

Case Study

The Senior Mentoring Program at VCU's School of Medicine

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Educational Objectives

1. To demonstrate the value of senior mentoring in geriatrics education for medical students.
2. To provide a framework for positively influencing student attitudes toward older adults.
3. To describe the underlying human relationships that contribute to patient-centered care.
4. To describe effective verbal and non-verbal skills to establish and build relationships.

Background

Senior mentoring is a medical education component whereby medical students and community older adults establish a connection, with the intention being a fuller understanding by the student of the complex lives of older adults who represent future patients.

Embedding geriatrics into U.S. medical education and practice is a relatively recent phenomenon. In 1974, the National Institutes of Health established the National Institute on Aging. In 1982, the Veterans Administration established two-year geriatrics fellowship programs at 12 VA medical centers and the first separate department of geriatrics was created at Mount Sinai School of Medicine. In 1988, the American Board of Internal Medicine recognized geriatrics as a specialty. At Virginia Commonwealth University, Peter Boling, MD, Professor of Internal Medicine and Chair of Geriatrics in the School of Medicine, has been championing geriatrics education since 1984. His 2001 *Strengthening Training in Geriatrics* grant from the Donald W. Reynolds Foundation increased geriatrics education for thousands of medical students, residents, and practicing professionals, always with the goal of improving geriatric care.

Senior mentoring programs began in the early 2000s as a geriatrics curriculum intervention in U.S. medical schools, funded by the John A. Hartford Foundation and the Association of American Medical Colleges; this initiative was noted as one of the most promising geriatrics curriculum strategies (O'Neil & Holland, 2005). Evaluation of early senior mentoring programs found students experiencing positive attitude change about geriatric patient care and better knowledge of geriatrics (Bates et al., 2006). Students reported enhanced sympathy and empathy, greater respect for older adults, and an appreciation that aging is an individualized process (Hoffman et al., 2006). Several of the Reynolds Foundation *Strengthening Training in Geriatrics* grantees adopted senior

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mentoring programs.

By 2008, various program models emerged (Eleazer et al. 2009), including one in which the student-mentor relationship is maintained throughout the college experience. Students and mentors would meet several times a semester and many student-mentor relationships became social, sharing meals, meeting families, and attending weddings and other social events. Another model is more formal, with the program scheduling joint student-mentor orientations, luncheons, and lectures. Both of these models are voluntary for students. A third model, the brief curriculum model, adopted by VCU in 2014, is a required experience with assignments using the student-mentor relationship and is concentrated into a single academic year. The Eleazer et al. evaluation of 10 senior mentoring programs found that for a significant proportion of both students and mentors, the relationship became a valued and poignant one.

In 2010, Dr. Boling received a *Next Steps in Physicians' Training in Geriatrics* grant from the Donald W. Reynolds Foundation to support programs to train medical students, residents, and physicians in geriatrics. The schools of Nursing, Social Work, Pharmacy, and Allied Health Professions (now the College of Health Professions [CHP]) made a commitment to student and faculty participation, technical support, and continuation of the educational program after this grant ended. One of the objectives was to implement a senior mentoring program for first-year medical students. Tracey Gendron, PhD, Associate Professor in the Department of Gerontology, CHP, developed the curriculum and administered the program from the Fall Semester of 2014 through the Spring Semester of 2017. Leland "Bert" Waters PhD, Assistant Professor at the Virginia Center on Aging, CHP, has been program administrator since then, and Madeline McIntyre, B.A., serves as program coordinator.

Dr. Boling chose to include the adoption of a senior mentoring program in the VCU medical school curriculum as part of the *Next Steps in Physicians' Training in Geriatrics* grant because he "wanted to show medical students meaningful aspects of life for older people and how physicians could make a difference." When asked why he chose the brief curriculum model for first-year students he said, "We

wanted to get the students before they became jaded and distracted by all the biomedical issues and the difficulties they were going to face in the course of their career."

