

Case Study

Safe Driving for the Mature Adult: Selected Issues

by Rebecca Parsio, RN
Virginia Department of
Motor Vehicles

Educational Objectives

1. Examine issues related to aging and driving assessment.
2. Review Virginia's Mature Drivers Study.
3. Discuss the levels of care for prevention of driving disability and resources available at each level.
4. Explore the impact of medications and substances (both prescribed and not prescribed) on driving ability.

Background

The baby boomer generation is entering retirement years living longer and being more active than any previous generation. These older adults are expressing a desire and an expectation that they will remain mobile in their community and enjoy the associated freedoms that come from driving for as much

of their lifespan as possible. At the same time, regardless of profession, most service providers will be working with older adults in the next several decades. So, understanding the public health implications of an aging population and applying levels of prevention are essential to reducing injuries among older drivers.

Virginia's Mature Driver Initiative

Anticipating the increase in the number of mature drivers in the Commonwealth, and recognizing the need to help older drivers stay safe on Virginia's roadways and prevent crashes, in January 2013, Chairman Joe May, House Transportation Committee, and Chairman Stephen Newman, Senate Transportation Committee, charged the Department of Motor Vehicles (DMV) with examining the research and data available to determine whether the Commonwealth should adopt additional criteria in current license renewal requirements, as a means of assessing mature drivers' capability to remain safe on the road as they age.

The request from Chairmen May and Newman was in response to the Federal Highway Safety Program Guideline (#13) issued by the National Highway Traffic Safety Administration (NHTSA, 2012). This advises that each state, based on its own demographics, should develop a comprehensive highway safety program for older drivers in an effort to reduce crashes, injuries, and death. Consequently, DMV established the Mature Drivers initiative, with an executive oversight committee and a stakeholder committee to study the issues outlined in the charge letters from Delegate May and Senator Newman. The Commissioner of the DMV led the executive oversight committee, which included representatives from other state agencies and institutions of higher education. DMV staff provided the administrative support. The stakeholder committee comprised more than 30 additional participants who contributed expertise from their respective fields, including various health professions, senior care agencies, state agencies, law enforcement, insurance, safety organizations and concerned citizens.

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The Work of the Committees

The stakeholder committee was tasked to examine three main topic areas and each became a focused subcommittee: driver licensing requirements, the DMV medical review process, and existing outreach and education resources. The three subcommittees compiled extensive research and relevant data from other states and requested assistance from leading researchers in the area of traffic safety, such as the National Highway Traffic Safety Administration, The University of Virginia, and TransAnalytics, LLC. The subcommittees met repeatedly throughout the year, compiling findings for the DMV. The DMV issued its full report, *Mature Drivers Study – 2013 Report*, in November 2013 with an appendix of over 20 pages of suggested legislation. The Report's Executive Summary is at: <http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/61e49ff4b0fa765485257c37007334b0?OpenDocument>.

Key Findings

The Mature Drivers Study led the DMV and other agencies to adopt the philosophy of function rather than age as a determining factor when deciding when an individual should continue to drive. Drivers may be safe or unsafe behind the wheel at any age. In general, younger, more inexperienced drivers tend to have the worst driving records, and experienced, middle-age drivers tend to have the best. Compared with younger drivers whose motor vehicle crashes are frequently related to inexperience or risky behaviors, crashes by older

adult drivers tend to be related to the slowing of reaction time and visual processing speeds (NHTSA, 2009b). Contributing factors in motor vehicle crashes by older adults include failure to heed signs, keep in lanes, and grant the right-of-way and improper left-hand turns (Owsley et al., 2013). These issues may be related to difficulties judging the distance and speed of other vehicles and determining the space and time needed to execute a maneuver.

It is clear that driving skills tend to decline as a driver ages (Owsley et al., 2013). An identifiable decline is especially noted in mature drivers who take certain medications or have conditions associated with the aging process, such as vision problems, cognitive changes, or diseases that diminish physical agility (Ball, Roenker, et al., 2006; NHTSA, 2009a; Substance Abuse and Mental Health Services Administration, 2012). Declines that occur, however, tend to happen in different drivers at different times.

The Mature Drivers Study noted that the number of older adult drivers is increasing at a rapid pace (3% a year for the next 10 years) and that these adults spend more time behind the wheel than any previous generation. Many (but not all) older adult drivers self-regulate their driving. While driving cessation is inevitable for most adults, it is often associated with poor outcomes such as self-neglect and malnutrition. Care providers need to approach the assessment of older drivers and the recommendation to cease driving with a tiered approach. We know that a mature driver who experiences a motor

vehicle crash is much more likely to experience injury or death; this is true for both the driver and the passenger (NHTSA, 2009b; Owsley et al., 2013). The interest of both the driver and the public must be considered when determining fitness to drive.

Legislative Actions

In response to this study, House Bill 771 passed the General Assembly during the 2014 General Assembly session. The bill lowered the age at which drivers are required to renew their licenses in person from 80 to 75, and requires that licenses issued to persons ages 75 or older be valid for no more than five years. It further requires that renewal take place in person (rather than by mail or on-line) every five years and that the individual must take the vision test when renewing. Additionally, judges were given the option to order mature drivers to take a mature driver motor vehicle crash prevention course when adjudicating defendants. The mature driver motor vehicle crash prevention course is a course for persons ages 55 and older that has existed for several years in VA. The legislation became effective January 1, 2015.

The Mature Drivers Study outlines many additional recommendations for raising awareness and conducting outreach to the health care, law enforcement, and community providers. Virginia agencies participating in the study recommended making www.granddriver.net a hub for awareness efforts and resource information.

Levels of Prevention with Driving Disability

The American Geriatrics Society, in partnership with NHTSA, recently published the third edition of *Clinician's Guide to Assessing and Counseling Older Drivers* (American Geriatrics Society & Pomidor, 2016). They recommend adopting a public health injury prevention model to assess and counsel drivers who show diminished capabilities behind the wheel. Efforts should occur at the primary, secondary or tertiary levels depending upon the individual driver.

Primary prevention refers to assessing the older adult and referring him or her to resources that can intervene in order to prevent the loss of driving ability. For instance, the American Automobile Association has an online tool, CarFit, which is useful in keeping skills fresh. It is a program that helps the older adult with modifications that make interface with the vehicle functional. CarFit technicians can be located through either the American Automobile Association or the Virginia Department of Aging and Rehabilitative Services website.

Secondary prevention addresses the issues that may have caused a loss of driving ability. This may mean modifying medication regimens, referring for substance abuse treatment or sending a driver to a rehabilitation specialist who can assist with skill remediation or vehicle modifications. (We discuss secondary prevention in greater detail later.)

Tertiary prevention focuses on the cessation of driving when skills

have diminished and are irretrievable. This can be traumatic to a driver because loss of driving represents a loss of independence. When making this recommendation, it is vital to assess for changes in self-care and evidence of depression. Alternative means of transportation should be explored, as should alternative means of obtaining needed services, such as meals on wheels. The Commonwealth of Virginia has developed a website that can point providers and caregivers to resources available: www.granddriver.net.

