faith and works to live out that faith in her daily life. She loves people, from babies to great grandpas... and animals, the latter apparent by the menagerie that is part of her family. She hopes to add miniature cows, donkies, and goats soon. She enjoys festivals and fairs and art shows, experiencing different cultures and seeing the talents of others through what they have created with their hands. She loves eating out and baking in. One of her great pleasures is watching the face of someone when she delivers a specially decorated cake

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## Memory May Go Up in Smoke



Smoking is linked to an increased risk for memory deficit and cognitive (thinking, learning, remembering) decline in middle age, according to a

study published recently in the *Archives of Internal Medicine* and reviewed by Marlene Busko and Penny Murata, MD, in *Medscape Psychiatry*. Séverine Sabia, MSc, at the Institut National de la Santé et de la Recherche Médicale, in Villejuif, France, and colleagues found that, compared with study participants who had never smoked, after adjustment for other confounding factors, smokers were much more likely to show evidence of poor verbal and memory functioning, e.g., scoring in the lowest quintile on a memory test, being able to recall fewer than five of 20 words. Finding this link at midlife could support the hypothesis that smoking is involved in the pathogenesis of preclinical cognitive deficit and decline, which is a risk factor for later dementia.

Since populations are aging and the prevalence of dementia tends to increase with age, identifying modifiable risk factors is important. "Our results suggest that smoking had an adverse effect on cognitive function in midlife, [but] 10 years after smoking cessation, there was little adverse effect of smoking on cognition," Sabia stated. "Thus, public health messages should target smokers at all ages."

Sabia and her colleagues observe that a recent meta-analysis concluded that smoking is a risk factor for dementia, adding that it is problematic to study the link between smoking and cognition in older people because many study participants do not return for follow-up visits, or they die from smoking-related diseases. At the same time, there is increasing evidence that midlife risk factors play a role in later dementia.

### Does Smoking Affect Memory?

To answer this question, Sabia and her colleagues analyzed data from the Whitehall II study, which was designed to examine the relationships between socioeconomic and health and disease. Whitehall II enrolled 10,308 London-based civil servants (6,895 men and 3,413 women) aged 35 to 55 years at baseline (Phase 1) from 1985 to 1988. Cognition was assessed at Phase 5, when participants were aged 45 to 68 years (mean age, 55.5 years) and five years later, at Phase 7, when participants were aged 50 to 74 years (mean age, 61 years). Cognitive data from tests of memory, reasoning, vocabulary, and semantic and phonetic fluency were available for 5,388 participants at Phase 5 and 4,659 participants at Phase 7. Smoking was assessed at baseline and at Phase 5. At baseline, the smokers smoked an average of 14 cigarettes a day; 25% were light smokers ( $\leq 5$  cigarettes/day) and 25% were heavy smokers (1 - 2 packs/day), but only 27 participants smoked more than two packs/day.

### Four Key Findings

First, smoking in middle age was associated with memory deficit and decline in reasoning abilities. At Phase 5, after adjusting for sex, age, socioeconomic differences, health behaviors, and health measures, current smokers versus participants who had never smoked had a 37% greater risk of being in the lowest quintile of cognitive function.

Second, compared with smokers, long-term ex-smokers (those who had stopped smoking before the beginning of the study) had a 30% lower risk for poor vocabulary and low verbal fluency.

Third, giving up smoking in midlife was accompanied by improvement in health habits such as drinking less alcohol, being more active, and eating more fruits and vegetables.

Fourth, compared with nonsmokers, smokers were more likely to die by Phase 7 (an average 17.1 years of follow-up) or not to participate in cognitive tests, suggesting that non-participants had cognitive deficits and that, therefore, the association between smoking and cognition in late midlife could be underestimated.

Sabia and her colleague say that these findings are important because other research suggests that individuals with mild cognitive impairment progress to clinically diagnosed dementia at an accelerated rate. These researchers conclude that it is never too late to stop smoking. Based on the current study, "public health messages on

smoking should continue to target smokers at all ages."