Program Structure

Dr. Gendron originally designed the senior mentoring program curriculum as an interprofessional education (IPE) experience. First-year medical students, who were required to complete the course, were paired with volunteer nursing, pharmacy, and social work students. The teams, consisting of 2-3 students each, were matched with an older adult mentor, many of whom were recruited from assisted living communities in the Richmond area. The initial goals of the program were to increase knowledge, improve attitudes, and to expose students to different professional perspectives on aging while working with older adults. The task of recruiting both nursing and pharmacy students became more challenging as there was an increase in competing IPE requirements, so the program administrator decided to focus only on pairs of first-year medical students who are matched with one senior mentor or one couple.

The course is delivered through a learning management system called Blackboard. An online orientation lecture introduces the topics of person-centered care, effective communication with older adults, and awareness of ageist stereotyping. Students view a service-learning video that details best practices for volunteering with elders in the community. A pre-interview journal assignment poses two questions: (1) How do you feel about your own aging? (2) How do you feel about working with older adult patients after you complete your medical training?

Each team, usually two students, is required to meet with its senior mentor three times over the course of two semesters. In a few instances, married couples choose to meet with an individual student team. The students are required to make initial contact and meet the senior mentor at a time and place of the mentor's convenience. The students have reading assignments and guided interview questions, which are used as a starting point for conversation. Assignment topics include: 1) aging and health, 2) life-space, 3) quality of life, and 4) generativity.

The first assignment on aging and health introduces the processes of normal aging, activities of daily living (ADLs), instrumental activities of daily living (IADLs), and functional status that is determined by looking at both physical and cognitive actions. The students ask questions in the first interview about their mentor's perception of health and their experiences with the healthcare system and are required to post an individual reflection on the Blackboard site for this and each subsequent interview. Reflections are not graded but are reviewed by the course instructors for completion.

At the second interview, the students conduct a life-space assessment and interview their mentors about quality of life. A larger life-space is associated with better quality of life and health, while a slightly constricted life-space, such as going into the neighborhood fewer than four times a week, is an important marker of or risk factor for, the development of frailty. A severely constricted life-space, such as never leaving for home, indicates a high risk of mortality.

Quality of life represents an individual's perception of his or her well-being, including emotional, social, and physical aspects of their own life. It is a broad-ranging concept that encompasses level of independence, social relationships, personal beliefs, and relationships to salient features of their environment. Quality of life is a subjective term and for older adults may include aspects of maintaining independence and autonomy. Within a healthcare context, being able to make decisions about one's own health may be key components to quality of life.

The third and final interview focuses on generativity, an evidence-based, psychosocial concept, which is defined as a desire by older adults to nurture and guide upcoming generations, in order to make meaning of their own lives. Examples of generative actions include sharing accumulated wisdom and life experience, mentoring younger people, and giving practical support. There is empirical evidence that older adults who display generative behaviors derive a sense of personal meaning from their nurturing actions and that generativity may be a strong predictor of emotional and physical well-being in later life. It has also been suggested that older adults who do not develop generative behaviors may face a life

conflict in which they stagnate, with their energy and interests turned inward rather than outward towards a concern for creating a legacy for future generations. The students ask advice from their mentor and ask about their mentor's perceptions of themselves and the world.

The final reflection requires the students to answer the same two questions asked in the pre-test: (1) how do you feel about your own aging? (2) How do you feel about working with older adult patients after you complete your medical training?

After each interview with their mentors, students are required to post their reflections. Dr. Gendron's requirements for these reflections mimicked the Twitter brevity limit at the time, 140 characters. Students were instructed to create a tweet that represented the learning gained from the interview with their mentor, and these tweets were posted on Blackboard, viewable by all course participants and instructors.

When the Virginia Center on Aging (VCoA) assumed administration of the program in 2017, it eliminated the 140-character limit. Now, the student's assignment is to write a paragraph-length post-interview reflection. VCoA also started to recruit community-dwelling older adults from the Lifelong Learning Institute (LLI) in Chesterfield and the Jewish Community Center (JCC) in Richmond. The senior mentoring program decided to recruit older adults living independently and experiencing normal psychosocial issues of aging without major medical problems. This proved so successful that in the second year the program began recruiting only older adults living independently in the community and no longer recruited older adults living in assisted living communities. We also recruited a more diverse group of mentors from a Friendship Café site associated with Senior Connections, The Area Agency on Aging; the Café in inner city Richmond offers social programs for community-dwelling older adults who are not homebound and are physically, mentally, and medically able to attend.