Some Clinical Risk Factors: “Red Flags” That May Indicate Impaired Driving

A review of systems can reveal symptoms that may interfere with driving. For example, a recent loss of consciousness, reports of confusion, or muscle weakness are all signs that there may be an issue that can interfere with driving. Some of the potential indicators include:

- Recent history of falls
- Impaired sensation in the extremities
- Loss of visual acuity or cuts in the visual field
- Functional impairment in the extremities
- Decreased ability to turn one's head to check the blind spots
- Decline in cognitive ability (executive function, short-term memory)
- Poor judgement
- Distractibility

These and other causes for concern may be reflected in reports from family or friends of a decline in driving ability, such as turning from

the wrong lane; pedal confusion; hitting curbs during parking; inappropriate stopping; inappropriate use of turn signals; failure to obey stop lights, stop signs, yield signs; unusual violations; dings or dents in the vehicle; getting lost; driving on the wrong side of the road, and more. Of course, the best predictor of a future crash is a history of a crash.

Case Study #1

Mr. Jones is a 68-year old man who drove a tractor trailer for 40 years. He gave up his Commercial License two years ago after suffering a stroke and has not driven his personal vehicle since. The stroke left him with decreased visual ability and weakness on the left side of his body. His physician recognizes that his ability to drive may be affected by both his vision and physical limitations, and that his cognitive function will also need to be evaluated. Dr. West refers Mr. Jones to a Certified Driving Rehabilitation Specialist who is able to perform a comprehensive evaluation of driving ability and recommend vehicle modifications. In this case, Mr. Jones demonstrates intact cognition, but the specialist notes that the left-sided weakness impairs Mr. Jones' ability to use a turn signal and turn his head. The specialist arranges for Mr. Jones to have a turn signal adaptor and additional mirrors added to his vehicle. Mr. Jones then spends 10-12 hours with the specialist adapting his driving to the equipment. He is referred to a vision specialist to ensure that his vision still meets State Code requirements. Once cleared by the specialist and his physician, Mr. Jones contacts DMV to arrange for

testing. He is successful with both the knowledge and road skills examinations and, therefore, receives his driver's license with the restrictions for an automatic transmission and adaptive equipment.

General Recommendations for Secondary Interventions

When an older adult has difficulty maintaining driving ability, there are a number of approaches that may remedy the condition. Perhaps there is an underlying medical condition that can be treated. Both acute and chronic conditions can affect driving. For example, a driver with insulin dependent diabetes has a chronic condition and, with proper care, can operate a vehicle safely. If, on the other hand, this same driver has a history of poor control and multiple hypoglycemic episodes, the driver is at high risk for an acute event. Driving may need to be curtailed while he or she improves self-care and reduces the risk of an acute episode.

A complementary approach is to isolate and identify specific functional deficits to determine the sources of deficit, and then to correct the source, if possible. For example, if reaction time is slowed and a medication is identified as a possible cause, it may be possible to change the medication, reduce the medication or consider eliminating the medication. If the functional deficit can be addressed through vehicle modifications, such as hand controls or a left foot accelerator, refer the individual for a driving evaluation with a Certified Driving Rehabilitation Specialist. For acute or episodic illnesses like

a seizure disorder, clinical judgment and specialist input are advised. See related Virginia DMV policies on the DMV website:

www.dmv.virginia.gov/drivers/#medical/index.html.

It's important to talk openly with older adults we are close to about the risks and having a plan for when driving cessation becomes necessary. Monitor the individual and make referrals for evaluation when a decline is evident. Move to the tertiary level and advise against driving if an individual's skill loss becomes irreversible and is incompatible with safe driving. The publication cited earlier, *A Clinician's Guide to Assessing and Counseling Older Drivers*, contains a section on communicating with drivers and their families.

Medications and Driving

Medications are especially relevant in any discussion of older drivers, for older adults often have one or more chronic health conditions which necessitate prescriptions and older bodies can present special challenges to the intended outcomes of various drugs. The impact of multiple comorbidities in the driver is the subject of ongoing research. What is known is that some conditions have been associated with driving impairment because of both symptoms and treatment, for instance, orthopedic injury treated with opioids. Older adults often not only take more medications but also are more susceptible to unwanted side effects. The Beers Criteria lists medications that can be inappropriate for the older adult and should not be used or, if taken, should be monitored

closely. First developed by Dr. Mark Beers in 1991 and subsequently maintained by the American Geriatrics Society, the list identifies medications that are potentially inappropriate for older adults. The list is useful when checking a driver's medications. While the Beers List is complicated, being intended for health care professionals, those who care about older drivers with declines in their driving ability, should be aware of it and include it in discussions with the driver's health care providers. A sample can be found at: www.pharmacist.com/node/84786.

Adverse effects of certain medications, such as drowsiness, can affect the ability to focus and drive safely. Whenever a new medication is prescribed or the dosage of a current medication is changed, it is important to educate the individual about the drug and have him or her avoid driving until the effects of the drug are known. Older adults are particularly vulnerable during medication changes because they may already have delayed reaction time or cognitive processing speed and the combination of existing physical or cognitive losses with medication induced losses can lead to seriously impaired driving. Whenever possible, clinicians should select medications that will not affect driving performance. Also, when prescribing new medications, clinicians should always consider the individual's existing medication profile of prescription and nonprescription medications. Additionally, even older adults should be screened for substances that are not prescribed such as alcohol. Drugs in combination may produce interactions together that would not normally

impair driving individually.

Many seemingly innocuous medications can have effects when taken by older adults. A non-exhaustive list of drug classifications that are known to impair driving include: anticholinergics, anti-convulsants, antidepressants, antiemetics, antihistamines, antiparkinson agents, antipsychotics, Benzodiazepines and non-benzodiazepine hypnotics, muscle relaxants, and narcotic analgesics. Of particular concern are benzodiazepines when they are used in conjunction with opioids.

Case Study #2

Anna Smith is a 74-year old woman who is being treated for chronic back pain and insomnia. She is also currently receiving chemotherapy for breast cancer. Her medications list includes opioid pain medication and a sleep aid. In addition, she takes medication for urinary incontinence and mild glaucoma.

DMV receives a report that Mrs. Smith was found unconscious on the side of the road, so it requests a medical report from her physician. Mrs. Smith is adamant that she accidentally took a sleeping pill in the morning instead of at night and that this is the reason she fell asleep behind the wheel. The medical report, however, while citing the medication error, also noted cognitive changes, possibly dementia. DMV asked Mrs. Smith to undergo a knowledge exam, which includes a road sign recognition portion and a section on general knowledge of the rules of the road. After three attempts at taking this examination, she was unable to pass. She was

then referred for a driving rehabilitation evaluation which she was unable to pass. As a result, the DMV informed Mrs. Smith that she would no longer be allowed to drive. While the crash may have been related to a medication error, an underlying health condition contributed to the error. Two years later, Mrs. Smith contacted DMV and asked to be reevaluated. She was referred and retook a comprehensive driving evaluation which she completed successfully. She was allowed to retest for her license and was restored. In a later conversation with Mrs. Smith, she reported that once she finished chemotherapy and cut down on the amount of opioid medication, she felt like her “head cleared.”