*This study was supported by the British Medical Research Council, the French Ministry of Research, and the European Science Foundation. The Whitehall II study was supported by the British Medical Research Council; the British Heart Foundation; the British Health and Safety Executive; the British Department of Health; the National Heart, Lung, and Blood Institute; the National Institute on Aging; the Agency for Health Care Policy and Research; and the John D. and Catherine T. MacArthur Foundation Research Networks on Successful Midlife Development and Socioeconomic Status and Health.*

## **Chesterfield County Senior Ambassador Program**

Older adults in Chesterfield who wish to remain engaged in community service have a new way to be involved. The Senior Advocate's office will launch an 8-week program on February 25 called Senior Ambassadors. This eight-week course will allow adults 55 and older to broaden their knowledge of the county and to learn how they can use their creative energies to better the community through volunteerism and self-enrichment. The group will get a snapshot of the many different areas of Chesterfield County as the program will emphasize a different topic each week. To find out more about the program and to request an application, contact Debbie Leidheiser at (804) 768-7878.

## **It's More than a "Pie Hole"**



All the food we eat has to pass through the mouth, but

does the state of our teeth affect our food choices? Dr. Torgny Alstad has addressed this question, with respect to the dental health of older adults, in his Doctor of Dental Science thesis at the Institute of Odontology at the Sahlgrenska Academy in Sweden. The results, just published this winter, demonstrate that those with many teeth eat more fruit and vegetables, while those with fewer teeth drink more milk and eat more cake and biscuits.

"This may be due to the fact that it is difficult to chew when you don't have many teeth left. Difficulty in chewing also means that food remains in the mouth for a longer time, which also increases the risk of tooth decay, leading to an increased risk of losing even more teeth," explains Alstad.

### **The more teeth, the better the eating habits**

Carbohydrates, specifically, which form of carbohydrates one favors, appeared to be associated with the number of remaining teeth. Fructose, dextrose and fiber intake were linked to a greater number of teeth because of a greater intake of fruit and vegetables, known to be beneficial for dental and overall health. In contrast to these types of sugar, the intake of ordinary sugar and lactose was greater in those with fewer teeth because they ate more cake

and biscuits and drank more milk. "Since we in Sweden do not eat enough fruit and vegetables, and tend to eat too much ordinary sugar and confectionery, it is interesting to note that the number of teeth and the eating habits of the elderly are so closely linked. In other words, the greater the number of teeth possessed by the elderly, the better their eating habits. Although the intake of lactose was higher in those with fewer teeth, it was only ordinary sugar that was associated with the number of dental cavities," reports Alstad.

### **The link between dental status and disease**

Losing one's teeth increases the risk of developing bad eating habits, which then contribute to premature aging. But losing teeth also increases the risk of losing even more to dental caries. Alstad concludes, "Retaining your teeth, or restoring them, is, therefore, important not just for the teeth themselves but also for the rest of the body. It is, therefore, important for the dental services, as well as for health services in general, that methods are developed to identify and help those that have eating problems caused by poor teeth."

## Age-Related Farsightedness: You Are Not Alone

More than **one billion** individuals worldwide in 2005 had presbyopia, or age-related difficulty in seeing objects nearby, with an estimated 410 million with the condition unable to perform tasks requiring near vision, according to a report in the December 2008 issue of *Archives of Ophthalmology*, one of the *JAMA/Archives* journals.