In 2018, the Department of Gerontology at VCU collaborated with Leading Age, a Washington D.C. based aging advocacy nonprofit, to develop curriculum to address ageism. They produced three

three-minute videos appropriate for a wide range of audiences. We required all students in the 2018 senior mentoring cohort to respond to several questions after reviewing these ageism videos. Their responses were overwhelmingly positive. Over 98 percent of the students reported having a better understanding of ageism after watching the videos and said they would apply what they learned to their practice. All of the students reported that they were motivated or willing to change how they think or act and would apply what they learned from the videos in their everyday lives.

Case Study #1

Y and B are each second-year medical students who participated in the Senior Mentoring Program during the 2017-18 academic year, as members of different student teams. Both students reported they did not know what to expect going into their first assignment, as most of their prior experience with older adults and aging was limited to their grandparents; they did understand, however, that a great amount of individuation occurs among older adults. They both admitted to not wanting to linger too long with their respective mentors because of their own busy schedules.

The time limit expectation quickly disappeared after the first interview. Y's mentor was the one to end the first meeting after more than an hour and a half because Y and her partner were so engaged. B, in turn, stated that the interview was more like a conversation with a peer rather than a task to collect information, for there was "a lot more give and take" than expected. Both students relied on the guiding questions in the first interview to broach more difficult topics, such as life satisfaction, but the subsequent interviews were less scripted and students followed the flow of conversation wherever it went.

Because of the depth of the initial conversation, the second interview was more of an update instead of a discussion solely about life-space and quality of life. Y and her mentor spoke mostly about relationships with her doctors, family, friends, and her community. B and his mentor delved into healthcare and her progress towards some of her health goals. Y and B said their mentors wanted to know just as much about how they were doing, with a particular focus on what

they were currently learning in medical school.

The easy familiarity continued into their third and final meetings a few months later. "[It] felt more like catching up with a friend," said Y. This final meeting was designed to allow for more reflection by the mentors and the medical students. Both students felt the introspective nature of the conversations. B stated that the first two interviews applied more specifically to his future career, whereas the third interview became an opportunity to gain more general life advice from his mentor. His mentor stressed the importance of pursuing one's passions, "both in our careers and our lives outside of work," and Y's mentor stressed the importance of hard work in creating happiness.

At the end of the three interviews, the students found it difficult to end the relationship with their mentors even though they had only spent a short amount of time together. B felt there was far more that they could learn about each other, while Y found talking with an older adult outside of her family to be "almost therapeutic," since her mentor had such a breadth of life experiences to share and no topics were off limits. Both students stated that the VCU Senior Mentoring Program provided an opportunity to learn both professionally and personally about older adults and aging.

Case Study #2

Ms. D volunteered in the senior mentoring program during the 2017-18 academic year and agreed to volunteer again this year (2018-19). She has been retired for about 12 years. She is a member of the LLI and the JCC. She holds an advanced degree and volunteers in the community at a hospital and a legal aid center. She moved away from her grandparents while growing up and her parents died at relatively young ages, so she had little experience with older adults as a young person. The meetings with her mentees occurred at Ms. D's house first, then at a shopping mall, and for the final interview, they walked from her house to a nearby coffee shop. Each session lasted over an hour.

Between her first and second meetings with her mentees, Ms. D experienced a medical event. "I had

fallen and I recovered fine, but something like that does change you when you are older, and they saw that.” She knew that falls were seminal events for older adults, sometimes leading to loss of independence, and that it was important to alert the students to the reality that a fall can be a different life event for people in their 70s compared to medical students in their 20s.

When asked to reflect on her experience with last year’s students, she said, “They were both surprised about how much they ended up liking me as a person. I do not think that it impacted at all their interest in aging or not. One of the students was always interested in being a family [physician], not a geriatrician. Some of the things I talked about had to do with their relationship with aging, and how important that is [with] me being a recipient of services [and my] not being dismissed.”

Last year she was paired with one male and one female student, and this year her mentees are both female students. When asked about her first meeting with this year’s students, she said, “I had such a good experience the first year that my expectations were high.” She wanted the students to be as interested and engaged as last year’s students were. She was pleasantly surprised that the students this year “were so delightful.”