Alcohol and Medications

According to the Substance Abuse and Mental Health Services Administration, substance abuse in the older population is on the rise (SAMHSA, 2012). Clinicians often fail to identify substance abuse, however, because it has not been on their radar. The substance most often abused is alcohol. One serving of alcohol (1.25 oz. liquor, 12 oz. beer, or 5 oz. glass of wine) can impair driving ability in many older adults. Age-related physiological changes such as an increase in body fat and a loss of lean muscle make an older adult more vulnerable to the effects of alcohol. Alcohol consumption can exacerbate a number of health conditions like cirrhosis, malnutrition, GI bleeding, hypertension, and depression. Older adults may be impaired without being aware of it because, while their intake is unchanged, the substance is no longer processed by the

body in the same way.

Alcohol is not the only cause of intoxicated driving but it is the most common. Other substances including marijuana, cocaine, opiates, and benzodiazepines may also impair driving skills, especially when used in combination. What may look like a cognitive change may be a substance abuse symptom. According to SAMSA, older adults, contrary to popular belief, do respond to interventions targeting substance abuse issues.

Conclusion

Many older adults can and do drive safely. It is important to keep in mind that every driver is likely to reach a point where it is best to consider retirement from driving. Planning for this eventuality well before it occurs can make the transition to non-driving status easier. Providers of all types should be willing to address this difficult topic with the people they serve.

An individual’s diminishing capability behind the wheel should be addressed at different levels of prevention specific to the person’s needs. Often, driving cessation is gradual and begins with reduced or restricted driving. Some driving skills can be remediated and the goal should always be to allow for as much independence as is safe. Additionally, some causes of diminished capability can be identified and addressed. Ultimately, however, concerned family members and professionals need to be willing to say “no” to driving when the time comes where it is no longer safe for an individual to drive without risk to his or her own safety and the

safety of others.

Study Questions

1. What factors can affect driving performance as a person ages?
2. What are the key recommendations of the Mature Drivers Study?
3. How do the considerations of an older driver's diminished capabilities affect which interventions to initiate?
4. Are there appropriate referral resources that you can identify?

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About the Author



Rebecca has worked for the Commonwealth of Virginia for 20 years, initially with the Virginia Department of Health and most recently with the Virginia Department of Motor Vehicles. She is the Healthcare Compliance Officer for DMV and works with the public to ensure fitness to drive. E-mail her at Rebecca.Parsio@dmv.virginia.gov.

Editorials

From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

Meeting Aging-Related Needs in 2016

Our Virginia Center on Aging has four program focuses. All benefit from partnerships, community, institutional, business, and individual. These programs are (alphabetically): dementia, elder abuse and domestic violence in later life, geriatrics education, and lifelong learning. Each achieved substantially in calendar 2016.

A. Dementia. VCoA administers the **Alzheimer's and Related Diseases Research Award Fund (ARDRAF)** for the Commonwealth as a seed grant program to help Virginia researchers investigate promising lines of inquiry into the causes, consequences, and treatments of dementing illnesses. Researchers submit proposals, which we have screened and evaluated by third party reviewers both in Virginia and around the world, depending on the research topic of the proposal. Often, awarded researchers use their pilot findings to obtain far greater awards from NIH and other federal and foundation sources, returning many times our investment in them.

In calendar 2016 we granted seven ARDRAF awards. These included the following recipients and research topics: Christopher Newport University: blood lipid profiles and olfaction in a mouse model of Alzheimer's Disease; Uni-

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versity of Virginia (UVA): mechanistic link underlying amyloid beta, nutrient signaling, and mitochondria dysfunction; UVA: brain structure volume and the APOE gene in early and advanced Parkinson's patients with dementia; Virginia Tech: diverse approaches to caregiving for persons with Alzheimer's disease living in Appalachia; VCU: the influence of tau on hippocampal inhibitory neurons and pathological synaptic connections; VCU: use of antipsychotic medications among older adults with dementia residing in assisted living facilities; and College of William and Mary: altered gene expression in Huntington's disease. Importantly, a generous gift from the family of Mabel Sullivan in Fredericksburg enhanced these awards.

ARDRAF has grown to be the most effective state-funded research program in the United States and a significant lever for research on dementia in Virginia, with researchers subsequently returning to Virginia an average of \$9.75 for every \$1.00 of General Fund appropriation.

B. Elder abuse and domestic violence in later life. VCoA in 2016 administered three externally funded projects related to these too-often overlooked issues. 1) In the **Virginia Elder Justice Training and Services** project, VCoA partnered with the Virginia Department on Aging and Rehabilitative Services and other statewide and local collaborators on a local/statewide elder abuse training and collaboration project, funded by USDOJ Office on Violence Against Women. The project operated in southwest Virginia in Washington County and

the City of Bristol, and ran from October 2012 through September 2016. In 2016, we staffed local monthly meetings of the Coordinated Community Response Team subcommittee for Abuse in Later Life, working with these partners to review policies and procedures to ensure that they include considerations for older victims; coordinated multidisciplinary trainings for law enforcement and victim services in Bristol; and, importantly, provided technical assistance to our local partners in their successful efforts to secure funding to continue their new services beyond the life of the grant.

2) VCoA received continuation funding in 2016 for the **Central Virginia Task Force on Domestic Violence in Later Life Project**, through the Virginia Services, Training, Officers, Prosecution (V-STOP) Violence against Women grant program, administered by the Virginia Department of Criminal Justice Services (DCJS). We are working with partners to develop a comprehensive, coordinated, and cross-trained community response to domestic violence and sexual assault in later life. In 2016 we conducted seven site visits/consults to partner agencies; served on five task forces and coalitions; trained 166 law enforcement, allied service professionals paraprofessionals, judicial/court personnel, and volunteers; worked in Multi-Disciplinary Teams in three jurisdictions to provide stronger collaboration among law enforcement, Adult Protective Services, and local service providers; served as the Team Organizer for the Metro Richmond Adult Fatality Review Team (MRAFRT), the first in Virginia, to finalize its

mission statement and operating guidelines; and much more.

3) In the **Family Violence Project**, VCoA, as lead agency, received continuation funding through the Virginia Domestic Violence Victim Fund, DCJS, to develop a coordinated community response to family violence in later life, employing initiatives similar to the V-STOP project above. In 2016 we conducted six site visits/consults and technical assistance to partner agencies; served on four task forces and coalitions, and trained 108 law enforcement, allied service professionals, paraprofessionals, judicial/court personnel, and volunteers.