Presbyopia occurs with age, as the eye's lens loses its elasticity and ability to focus on close objects. Although known physiology and population demographics suggest that presbyopia is common or nearly universal in people older than 65 years, direct estimates of prevalence are rare, say Brien A. Holden, Ph.D., D.Sc., of the University of New South Wales, Sydney, Australia, and colleagues in their article. The total number of people with presbyopia, of course, is a precursor to the number with impaired

vision due to uncorrected or under-corrected presbyopia, which, in turn, correlates with mobility, social interaction, health and overall functioning in daily life. Holden and colleagues analyzed multiple surveys to estimate the global prevalence of presbyopia, along with the rate at which the condition is corrected and the vision impairment caused when it is not. They then used the International Data Base of the U.S. Census Bureau to extrapolate estimates for the future.

### Confident Living Program for Senior Adults Who Are Hard of Hearing and Blind or Visually Impaired Helen Keller National Center, Sands Point, New York

**March 30- April 7, 2009**

*(Seniors arrive on Sunday, March 29 and leave on Tuesday, April 7)*

This one-week program has been specially designed for Senior Adults (age 55 and better) who are hard of hearing and blind or visually impaired, and who do not use sign language as their primary means of communication.

Participants in the 2009 program will obtain information and an introduction to skills in:

**Coping with hearing and vision loss**  
**Enhancing independent living skills**  
**Enhancing communication skills**  
**Experiencing new technology**  
**Emergency preparedness**  
**Utilizing Support Service Providers (SSPs)**  
**Having FUN**

**Self advocacy**  
**Elder law**  
**Community integration**  
**Leisure activity options**  
**Developing community resources**  
**Sharing life experiences with others**

**For an application and more information, please contact:**

Admissions Coordinator, Helen Keller National Center, 516-944-8900 V/TTY Ext: 258, [www.hknc.org](http://www.hknc.org)

**Program cost for tuition, room and board is \$800.**

# **ATTENTION VIRGINIA ALZHEIMER'S FAMILY CAREGIVERS!**

**The Department of Psychology and the Virginia Center on Aging at Virginia Commonwealth University are conducting a brief survey study of caregiving spouses or relatives of individuals coping with Alzheimer's disease.**

**This project concerns the psychological support needs of Alzheimer's family caregivers.**

For more information, please contact:

Kirk Warren Brown, PhD  
Virginia Commonwealth University  
Department of Psychology

Tel: (804)828-6754  
kwbrown@vcu.edu

**Caring for a spouse or relative with Alzheimer's disease offers special challenges, and this survey will help us design a high quality support program that better meets the psychological needs of Alzheimer's family caregivers in Virginia.**

**The survey will take about 10 minutes, and asks easy-to-complete questions about your caregiving experiences, challenges and stresses, and interests in various support program components.**

**Participants will have the opportunity to win one of five prizes of \$10 Amazon gift cards and to receive a copy of the survey findings.**

**Your timely participation in the survey is very important. Please contact the investigator to receive a hard copy of the questionnaire or complete the survey online at:**  
[www.alzpossible.org/survey.html](http://www.alzpossible.org/survey.html)



## COMMONWEALTH OF VIRGINIA

### Alzheimer's and Related Diseases Research Award Fund

#### DELAYED FINAL PROJECT REPORT FROM THE 2007-2008 ALZHEIMER'S RESEARCH AWARD FUND

The Alzheimer's and Related Diseases Research Award Fund (ARDRAF) was established by the Virginia General Assembly in 1982, and is administered by the Virginia Center on Aging at Virginia Commonwealth University. The summary of a delayed final project report funded during the 2007-2008 round of competition is given below. To receive the full report, please contact the investigators or the ARDRAF administrator, Dr. Constance Coogle ([ccoogle@vcu.edu](mailto:ccoogle@vcu.edu)).