Ms. D reported a marked contrast between last year’s mentees and this year’s mentees. “Last year they followed scripted questions and this year they didn’t. That was not a bad thing, and they were very interested in me.” Ms. D mentioned that a close friend who had volunteered as a senior mentor last year did not have the same uplifting experience. Her friend, Ms. R., was paired with two male students who did not initiate the conversation or ask specific questions. She had the feeling that they were not interested in her as a person.

When Ms. D was asked if the students had mentioned the new ageism module for this year’s cohort in their first encounter, she said, “They were telling me about the videos, and they were quite taken with that. One [student] in particular was telling me what she learned in that and that she wasn’t aware of [ageism].”

At the end of the interview, Ms. D reiterated the most important aspect of her experience as a senior mentor was realizing that as she ages, she is still the same person. “Now, I sense the way people treat me, not in a bad way, but I am still the same inside.” She hopes her efforts to mentor medical students may help bridge the gap of perception between young physicians and older adults.

Conclusion and Lessons Learned

Senior mentoring can help shape the perspectives that future physicians hold about older patients. An evaluation of the effectiveness of a senior mentoring program for first-year medical students (Hoffman et al., 2006) found that, through informal interactions with their senior mentors, their sympathy and empathy grew for older persons. As the students learned the elder’s stories, they gained an appreciation that aging is an individualized process, abandoned preconceived notions, and came to recognize the person within. Themes that arose from this study included recognition of the commonality among generations, that one can learn strategies to deal with experiences from other generations, and that the complexity of the healthcare system can have a differential impact on the older population.

A qualitative study exploring the benefits of being a senior mentor (Halpin et al., 2017) found that mentors had decreased levels of concern and anxiety over ageism at the end of the program. Mentors indicated that they viewed participation as an opportunity to affect positively how future health care professionals will interact with older patients.

Of note in these programs is the reciprocal nature of the interaction between the students and the senior mentors. Both groups can have a generative experience in which the mentors provide their wisdom and the students develop a bedside manner. When VCU’s Dr. Gendron hosted an end-of-year reflection session for both mentors and students several years ago, participants shared experiences and learning gained from the visits; the reciprocal capacity of the program in building relationships was evident. In the present study, both Y and B successfully established and built on their relationships with their mentors as the meetings progressed. When B and his mentor delved into

her progress towards her health goals at their second meeting, he was in effect practicing patient-centered care strategies. This experience allowed an opportunity for medical students to practice a patient-provider partnership approach to care.

The VCU Senior Mentoring Program will implement changes in the program administration based on feedback from the students and senior mentors. We will prompt students more explicitly to use the questions given in the assignments or create their own questions, rather than allowing them to go into the interviews with no framework. Because of Ms. D's friend's experience with paired males, and similar comments from other mentors, students will be randomly paired, with a priority given to mixing genders. Some medical students interviewed also mentioned that they knew of other students in their cohort who had teamed with a friend and did not understand the importance of the senior mentoring experience, which further supports the decision to randomize the pairs. In addition, beginning next year, we will require a joint final reflection, a sharing by students and senior mentors, in order to provide follow-up and closure for the relationship.

Study Questions

1. What are the benefits of providing several hours of dialogue between medical students and an older adult living independently in the community?
2. What is the value of viewing health care through the eyes of an older adult?
3. Can one learn strategies to deal with experiences from other generations?
4. How does informally interacting with medical students help older adults?

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www.vadars.org

Editorials

From the **Director, Virginia Center on Aging**

Edward F. Ansello, Ph.D.

Loneliness in Later Life

Loneliness is a self-assessment of insufficient, meaningful social connections.

About 30% of older adults report being lonely, according to the National Social Life, Health and Aging Project (NSHAP), an on-going study of social conditions and health in the United States, based at the University of Chicago.

Isolation and living alone may or may not be predictive of loneliness.

As in living on the edge financially where a person may be one paycheck away from disaster, so are some people one relationship away from loneliness.

Research on satisfaction with one's life in later life is voluminous with varying definitions, variables, studied populations, and contexts; but to my mind the findings tend to reduce to three major contributors: a) the presence of a confidant(e), that is, someone to whom we confide, who lends an ear, someone who accepts and supports the confider; b) having friends of substance, that is, individuals who are more than nodding acquaintances but rather are those with whom one has built some type of relationship through shared experiences or values; these are evolved relationships where one might have raised children together in the same neighborhood, prayed in the same house of worship, traveled or volunteered together, and the like; and c) the ability to participate in meaningful activities, with "meaningful" being self-defined and perhaps even highly idiosyncratic; engaging in such activities may bring a sense of pleasure, accomplishment, or personal growth.