C. Geriatrics Education. VCoA administers the **Geriatric Training and Education (GTE)** initiative for the Commonwealth. It strengthens the geriatrics and gerontology workforce by supporting locally identified, needs-based training with small monetary awards, after objective third party reviews. In calendar 2016 we supported 15 workforce development training events across Virginia. A sample of recipients and their training areas included: The Riverside Center for Excellence in Aging and Lifelong Health (Williamsburg) on Mental Health and Aging; Arlington Community Foundation on Advance Care Planning Education and Skill-Building; Southwest Virginia Westminster Canterbury (Charlottesville) on Creating a Dementia-inclusive Community in the Shenandoah Valley; SeniorNavigator (Richmond) on Promoting Caregiver Health through Interdisciplinary Education and Innovation; Virginia Geriatrics Society

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(statewide) for Virginia Community Provider Geriatrics Education Scholarships to attend its annual conference; Palliative Care Partnership of the Roanoke Valley (Roanoke) on The 3-R's of Advance Care Planning Navigation, for Care Managers, Community Health Workers, and Clergy/Health Ministries; Virginia Coalition for Prevention of Elder Abuse (statewide) for Conference Scholarships for its 21st Annual Conference in Virginia Beach; Alzheimer's Association, Central and Western Virginia Chapter (Charlottesville) for Creative Expressions in Dementia Care: A one-day training workshop for sustainability of arts programming in four rural regions; and more.

The Geriatric Workforce Enhancement Program (GWEP) is a consortium of VCU, UVA, and Eastern Virginia Medical School (EVMS), supported by the Health Resources and Services Administration, USDHHS. Its purpose is to train pre-clinical students, health care providers, and other professionals so that they think and act as interprofessional teams in geriatrics, and to educate family caregivers so that they have greater capacity in dementia-related issues. We accomplish this through such initiatives as year-long and semester courses, multi-week on-site contact hour training, teleconsults, single day conferences, and more. This year we trained: 603 VCU pre-clinical students in medicine, nursing, pharmacy, and social work to work as teams through a one-semester, web-based course based on an unfolding complex case in geriatrics; 26 pharmacy students at Hampton University; 97 health professionals in grand

rounds at EVMS; 55 health professionals and 92 caregivers and community elders through VirginiaNavigator; and three teleconsults with staff at Mountain Empire Older Citizens, Inc., on topics they requested as needed and supported two staff trainings for 181 nurse aides there; and more.

In GWEP we offered two 24-contact hour evidence-based practice (EBP) programs on falls prevention, the first at Riverside Regional Medical Center in Newport News and the second at Bonview nursing and rehabilitation center in Richmond. We completed one 200-hour Faculty Development Program with 12 Scholars and began another with 21 new Scholars. With our community partners across Virginia, we also offered dementia-related conferences for health professionals, direct service providers, and family caregivers in Danville, Fairfax, Norfolk, and Roanoke, plus staff training at the Richmond Alzheimer's Chapter.

Also, we have been measuring the impact of our interprofessional geriatrics training on falls prevention by accessing the patient charts of individuals being cared for by the various professionals we have trained at Riverside in Newport News and the McGuire Veterans Administration Center in Richmond. There are no specific patient identifiers like names. We examine these charts three-months before we train their providers and then at different points after the training; we employ between 25 to 150 metrics per patient for each professional (nurse practitioner, OT, PT, pharmacist). Findings so far show these changes in practice: increased doc-

umentation of the causes of falls, increased assessment of risk factors, increased EBP interventions, minimized medications, implemented home modifications, implemented patient education, implemented management of postural hypotension, and more.

D. Lifelong Learning. We offer residential lifelong learning experiences for older adults in several locations across Virginia through **Road Scholar**, an international, non-profit organization. Learners attend college-type, non-credit courses for several days to a week on a variety of subjects, from nature to Shakespeare. We contract with hotels for lodging and meals, businesses for transportation, faculty and local experts for instruction, and local course-related sites for admissions. In 2016, we drew 520 learners from across the country to our 24 residential programs in Big Meadows, Fredericksburg, Harrisonburg, Richmond, and Staunton.

The Lifelong Learning Institute (LLI) in Chesterfield County, founded and co-sponsored by the Virginia Center on Aging, Chesterfield County Public Schools, and Chesterfield County government, has grown to become a magnet for mid-life and older adults. It offers a rich menu of daytime, nonresidential, college-level courses and related activities. Membership grew to 1,092 participants in 2016. Our LLI offered 595 classes over three semesters, with 17,438 registrations, taught by 196 peer instructors. LLI learners, all Virginians, represented 29 different zip codes.

Editorials

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

by Katie Roeper,
Assistant Commissioner
Virginia Department for Aging
and Rehabilitative Services

Change is Hard in the Digital Age

Whoever said “Change is hard” wasn’t kidding. In fact, I’m not sure I can ever remember participating in a transformative initiative that did not require patience, stamina, creativity, flexibility, partnership, and a “can do” attitude no matter what. *No Wrong Door* is no exception.

Indeed, Virginia has been working on *No Wrong Door* since a Legislative Study was conducted under Jane Woods (then Secretary of HHR), reflecting what lawmakers, government leaders, and community providers had suspected for years, namely, that individuals begin their journey to seek long term services and supports through a variety of doors; and that supports are more effective and more person-centered, if we meet individuals where they are, instead of trying to drive them through single points of entry that cannot be all things to all people and often may not reflect their personal goals. Hence, *No Wrong Door* was born.

This innovation was a tall order: to develop one statewide referral system for long term services and supports; include both public and private pay; place the individual at the

center of the process; meet data security requirements of HIPAA and the Commonwealth of Virginia; integrate Virginia’s Uniform Assessment Instrument; and build the network, beginning at the grass-roots level, acknowledging that success is largely dependent on community partnerships, trust, and relationships.

The *No Wrong Door* vision is mirrored on the local, state, and federal levels:

To provide a high-quality, sustainable, person-centered, single state-wide No Wrong Door system of long-term services and supports and to support individuals of all ages and disabilities in achieving their unique goals for community living; streamline access to community supports; and promote efficiencies.

This alignment among the local, state, and federal partners is not the case in all states, however. Virginia is fortunate to have a long history of successful public-private partnerships that have served as valuable models for *No Wrong Door*. Specifically, the Commonwealth’s collaboration with VirginiaNavigator, a 501c3 non-profit that owns and manages a provider database of over 26,300 long term services, has gained Virginia national attention for best practices in public-private partnership.

One additional focus in building *No Wrong Door* has been sustainability, requiring everyone to put some “skin in the game.” From the beginning, there was a cost (albeit small) for the private sector to join the system. And, while public

agencies have not had to pay outright, they have invested heavily with their contributions of time, expertise, and human resources. No local provider network has contributed more than Virginia’s Area Agencies on Aging, who by Code of Virginia, serve as the designated “local lead,” overseeing *No Wrong Door* expansion in their service area.

The General Assembly has shown its continued support for *No Wrong Door* with a small but constant allocation from the General Fund. Federal support has come from a variety of discretionary competitive grants through a partnership between the Administration for Community Living, Centers for Medicaid and Medicare, and the Veterans Administration. Additionally, corporate support has come through multi-year grants from the Dominion Foundation, and local funders such as the United Way and Centra Health Foundation.