**VCU Richard A. Glennon, Ph.D. (Dept. of Medicinal Chemistry, School of Pharmacy) "Positive Allosteric Modulators of Cholinergic Receptors"**

Alzheimer's disease is related, in part, to a deficiency in the neurotransmitter acetylcholine in relevant brain areas. Acetylcholine activates several types of brain receptors, and one current treatment modality is to prevent the degradation of acetylcholine by agents that block its metabolism (i.e., cholinesterase inhibitors). This "shotgun" approach can lead to undesirable side effects. Another approach would be to activate selected acetylcholine receptors using a novel agent. There are growing implications for the involvement of the nicotinic acetylcholine (nACh) receptor type. Unfortunately, there are multiple subtypes of these receptors making it difficult to specifically target the particular receptor subtype of interest. A natural product, desformylflustrabromine (dFBr), isolated in small quantities from a marine organism, was found to potentiate the effects of ACh. But it does so through a unique mechanism that does not involve direct receptor activation (i.e., it is a positive allosteric modulator). Being the first member of a novel mechanistic type of agent that selectively activates the actions of ACh at the target nACh receptor subtype of interest (i.e.,  $\alpha 4\beta 2$  nACh receptors), it offered a new target for exploitation. The purpose of this work was to a) synthesize a sufficient quantity of dFBr as a water-soluble salt for pharmacological study, and b) identify which structural features are important for activity. The first goal was achieved, and structural features important for the potentiating action were identified. NIH funding is now being sought in order to utilize the information obtained so that activity might be optimized. (*Dr. Glennon can be reached at 804/828-8487*)

## Beard Center on Aging at Lynchburg College Upcoming Events

**February 5, 12, 19, 26 &  
March 5, 2009**

Winter educational series entitled the "Life Course: Mini Series on Healthy Aging." Programs are held each Thursday at 3:30 p.m. at Brewer Townhouse Meeting Room on the Lynchburg College campus. Programs will address healthy aging, financing help when you need it, aging in place: tricks of the trade that help you maintain independence, fall prevention and safety, and making end-of-life decisions and talking with family members about your desires. Free.

**June 9, 2009**

The Beard Center on Aging, in partnership with Centra, is sponsoring a Conference on Aging on Tuesday, June 9, 2009. This year's theme "Fearless Aging" will address, among others, coping with economic uncertainty, fall prevention, developing resiliency and positive self esteem, preventing elder victimization, practicing forgiveness, coping with the end of life and death, making the most of your personal resources (time, money, energy and abilities), and soul work and empowerment for aging women. Eve Reid, author of "Fearless Aging" and Dr. Peter Betz, Centra psychiatrist who specializes in geriatrics, will serve as keynote speakers for the conference. The conference will be held at the Lynchburg College Campus.

For additional information on either program, call (434) 544-8456 or [scruggs.dr@lynchburg.edu](mailto:scruggs.dr@lynchburg.edu).

## Circle Center Adult Day Has A New Home

After nearly 33 years of service to the Richmond community in leased space and five years of planning, Circle Center Adult Day Services moved in January 2009 to property it purchased at 4900 Marshall Street, located near the Willow Lawn shopping center. The Center occupies a totally renovated 15,000 square foot state-of-the-art facility. An additional 11,000 square feet have been leased until needed for further expansion. The Circle Center's new location allows for increased participant capacity to meet the growing demand for reliable, affordable eldercare. It is designed for the comfort and enjoyment of participants and staff who spend the day together, while families work or take a break from 24-hour caregiving. The \$4.3 million project is being accomplished with widespread support from foundations, corporations, service organizations, faith communities, state and local governments, and generous individuals.

Circle Center, a licensed adult day healthcare center, offers caregivers of dependent older adults quality daytime care for up to 10 hours for a fraction of the cost of in-home care. The Center is open Monday through Friday from 7:30 a.m. to 5:30 p.m. and Saturday from 9 a.m. to 5 p.m. It specializes in care for persons ages 50 and more who are frail and/or functionally impaired, e.g., have Alzheimer's, Parkinson's, or have had a stroke, as well as others who need care and supervision. Each day includes a full schedule of therapeutic activities, nutritious

meals and snacks, health monitoring, medication management, personal care assistance, and interaction with peers. Caregiver support and educational services will continue to be vital to the partnerships between the Center and families it serves.