Clinically measured health seems less predictive of life satisfaction than self-reported health, and the latter may be influenced by several factors, including social connections and self-esteem.

Insofar as satisfaction with one's life seems rooted in connections with others, it's not surprising that loneliness and life satisfaction are correlated; for the person lacking relationships with others may well self-assess as "lonely."

A difficulty in later life is that so many of the components of life satisfaction referred to above may become missing with advancing years. The confidant(e) may be a spouse, a sibling, a good neighbor, or a clergy person; with age these may pass away, relocate or be reassigned. For men, their confidante is often their spouse; if the spouse dies, there's may be an unfillable absence.

Similarly, advancing age tends to disrupt some interactions with substantive friends, especially face-to-face meetings, if not because of their passing then because of circumstances like physical incapacities and transportation barriers. Many self-defined meaningful activities involve other people but, fortunately, many do not; reading, some aspects of gardening, lifelong learning, and spirituality come to mind. Parenthetically, academics who love research and investigation (as meaningful activities) are often able to continue their work well into later life, even well into retirement, and this may contribute to the historically long life spans they've enjoyed.

Again, isolation does not necessarily correlate with loneliness. Individuals can live in isolation in remote areas or alone in the midst of thousands of others and not self-report as lonely. Living alone, also, is a poor predictor of loneliness; for instance, in later life many women are widows, living alone, yet actuarially they can expect long lives and not self-report as lonely. Conversely, someone caring for a loved one with advanced dementia may have that other person present constantly and yet define herself as lonely.

Defining oneself as lonely, being in a state of loneliness, is a significant risk factor for depression, substance abuse, malnutrition, self-neglect (the most common substantiated form of elder abuse), and exploitation (witness the alarming growth of scams targeting older adults, many scams relying upon the victim's need to "belong" and to have social connections).

Editorials

It may be that longevity, too, is affected by loneliness. A large cross-sectional study of over 73,000 New Zealanders over age 65, including 191 centenarians found that the longest lived were significantly less likely than their younger counterparts (average age 84) to be depressed or lonely. “Centenarians were more likely to be female, widowed, living alone or with relatives, receiving family support, and not depressed compared with those aged 65 to 99 years. Loneliness was significantly less common with older age.” (Leitch, Glue, et al., *JAMA*, October 2018)

What can be done about loneliness in later life, our own lives or those of others? I wish there were a universal ointment. But because loneliness is a self-assessment and we grow less alike as we age, there’s no single antidote.

However, there are actions we can take. For instance, Nurse Next Door, a provider of home care services, suggests four avenues: a) hobbies, such as crafts, genealogy, and photography; b) technology, from computer classes to digital home assistant devices to extra lighting in the home, for light therapy does seem to be effective with mild depression; c) pets, from goldfish to the four-legged kind; and d) obtaining family and friend support, either in person or by phone or computer. Notably, these actions are relatively inexpensive, can be undertaken even if one lives alone and finds it difficult to get out, and, importantly, may create some type of social connection. I think that we can add reflection, meditation, spiritual exercises and other aspects of conscious aging to the list, as relevant for some older adults.

The National Health Service (NHS) in New Zealand publishes other suggestions. Even though the NHS conflates loneliness and social isolation, conditions that can be mutually exclusive, their suggestions are helpful: forcing oneself to smile (remember the research cited in a previous editorial that demonstrated that even forced laughter improved health status); keeping a diary; and engaging in lifelong learning, among other steps.

The NSHAP project at the University of Chicago notes that persistent loneliness in later life is the exception rather than the rule. When it occurs, it’s most likely to be a transient condition and remediable.