Change is hard, but perseverance and time invested in developing partnerships have paid off. *No Wrong Door* now has:

- A Strategic Leadership Team with decision-makers from the Office of the Secretary of Health and Human Resources, Department of Medical Assistance Services, Department of Behavioral Health and Developmental Services, Department for Aging and Rehabilitative Services, Virginia Hospital and Healthcare Association, and VirginiaNavigator;
- A 37-member volunteer Resource Advisory Council representing state agencies, statewide provider associations, and consumers, guiding *No*

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Wrong Door policy;

- Four Implementation Groups focused on Communication and Marketing; Person-Centered Practices; Streamlined Access to Supports; and Governance and Administration.

With a focus on expansion, the *No Wrong Door* Partnership Network has grown significantly, especially in the past two years; there are now nearly 100 partner organizations using the system across the state, representing over 625 professionals licensed to make automated referrals and securely share individual-level data. Last year *No Wrong Door* partners provided support to over 50,800 unique individuals and families seeking long term services and supports.

As *No Wrong Door* serves more and more individuals, valuable data also increases, providing opportunities to explore trends and test research. To that end, Virginia is:

- Developing metrics for “Community Tenure” to measure how *No Wrong Door* (and possibly even individual supports) can help individuals stay in their homes and communities;
- Working on a National Outcomes Workgroup, by invitation, to explore using systems-level and consumer-level data to determine national core measures related to *No Wrong Door*;
- Securely sharing valuable data with VCU Department of Gerontology for analysis and further research with University partners, as part of its Age Wave partnership

with Senior Connections, the Capital Area Agency on Aging, in an effort to develop a risk index for social isolation and improve social connectedness.

Many thanks to everyone who has contributed to the success of *No Wrong Door* over the years. Change is hard but together we are making a positive difference in the lives of older adults, individuals with disabilities, veterans, and families in Virginia. For more information on *No Wrong Door* expansion, please contact Kathleen Vaughan at Vaughan@dars.virginia.gov or for information about the development of metrics, contact Sara Link at sara.link@dars.virginia.gov.

2016/2017 DARS Meeting Calendar

Commonwealth Council on Aging
January 25, April 12, July 12, and September 20, 2017

Alzheimer’s Disease and Related Disorders Commission
March 7, June 6, August 29, and December 12, 2017

Public Guardian and Conservator Advisory Board
March 23, June 22, September 14, and November 9, 2017

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

Visit Our Websites

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

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

Southern Gerontological Society Annual Meeting

The 38th Annual Meeting of the Southern Gerontological Society will be held from April 6 – 9, 2017, in Asheville, NC. Asheville sits in western North Carolina nestled among the Blue Ridge Mountains. It is an eclectic city known for its locally-owned restaurants, historic architecture, vibrant art scene, and roughly 25 micro-breweries. The meeting will be held at the DoubleTree by Hilton in the Biltmore Village district.

This year’s theme is *New Horizons in Aging: Advances in Research and Practice*. We encourage those who are examining critical aspects affecting the older adult population through innovative research and those using creative approaches and programming to address the needs of this population to share your work at our meeting. The Southern Gerontological Society prides itself in being a welcoming and supportive network of students, researchers, practitioners, policy-makers, and other gerontology professionals. We embrace a diversity of perspectives and want to highlight your work in an effort to promote applied research and effective practice that together expand our understanding of the experiences of older adults and their families. As such, we promise a dynamic and rewarding conference experience!

For additional conference information and links for abstract submissions, please visit our website at: www.southerngerontologicalsociety.org.

COMMONWEALTH OF VIRGINIA

Alzheimer's and Related Diseases Research Award Fund

Program Announcement

- 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 \$45,000 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 in Virginia.
- Schedule:** By March 10, 2017 prospective applicants are required to submit a non-binding letter of intent that includes a descriptive project title, contact information for the principal investigator, the identities of other personnel and participating institutions, a non-technical abstract, and four to five sentence description of the project in common, everyday language for press release purposes. Letters on letterhead with signature affixed will be accepted electronically on the due date. Applications (original and three hard copies sent by carriers who date stamp on or before the due date required, with an electronic copy also e-mailed on or before the due date) will be accepted through the close of business April 3, 2017, and applicants will be notified by June 23, 2017. The funding period begins July 3, 2017 and projects must be completed by June 29, 2018.
- 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 found at <http://go.vcu.edu/ardraf> or by contacting:

Constance L. Coogle, Ph.D.
Virginia Center on Aging
School of Allied Health Professions, Virginia Commonwealth University
730 E. Broad St., Room 2088
P. O. Box 980229
Richmond, Virginia 23298-0229
Phone: (804) 828-1525
FAX: (804) 828-7905
E-Mail: ccoogle@vcu.edu

Bryan Lacy, 1956-2016

by Ed Ansello



His smile was what people who knew him remembered. It was contagious

and we involuntarily responded in kind. Bryan not only rose above his impairments but also raised us up with him.

He and I worked together regularly for some six years in the Cerebral Palsy and Aging coalition that we co-chaired in metropolitan Richmond. Its 15 or so members comprised a half-dozen adults with CP, including Bryan and Thomas Hock, some family caregivers like Martin and Betty Hancock, academics, and service providers.

It grew out of recognition that individuals like Bryan were aging into new longevity territory and we had to alert colleagues in higher education, public policy, health care, and human services about it. Until recently, the common wisdom was that cerebral palsy was a static condition, one that remained relatively stable through the life course. Bryan and others with CP lived the truth: it's progressive and can be unforgiving.

Bryan was an attorney, intellectually sharp, and, as noted, quick to laugh. His CP made it difficult for him to communicate and I empathized that his mind must have been racing far ahead of his speech, and it must have frustrated him mightily. Not that you'd know it. He was patient with us. If we

returned the favor, it was worth it.

Bryan's speech was slow and indistinct. It was an effort every time. His companionable personal assistant Ann would often interpret for us. But usually we would just give him the time. Our coalition meetings developed their own rhythm, more slow-paced and focused so that we all listened to each other. What a gift.

Bryan was born in Norfolk in 1956. His brother Cam, an architect with whom Bryan collaborated professionally, recalls,

"As kids growing up together, Bryan and I had a special bond beyond the typical sibling connection. I became his voice and interpreter, as he had great difficulty speaking; his legs, as I would help lift him from his bed or bath into his chair and out into the world; his secretary/typist, taking notes or organizing files of the various projects he was researching; his mechanic, in devising ways to make the house more accessible, altering his chair tray to hold more books, adding typewriter doodads to allow him to type or, later on, customizing his van lifts and seating, and, most importantly, his friend. It was common for us to go into uncontrollable laughter over some discussion we were having where we would have to pause to breathe, and then do it all over again."

Bryan attended the Richmond Cerebral Palsy Center from 1959 to 1970. The family moved to New Hampshire so he could benefit from the skills of the Crotched Mountain Center there from 1971-74. This was all before federal legislation to

integrate children with lifelong disabilities into the school system and years before the Americans with Disabilities Act (ADA).