The Center is adding two new opportunities to its schedule of services and activities for participants and caregivers. One is a *wellness program* that provides dedicated space and staff for activities such as participant flexibility, strength and balance, chair yoga, relaxation, and other wellness services. The second one is an expanded *Montessori-based memory support program* and the addition of a *Snoezelen* (multi-sensory) environment.

For more information or to schedule a tour, call Ann Spinks, social worker, at (804) 355-5717 or visit the website at [www.circlecenter-ads.org](http://www.circlecenter-ads.org).

## Time Goes By Website

Time Goes By ([www.timegoesby.net/weblog/](http://www.timegoesby.net/weblog/)) is a site that subtitles itself *What it's really like to get older*. This may be a bit of exaggeration but the bloggers who contribute to it, the subject matter, and the focus are decidedly older. Recent visits to Time Goes By (TGB) found TGB Geriatrician, a bi-monthly column by Dr. Bill Thomas, founder of the Eden Alternative in long-term care; TGB Features, including tabs for Best Books on Aging; Elder Video, where most anything depicting elders, such as commercials, might be discussed; Geezer Flicks, which contains comments on films about aging or with older actors; and a section called The Elder Storytelling Place, where short stories and vignettes may be contributed by adults ages 50 and older. A recent contribution entitled the "Bride of 5th Avenue" described a momentary meeting between strangers, doing so with a poignancy and perspective most likely gained from years of observing life. A commentator who calls herself Crabby Old Lady in a column titled "Do Elders Gain Rosier Memories with Age?" critiqued the conclusions reported in *Science Daily* of a Duke University study of elders' memories of negative images they were shown during the research. The report generalized that older adults tend to see the past through rose-colored glasses because they live in a world of negatives. Crabby Old Lady deftly questioned the conclusions and the assumptions behind them. Because Time Goes By is a blogging space, there is a stimulating diversity of opinions and the content remains alive.

COMMONWEALTH OF VIRGINIA

Alzheimer's and Related Diseases Research Award Fund

THE VIRGINIA CENTER ON AGING  
VIRGINIA COMMONWEALTH UNIVERSITY

- Purpose:** The Commonwealth of Virginia established the Award Fund in 1982 to promote research into Alzheimer's and related diseases. Because of a commitment to program balance, the Fund encourages scientifically rigorous applications from a broad spectrum of disciplines. Studies may involve:
- (1) the underlying causes, epidemiology, diagnosis, or treatment of Alzheimer's and related diseases;
  - (2) policies, programs, and financing for care and support of those affected by Alzheimer's and related diseases; or
  - (3) the social and psychological impacts of Alzheimer's and related diseases upon the individual, family, and community.
- Funding:** The size of awards varies, but is limited to \$40,000 each. Number of awards is contingent upon available funds.
- Eligibility:** Applicants must be affiliated with colleges or universities, research institutes, or other not-for-profit organizations located in Virginia. The Fund encourages partnerships between community-based agencies/facilities and academic institutions.
- Schedule:** A non-binding letter of intent with tentative title, non-technical abstract, and a 4-5 sentence description of the project in common, everyday language for press release purposes ***must be received by March 6, 2009***. Letters on letterhead with signature affixed will be accepted electronically. Applications (hard copy required; with an *additional* electronic copy e-mailed subsequently) will be accepted through the close of business April 1, 2009, and applicants will be notified by June 19, 2009. The funding period begins July 1, 2009 and projects must be completed by June 30, 2010.
- Review:** Three qualified technical reviewers, one of whom is identified by the applicant, will review proposals for scientific merit. The Awards Committee will make the final funding decision.
- Application:** Application forms, guidelines, and further information may be obtained on the World Wide Web (<http://www.vcu.edu/vcoa/ardraf.htm>) or by contacting:

Constance L. Coogle, Ph.D.  
Alzheimer's & Related Diseases Research Award Fund  
Virginia Center on Aging  
P. O. Box 980229  
Richmond, Virginia 23298-0229  
Phone: (804) 828-1525  
Voice Mail: (804) 828-2243  
FAX: (804) 828-7905  
E-Mail: [ccoogle@vcu.edu](mailto:ccoogle@vcu.edu)



## Religion, Aging, and Spirituality

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Dr. Henry Simmons, Director of the Center on Aging at Union-PSCE (Union Theological Seminary and Presbyterian School of Christian Education) in Richmond, has patiently and carefully compiled one of the finest annotated bibliographies in the English language on religious and spiritual matters in later life. He calls his work “An Online Annotated Bibliography for *graceful aging*,” which is far too modest for this trove of resources or for the on-going labor that has gone and continues to go into producing it. Dr. Simmons and several colleagues have worked diligently to create this remarkable gift. Visitors to his website <http://gargoyle.union-psce.edu/aging/> encounter an impressive set of precisely annotated items, including books, articles, dissertations, chapters, and more, such as a featured article on the site’s opening page. To aid in one’s search of the materials, Dr. Simmons has organized the site into nine sections:

1. Church and Synagogue
2. Empowerment
3. Ethics
4. Personal Spiritual Growth
5. Life Review and Written Reminiscences
6. Death and Dying
7. Theology, Bible, Other Religions, History and Primary Source Documents (pre-1936)
8. Religious Professionals
9. Special Populations

Visitors can search materials by author, publication title or subject;

can submit works for annotation; and can request materials on loan. The Caregiving subsection, under the Church and Synagogue section, alone currently contains 219 entries, while the separate but related subsection of Filial Responsibility holds another 111 entries on such topics as understanding aging parents, cultural norms in caring, and nursing home care. All entries in this annotated bibliography are organized according to the call number in the Center’s collection.

This bibliography goes beyond ritual in organized religious traditions, embracing a broad conception of spirituality and spiritual life. The section on Personal Spiritual Life, for example, contains entries on meditations, devotions, and reflections on life’s meaning, with separate subsections for entries from those identified as an older adult (“senior”) and those not so identified. There’s also a small section on non-Western religious traditions which contains entries on such topics as the Sufi poet Rumi’s poetry on aging and Buddhist memorial observances.

Sensitive to the demographic evolution in later life, this website also has a section titled Special Populations, where one finds annotations of 169 works addressing the religious and spiritual needs of older adults with Alzheimer’s disease or other dementias, as well as the needs of adults who grow older with lifelong disabilities.

## Monica Hughes, continued

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she has made just for them.

Although her greatest joy is spending time with her family and friends, Monica shares an appreciation for lifelong learning with the LLI membership, seizing every opportunity she can to explore a new topic or uncover a new passion. A recent class reinforced the delight she finds in painting. With a personal excitement for lifelong learning, she knows first hand that it can nurture a person’s mental, physical, and emotional well being, contributing to an overall higher quality of life. She treasures being a part of an incredible organization that provides this opportunity for others.

## Calendar of Events

### January 28, 2009

*Virginia Center on Aging Annual Legislative Breakfast.* St. Paul's Episcopal Church, 815 East Grace Street, Richmond. 7:30 a.m. to 9:00 a.m. For information, call (804) 828-1525 or [eansello@vcu.edu](mailto:eansello@vcu.edu).

### February 5-6, 2009

*Second Annual Conference on Geriatric Care.* Sponsored by the University of Virginia and others. DoubleTree Hotel, Charlottesville. 8:30 a.m. - 4:30 p.m. each day. This year's theme is Sharing the Challenge: Innovations in Senior Care. For more information, contact Emily Hopkins at (434) 243-4849 or [EAH9S@hscmail.mcc.virginia.edu](mailto:EAH9S@hscmail.mcc.virginia.edu).