From the Commissioner, Virginia Department for Aging and Rehabilitative Services

George Worthington,
DARS Dementia Services Coordinator

ACL Grant Brings Microlearning Lessons on Dementia to Primary Care Workforce

The Virginia Department for Aging and Rehabilitative Services (DARS) received a nearly \$1 million grant in 2015 from the federal Administration for Community Living (ACL) to develop and deliver several innovative programs to support people living with dementia and their care partners, as intended in Virginia’s Dementia State Plan. In one of these programs, DARS partnered with the Riverside Center for Excellence in Aging and Lifelong Health (CEALH) to develop five brief “microlearning” lessons for primary care providers related to the delivery of a dementia diagnosis to patients (available on <https://www.AlzPossible.org/training>).

The principal objectives for this project were to develop microlearning video modules with the potential to increase person-centered approaches to persons living with dementia and their care partners, as well as overall dementia awareness, confidence, and knowledge among the participating providers; and to incorporate feedback on the developed modules from the primary care workforce.

The curriculum development was, first, to be person-centered, reflecting the perspective of persons living with dementia and their care partners, and offering approaches that honor the individualized needs and preferences of patients and family members. Second, it would be based on relevant research. And, third, it would be practical, so that primary care providers (PCPs) could easily translate and use the knowledge in their practices right away. For this project PCPs included Physicians, Nurse Practitioners, Physician Assistants, and Residents.

Editorials

The project employed the HRSA (Health Resources and Services Administration) Training Curriculum: Alzheimer's Disease and Related Dementias (<https://bhw.hrsa.gov/grants/geriatrics/alzheimers-curriculum>) as a starting point to identify general content areas. A literature review of research on the knowledge needs of primary care providers and on care experiences and needs of persons living with dementia, as well as the professional experience of the project team, further narrowed topic areas to: *Demystifying Dementia, Sharing the Diagnosis, Providing Guidance, Communicating, and More than Meds.*

Based on the experience of the project team on other microlearning projects, each lesson would be kept under 10 minutes. The template for each lesson included three segments: 1) identifying the challenge, 2) using a person-centered approach to address the challenge, and 3) putting it into practice.

In identifying the challenge, each video presented perspectives from persons with dementia and their care partners. For example, in sharing the diagnosis, persons with dementia and their care partners shared their experiences receiving their diagnosis, including things that went well and areas for improvement. Identifying the challenge also included any relevant research. In sharing the diagnosis, this research included data on the percentage of people with dementia who were told their diagnosis, as well as research on why providers did not share the diagnosis.

The project identified person-centered approaches through research, best practices, and advice from persons living with dementia and their care partners on how they wish to be approached. Putting it into practice included brief, tangible things providers could do to apply this knowledge to their practice.

The project worked with a purposive convenience sample of 35 PCPs. After providing informed consent, these participants completed an online pre-test prior to receiving the first lesson and an on-line post-test after completing the final lesson. With attrition, a total of 24 PCPs completed all lessons and assessments. The pre-and post-tests were designed to elicit participants' attitudes toward persons with dementia, as well as the training needed to perform their job. The pre-test included selected questions from one

validated survey instrument, the Dementia Attitudes Scale (DAS; O'Connor & McFadden, 2010) and also included several demographic items.

Each response on the pre-test was compared to that same item response on the post-test. When examining frequencies, the project staff combined the percentage of participants who responded "agree" or "strongly agree" and did the same with those responding "disagree" or "strongly disagree." For example, "I feel confident around people with dementia" increased from 48% at pre-test to 75% at post-test. A paired-samples t-test compared attitudes to persons with dementia before and after the training ($n=20$ pairs). Three items stood out where there were statistically significant differences: "I feel confident around people with dementia" increased ($p=.03$); "I can make a difference in the lives of persons with dementia" increased ($p=.02$); and "I believe I have ample training" increased ($p=.00$).

On the post-test ($n=24$), the project team included several additional items to solicit participant feedback on the utility of microlearning to deliver training on dementia care. None of the participants responded that they did not like the microlearning format. Feedback was strongly positive with 95.8% of participants reporting that "Microlearning is a helpful way to learn" and the same percentage reporting that "As a result of this training, I have a better appreciation for the perspective of persons with dementia." Participants also liked several other aspects of the training format, including the short lessons (87.5%), learning at their own pace (79.2%), and being able to access the lessons on demand (75%).

Given the timeframe and scope of this project, it was thought more valuable to get feedback rather than to test knowledge. Providers recognized the need to be patient with dementia patients and their families and to not rush through a diagnosis, and the importance of empathy when delivering the diagnosis. It became apparent that lesson four, *Communicating*, was the most preferred among the PCPs.