While he lived at The Virginia Home in his later years, Bryan created a PowerPoint presentation to explain "Who I Am." In it he says, "Motivation – I knew that whatever I did with my life had to be done with my mind."

And so it was. He attended Long Island University, Brooklyn Center, from 1974-79, earning his B.A. in political science. Of that experience he said, "They had 200 students with disabilities. This was the first time I was 'mainstreamed.' Volunteer students made carbon copies of their notes. I'm still close with one of them."

Bryan went to law school and earned his degree and license. He had a small law practice. He lived independently for more than 20 years until 2004, with the help of personal assistants, one of whom, Ann Green, I knew through our CP and Aging coalition meetings. He said that she helped with legal work but did basically whatever needed to be done during her two days a week with him; when I visited his ground floor apartment, she made the tea and sometimes joined our conversation but mostly "assisted."



Despite his great physical limitations, he contributed substantively to others' well-being. During 1989-93, he helped to set up the personal assistance program in the Virginia Department of Rehabilitative

Services for people who make too much money to qualify for Medicaid.

He and I met in 1995 and we co-established the CP and Aging coalition the next year. Our coalition members organized resource fairs and helped develop what we called the Caregivers Investment Bill as a tax credit to recognize and reinforce family caregivers; we talked with and educated legislators; after four years of work with the Virginia General Assembly, it was passed in the 2000 Session as the Virginia Caregivers Grant Program and Governor Gilmore signed it into law.

Our coalition hosted two highly successful conferences in Richmond on CP and Aging in 1998 and 2000. Bryan chaired them. The theme of our conferences was "Meeting Everyday Needs" and they focused on health care, assistive devices, and sexuality, the latter a much underappreciated aspect of the lives of individuals with CP and other lifelong disabilities.

In the memorial service at The Virginia Home, Bryan's brother Cam summed up Bryan's life as "inspirational."

Bryan said, "I tend to look at everyone as individuals because that is how I want people to look at me. Not everyone sees me as an individual. They assume that because my disability is physical, it is also intellectual."

Bryan's life teaches the importance of appreciating the person inside.

Patty Slattum Receives Endowed Professorship

Our colleague Patricia (Patty) W. Slattum, PharmD, PhD, received well-deserved recognition this month, being awarded the Victor A. Yanchick Professorship in the School of Pharmacy at Virginia Commonwealth University. The endowed professorship is named for the school's respected Dean who retired recently.

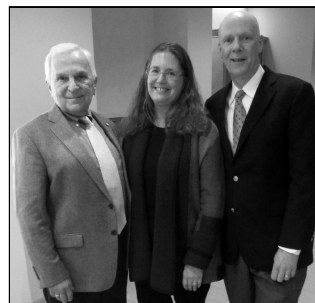
Patty is a dedicated educator, researcher, and highly valued innovator. Seemingly tireless, she has inspired the development and growth of geriatrics in the school's curriculum to the point that it is now "among the most robust in the nation in preparing pharmacy students to care for the growing aging population."

Patty has been a valued partner in all of the initiatives of the Virginia Geriatric Education Center, including our current Geriatrics Workforce Enhancement Program (GWEP) funded by the federal Health Resources and Services Administration.

She is a key instructor and mentor in GWEP's 200-hour Faculty Development Program, the Evidence Based Practice training on reducing the risk of falls, and the pass-the-torch Train the Trainer program. In addition, with our colleague Dr. Pam Parsons in the VCU School of Nursing, she developed, implemented, and continues to guide the Richmond Health and Wellness Program (RHWP) at seven Section 8 housing complexes for low-income elders across Rich-

mond. The RHWP serves as a screening and self-advocacy site for these residents, who meet with interprofessional teams of practitioners and students from various health-related disciplines. Housing residents, students, and professionals work together to improve the patient's well-being.

Congratulations on this honor, Patty.



Drs. Vic Yanchick, Patty Slattum, and Joe DiPiro, Dean of School of Pharmacy

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Income and Life Expectancy



The *Journal of the American Medical Association (JAMA)* published a landmark statistical study last year whose implications continue to resonate. Researchers Raj Chetty, Michael Stepner, Sarah Abraham, and others, variously affiliated with Stanford, MIT, McKinsey & Co., Harvard, and the US Treasury, obtained income data for the US population from 1.4 billion de-identified tax records from 1999-2014 and mortality data from the Social Security Administration death records. They assumed that pre-tax household earnings could serve as a measure of income. They then used the data to estimate race- and ethnicity-adjusted life expectancy at 40 years of age by household income percentile, sex, and geographic area, and to evaluate factors associated with differences in life expectancy. Verbatim excerpts from their “Key Findings” follow:

Life expectancy increases continuously with income. At the age of 40 years, the gap in life expectancy between individuals in the top and bottom 1% of the income distribution in the United States is 15 years for men and 10 years for women.

For individuals in the bottom income quartile, life expectancy at the age of 40 years differs by

approximately 4.5 years between the commuting zones with the highest and lowest life expectancies. Adjusting for race and ethnicity, life expectancy for individuals with low incomes is lowest in Nevada, Indiana, and Oklahoma and highest in California, New York, and Vermont.

Gaps in life expectancy by income increased between 2001 and 2014. Life expectancy did not change for individuals in the bottom 5% of the income distribution, whereas it increased by about three years for men and women in the top 5% of income distribution.

Correlational analysis of the differences in life expectancy across geographic areas did not provide strong support for four leading explanations for socioeconomic differences in longevity: 1) differences in access to medical care (as measured by health insurance coverage and proxies for the quality and quantity of primary care); 2) environmental differences (as measured by residential segregation); 3) adverse effects of inequality (as measured by Gini indices); and 4) labor market conditions (as measured by unemployment rates).

Rather, most of the variation in life expectancy across areas was related to differences in health behaviors, including smoking, obesity, and exercise. Individuals in the lowest income quartile have more healthful behaviors and live longer in areas with more immigrants, higher home prices, and more college graduates.

The authors used the variation in life expectancy across small areas

as a lens to evaluate theories for socioeconomic differences in longevity.... The differences in life expectancy across areas were highly correlated with health behaviors (smoking, obesity, and exercise), suggesting that any theory for differences in life expectancy across areas must explain differences in health behaviors.

One such theory is that health and longevity are related to differences in medical care. The present analysis provides limited support for this theory. Life expectancy for low-income individuals was not significantly correlated with measures of the quantity and quality of medical care provided.

A second theory is that physical aspects of the local environment affect health, for example through exposure to air pollution. Such theories predict that income gaps in longevity should be greater in areas with greater residential segregation by income. This explanation also does not find strong empirical support. Life expectancy among individuals in the lowest income quartile was higher in more segregated areas—both in absolute terms and relative to individuals in the highest income quartile.

A third theory is that poor health is related to inequality or a lack of social cohesion, which may increase stress for low-income individuals.... Among individuals in the bottom income quartile, there was no association between inequality and life expectancy across areas.... Inequality was more negatively correlated with life expectancy for individuals in the highest income quartile, contrary to

the prediction that inequality has the most adverse effects on the health of low-income individuals.