### February 6, 2009

*Eighth Annual Ronald Reagan Birthday Bash.* Presented by Nicole Riley and Young Adults for Alzheimer's Awareness to benefit the Alzheimer's Association Greater Richmond Chapter. The Colony Club, Richmond. 8:00 p.m. - Midnight. For more information, contact Nicole Riley at (804) 916-7113 or [Nicole.Riley@LeClair-Ryan.com](mailto:Nicole.Riley@LeClair-Ryan.com).

### February 17, 2009

*What Happens When You Leave the Hospital?* Sponsored by the Chesterfield Senior Advocate's Office & Senior Connections. Central Library, Chesterfield County. 1:00 p.m. For more information, call (804) 768-7878.

### February 21-22, 2009

Virginia Pharmacists Association's Midyear Meeting. Hotel Roanoke, Roanoke. For more information, call (804) 285-4145 or visit [www.vpha.affiniscap.com](http://www.vpha.affiniscap.com).

### February 26-March 1, 2009

*35th Annual Meeting and Educational Leadership Conference of the Association for Gerontology in Higher Education.* Crowne Plaza-Riverwalk, San Antonio, TX. This year's theme is Deep in the Heart of Aging: Promoting Healthy Futures through Education and Training. Preliminary program and registration information are available at [www.aghe.org](http://www.aghe.org).

### March 15-19, 2009

*Aging in America. 2009 Annual Conference of the American Society on Aging and the National Council on Aging.* Las Vegas, NV. For more information, contact ASA Customer Service at (800) 537-9728 or visit [www.agingconference.org](http://www.agingconference.org).

### April 6-7, 2009

*Virginia Association for Home Care and Hospice's 26th Annual Conference and Trade Show.* Renaissance Hotel, Portsmouth. For more information, call (804) 285-8636.

### April 7, 2009

*The Hidden Epidemic: Alcohol, Medication, and the Older Adult Best Practices 2009 Conference.* Virginia Commonwealth University Student Commons, Richmond. 9:00 - 4:30. For more information and to register, go to [www.abc.virginia.gov/educationapp/course\\_detail.jsp?schedule\\_id=631](http://www.abc.virginia.gov/educationapp/course_detail.jsp?schedule_id=631) or call Regina Whitsett at (804) 213-4445.

### April 16-19, 2009

*30th Anniversary Meeting of the Southern Gerontological Society.* Hilton St. Petersburg Bayfront, St. Petersburg, FL. This year's theme is "Past as Prologue." Preliminary program and registration information are available at [www.southerngerontologicalsociety.org](http://www.southerngerontologicalsociety.org).

### April 29, 2009

*6th Annual A Round to Remember.* Golf tournament to benefit the Alzheimer's Association Greater Richmond Chapter. For more information, call (804) 967-2580 or visit [www.alz.org/grva](http://www.alz.org/grva).

### May 19-22, 2009

Virginia Association of Nonprofit Homes for the Aging's 36th Annual Conference & Tradeshow. The Williamsburg Lodge, Williamsburg. For more information, call (804) 965-5500 or visit [www.vanha.org](http://www.vanha.org).

#### Age in Action

Volume 24 Number 1  
Winter 2009

**Edward F. Ansello, Ph.D.**  
Director, VCoA

**Linda Nablo**  
Commissioner, VDA

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

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

**Spring 2009 Issue Deadline:  
March 15, 2008**

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at Virginia Commonwealth University, Richmond, Virginia

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

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## 2009 Joint Conference on Guardianship, Elder Rights, and Disability Services

Presented by  
**Virginia Guardianship Association and Virginia Elder Rights Coalition**  
**April 27-28, 2009**  
**Sheraton Richmond West Hotel**

**Keynote Speaker:** Paul Greenwood, Esq., Deputy District Attorney, San Diego  
*Debunking Misconceptions Surrounding the Investigation and Prosecution of  
Criminal Elder Abuse Cases*

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