A fourth theory is that life expectancy is related to local labor market conditions. Empirically, neither unemployment nor long-term population and labor force change was significantly associated with life expectancy for individuals in the lowest income quartile.

None of the four theories for shorter life expectancy among low-income individuals was consistently supported by the data. Rather, the strongest pattern in the data was that low-income individuals tend to live longest (and have more healthful behaviors) in cities with highly educated populations, high incomes, and high levels of government expenditures.

There are many potential explanations for why low-income individuals who live in affluent, highly educated cities live longer. Such areas may have public policies that improve health (e.g., smoking bans) or greater funding for public services, consistent with the higher levels of local government expenditures in these areas. Low-income individuals who live in high-income areas may also be influenced by living in the vicinity of other individuals who behave in healthier ways. Alternatively, the low-income population in such cities might have different characteristics, consistent with the larger share of immigrants in these areas. Testing between these theories is a key area for future research.

Shepherd's Center Loses Two Stalwarts

by Ralph H. Graner
Immediate Past President, The
Shepherd's Center of Richmond

The Shepherd's Center of Richmond (TSCOR) lost two of its most consequential leaders this past fall.

The **Reverend Robert Stuart Seiler** helped create TSCOR, served as its first Executive Director, was an active Board member, regularly attended Open University with his late wife Peggy, and was honored at our 30th anniversary event. He truly exemplified "The Greatest Generation." Even before Pearl Harbor, he interrupted his studies at Cornell University to enlist in the U.S. Army, became a command bomber pilot with 33 combat missions, earned the Air Medal and Distinguished Flying Cross, and rose to the rank of Major. After World War II, he returned to Cornell, then entered the Episcopal priesthood. He served several Episcopal parishes. He passed away at the age of 97.

John Dickinson (Jack) Welsh, Ph.D., Phi Beta Kappa, was Professor Emeritus of Theatre and Speech at the University of Richmond, where he taught for 35 years. Jack did a lot for TSCOR: initiated Broadway excursions from Richmond, attended and lectured for the Open University, was a member of the education committee, chair of the travel committee, a board member, and became president in July 2016. He passed away at the age of 78.

Virginia Rural Health Telecommunications Consortium

The Virginia Rural Health Association is in the process of enrolling new members in the Virginia Rural Health Telecommunications Consortium. This program seeks to improve health information technology applications in rural communities by fostering the development and growth of a dedicated broadband healthcare network in Virginia and the surrounding region. Financial support will be provided through the Federal Communication Commission's Healthcare Connect Fund.

Benefits of membership in this consortium include:

- Up to 65% federal reimbursement on the cost of internet services and broadband upgrades,
- Upfront payments for equipment and healthcare provider constructed facilities,
- A competitive bidding process for broadband services,
- Streamlined application for program enrollment,
- Management by the Virginia Rural Health Association.

Eligible facilities must be either public or nonprofit. As of January 2017, skilled nursing facilities may also participate.

For information, contact Beth O'Connor at (540) 231-7923 or visit www.vrha.org/vrhtc.html to view a webinar recording of how the process works and to take the eligibility survey.

Commonwealth Council on Aging's 2017 Best Practices Awards

by Amy Marschean
Senior Policy Analyst, DARS

The Commonwealth Council on Aging (Council) is sponsoring the 2017 Best Practices Award Program (Program) targeted to organizations serving older Virginians and their families. Nominations for the 2017 Awards must be received by 5pm on March 1, 2017.

As Virginia struggles to meet the challenges of serving a rapidly aging population during a time of budget cuts and growing demand, we as a community need to share our best practices and applaud our successes. All nominations must be made on the official application form. Please read the 2017 Best Practices Awards Instructions prior to completing the nomination form. Both the application and instructions are available on the following website: www.vda.virginia.gov under What's New!

2016 marked the tenth anniversary year of the Best Practices Award Program and the Council wishes to congratulate all past award recipients. The Council is pleased to offer monetary awards to the top winners: The first place program will receive \$5,000; second place, \$3,000; and third place, \$2,000. The Council will also recognize three honorable mention programs.

The Best Practices Awards Program is designed to identify and recognize unique programs of excellence.

The awards support programs and services that assist older adults to age in the community. The awards recognize creativity in services that foster "Livable Communities" and "Home and Community Based Supports" - from transportation to housing, from caregiver support to intergenerational programming.

These programs may be sponsored by providers of aging services, including non-profit organizations, universities, faith organizations and local governments. Applications may be submitted by single organizations or a partnership including any combination of the above. The programs are judged for their innovation, cost-effectiveness, ease of replication and their impact on the quality of life of older Virginians, caregivers and family members.

Previous winners who have received honorable mention in a prior year without a cash award may resubmit an application or be nominated by another. The Council disseminates information on the award winning programs throughout the Commonwealth to encourage the replication of these model programs.

The Program's monetary awards are funded by Dominion Resources, Inc. Its generous contribution allows the Council to recognize these organizations for their dedication and work in advancing services for the aging.

Alcohol Basics for Older Adults



Virginia Department of Alcoholic Beverage Control's Education and Prevention Section recently released a series of free publications, including a

booklet for older adults. Some of the topics covered include: signs of alcohol misuse in older adults, physical changes that make alcohol more risky, and the dangers of alcohol and medication interactions.

To order the publications, visit www.abc.virginia.gov/education/publications. Organizations may order the free publications in bulk to provide in an office setting or to distribute during meetings addressing health and safety.

Please call (804) 977-7440 or e-mail education@abc.virginia.gov if you have questions or comments.



June is Alzheimer's & Brain Awareness Month and the Alzheimer's Association® needs your help to uncover the truth about Alzheimer's disease and other dementias. Everyone who has a brain is at risk to develop Alzheimer's, a fatal disease that is often misunderstood. During the month of June, you can help by raising awareness and taking action. Visit alz.org/abam to learn how you can participate.

Responding to Alzheimer's Disease: Techniques for Law Enforcement and First Responders

This no-cost, one-day event offered by the Virginia Department of Criminal Justice Services (DCJS) will provide Virginia law enforcement and first responders with the most current Alzheimer's and dementia training available. It features in-depth instruction to help law enforcement agencies enhance their capacity to handle calls involving people with Alzheimer's disease and related dementia.

Resources, handouts, and opportunities for networking and information sharing will be provided. To register, visit www.dcjs.virginia.gov/training-events/responding-alzheimers-disease-techniques-law-enforcement-and-first-responders or email Kristina.Fawcett@dcjs.virginia.gov

Hampton: January 30, 2017

Thomas Nelson Community College, Hampton, 8:00 a.m. - 4:30 p.m.

Charlottesville: January 31, 2017

Albemarle County Police Department, Charlottesville, 8:00 a.m. - 4:30 p.m.

Nokesville: February 1, 2017

Prince William County Criminal Justice Academy, Nokesville, 8:00 a.m. - 4:30 p.m.

Calendar of Events

January 23, 2017

Arthritis Exercise Classes and Tai Chi for Health Classes. Classes meet twice a week. Hopewell Community Center Parks/Rec, Hopewell. For schedules and information, call (804) 318-6673.

January 25, 2017

Virginia Center on Aging's 31st Annual Legislative Breakfast. St. Paul's Episcopal Church, Richmond. 7:30 a.m. - 9:00 a.m. For information, call (804) 828-1525 or e-mail eansello@vcu.edu.

February 2, 2017

Love Your Heart: Heart Health. Sponsored by Chesterfield Council on Aging and Senior Advocate's Office. 10:30 a.m.-12:30 p.m. Meadowdale Library, North Chesterfield. For information, visit <http://chesterfield.gov/seniorevents> or call (804) 768-7878.

February 22-March 29, 2017 Wednesdays

Caring For You, Caring For Me. An educational and support program series. 10:30 a.m. - 12:30 p.m. Southminster Presbyterian Church, North Chesterfield. Participants must sign up ahead of time. \$25 per person. For information, visit <http://chesterfield.gov/seniorevents>.

February 22, 2017

Healthy YOU: Drugs and Aging. Hosted by The Senior Center of Greater Richmond. 11:00 a.m. Brookdale Imperial Plaza, Richmond. For information and reservations, call (804) 353-3171.

February 23, 2017

Grief to Giggles: Learn how to work through Grief with Crater Community Hospice. 12:00 p.m. - 1:30 p.m. Complimentary Buffet Luncheon. The Crossings at Ironbridge, Chester. For information, call (804) 748-7000.

February 25, 2017

Connections: Engagement and Enjoyment in Life for Persons with Dementia. Presented by Ellen Phipps, CTRS, MSG. 2:00 p.m. - 3:30 p.m. Culpeper Library, Culpeper. For information, call (540) 825-8691.

March 9-12, 2017

The Future Is Here: Educating a New Generation of Professionals in Aging Worldwide. The 43rd Annual Meeting and Educational Leadership Conference of The Association for Gerontology in Higher Education. Miami Marriott Dadeland, Miami, FL. For information, visit www.aghe.org.

March 14, 2017,

Faithful Aging: A Faith-Based Conference on Aging. Presented by The Beard Center on Aging at Lynchburg College in collaboration with the Older Adult Council of the Virginia Conference of the United Methodist Church and Virginia United Methodists Home, Inc. For information, call (434) 544-8456 or e-mail Scruggs.dr@lynchburg.edu.

Calendar of Events

March 20-24, 2017

Aging in America: Annual Conference of the American Society on Aging. Chicago, IL. For information, visit www.asaging.org.

April 4-5, 2017

Virginia Assisted Living Annual Spring Conference and Trade Show. DoubleTree by Hilton, Williamsburg, VA. For information, visit www.valainfo.org.

April 6-9, 2017

38th Annual Meeting of The Southern Gerontological Society. DoubleTree by Hilton Asheville Biltmore, Asheville, NC. For information, visit www.southerngerontologicalsociety.org.

April 21-23, 2017

The 28th Annual Virginia Geriatrics Society Conference. Short Pump Hilton, Richmond. For information, visit www.virginiageriatricsociety.org.

April 30-May 2, 2017

Cultivating Hope through Strength-Based Practices. START National Training Institute. Provided by the Center for START Services, a non-profit, national initiative based at the University of New Hampshire Institute on Disability/University Center for Excellence in Disability. Doral Arrowwood Conference Center, Rye Brook, Westchester County, NY. For information, visit www.centerforstartservices.org/2017-SNTI.

May 3, 2017

Chesterfield Triad Senior Day. Healthy Living = Healthy Aging program by Dr. Ayn Welleford. 7:30 a.m. - 12:00 p.m. Victory Tabernacle Church, Midlothian. For information, visit <http://chesterfield.gov/seniorevents> or call (804) 768-7878.

May 9, 2017

Alzheimer's Education Conference. Presented by the Alzheimer's Association, Central Western Virginia Chapter. Germanna Community College, Culpeper. For information, call (800) 272-3900 or e-mail ephipps@alz.org.

May 22-23, 2017

Governor's Conference on Aging. Hotel Roanoke, Roanoke. For information, visit www.dars.virginia.gov.

May 22-23, 2017

27th Annual Aging with Developmental Disabilities Conference. Presented by The Association on Aging with Developmental Disabilities (AADD). St Charles Convention Center, St. Charles, MO. For information, visit <http://agingwithdd.org>.

May 31 - June 2, 2017

23rd Annual Conference of the Virginia Coalition for the Prevention of Elder Abuse. Virginia Beach Resort & Conference Center. For information, visit www.vcpea.org.

June 5, 2017

Annual Conference on Lifelong Disabilities by the Area Planning and Services Committee (APSC). Doubletree by Hilton, Richmond Midlothian. For information, e-mail ensello@vcu.edu.

June 6, 2017

Annual Conference on Aging: Aging Well in Mind, Body, and Spirit. Presented by The Beard Center on Aging at Lynchburg College, in conjunction with Centra Health. Lynchburg College. For information, call (434) 544-8456 or email Scruggs.dr@lynchburg.edu.

June 7-9, 2017

Annual Conference and Expo of LeadingAge Virginia. Norfolk Waterside Marriott, Norfolk. For information, visit www.leadingagevirginia.org.

June 8, 2017

Alzheimer's Education Conference. Presented by the Alzheimer's Association, Central Western Virginia Chapter. James Madison University, Harrisonburg. For information, call (800) 272-3900 or ephipps@alz.org.

Age in Action

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

James A. Rothrock
Commissioner, DARS

Kimberly S. Ivey, M.S.
Editor

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Virginia Center on Aging

at Virginia Commonwealth University, Richmond, Virginia

www.sahp.vcu.edu/vcoa

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www.dars.virginia.gov

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P.O. Box 980229
Richmond, VA 23298-0229

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The Commonwealth Council on Aging 2017 Best Practices Award Program

The 2017 Best Practices Award Program is sponsored by the Commonwealth Council on Aging and funded by Dominion Resources. The Council is committed to the independence, dignity, and security of the people it serves and helps state government meet the needs of older Virginians and their families. The Council is composed of 19 citizen members who are appointed by the Governor and legislators to represent all geographic regions of the Commonwealth and five nonvoting ex officio state government officials. The Council plans to select six programs for recognition in 2017, and will provide monetary awards for three of the winners.

Eligibility: Awards will be based on innovation and impact of program to assist older adults to Age in the Community. These programs promote “Livable Communities” and “Home and Community-Based Supports.”

Nominations for the 2017 Awards must be received by 5:00 p.m. on March 1, 2017. All nominations must be made on the official nomination form, which may be downloaded by going to the Virginia Division for the Aging’s website: www.vda.virginia.gov. Look under “What’s New.”

For more information, please contact Amy Marschean, Virginia Department for Aging and Rehabilitative Services (DARS), at (804) 662-9155 or via e-mail at bestpracticesawards@dars.virginia.gov with questions relating to the application process.

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