DARS and CEALH learned several important lessons from this project: 1) Finding and translating research is time consuming, but the inclusion of research adds to the relevance of the lessons, particularly for this

professional audience. It is important to know the audience and what speaks to them, while remaining true to the intent of person-centered philosophy and practice. 2) The voices of persons with dementia and care partners seemed to speak to providers in a way that encouraged empathy and possibly motivated change. 3) The inclusion of a person with dementia and a care partner on the design team provided invaluable insight into the content and delivery. 4) For future lessons, perspectives and voices of a diverse group of persons with dementia and care partners should be included.

2019 DARS Meeting Calendar

Commonwealth Council on Aging

March 13, July 10, September 18, December 18

Alzheimer's Disease and Related Disorders Commission

March 19, June 11, August 20, December 3

Public Guardian and Conservator Advisory Board

March 7, June 20, September 5, November 21

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Recently at the Greater Richmond Age Wave

by Catherine MacDonald,
Greater Richmond Age Wave Director

Here's an overview of our recent community education, research, and engagement projects, plus what's next for the Greater Richmond Age Wave.

Community Education: Since May, Age Wave has presented the *Aging for Life* educational course six times for about 165 community members. We recently conducted focus groups in order to develop the new Financial Health module for the course, which we will pilot next month. In 2019, UnitedHealthcare will sponsor 10 courses, to be held at regional Friendship Cafes.



Neighborhood

Livability: Based on community survey findings, Age Wave recently completed the *Garden at Home, Grow with Your Neighbors*

Community Impact project, supported by AARP. We partnered with groups in Highland Park to design, build, and deliver self-watering raised-bed garden boxes, and we hosted two educational sessions. Next up: We're launching our 2019 advocacy agenda and housing stability work. In addition, look for an exciting transportation project this spring.

Housing Stability: Homelessness overall has been declining since 2009 in our region. For older adults, however, it's on the rise and has almost doubled. The recent Homeward Point-in-Time Count queried social support status and revealed that perceived lack of social support and social isolation are high among older adults experiencing homelessness. Age Wave's housing stability efforts, supported by Richmond Memorial Health Foundation, will address these issues and create lasting impact.

Deep Neighborhood Engagement: Age Wave has spent the past year developing and implementing deep neighborhood engagement initiatives. Age Wave has been helping to lead the East End Coalition

for Older Adults. Our relationship with First Baptist Church of South Richmond has provided an enriching two-way street of knowledge sharing. And our interdisciplinary team recently was awarded a City Council Proclamation for our work in Richmond's Sixth District.

Business Roundtable: Business for Life is planning a Business Roundtable event, sponsored by DispatchHealth. We seek to engage regional and local businesses around topics such as: Hiring and retention of workforce; Welcoming the demographic shift; and Generations in the workforce. Know a business who wants to be at this table? Email beth.ludden@genworth.com.

Managing Someone Else's Money

Some 40% of older adults have been given a Power of Attorney. Managing another person's money can be challenging. Sometimes with little guidance, these financial caregivers may make simple mistakes that have heavy consequences. The Consumer Financial Protection Bureau (CFPB), a federal agency created after the big bank failures of 2007-2009, serves as, among other roles, an assistant to financial caregivers and a watchdog against fraud and abuse. The CFPB has created some very helpful guides for those of us who have undertaken the task of managing someone else's money.

Specifically, CFPB has produced four readable guidebooks for those who are: 1) Court-appointed guardians of property, 2) Agents under Power of Attorney, 3) Trustees, or 4) Government fiduciaries like Representative Payees for Social Security.

There's a good overview in a five-minute video at: <https://www.youtube.com/watch?v=1ssLr8GCaNs&feature=youtu.be>.

To obtain any of the above-mentioned guide books, go to <https://www.consumerfinance.gov/consumer-tools/managing-someone-elses-money/>.

You can order the printed versions here and CFPB will mail you copies or you can download them to your own computer and print your own copies.

SGS Changes Site of Annual Meeting Due to Hurricane



The SGS annual conference in April has been re-located because its meeting hotel in Panama City Beach, Florida, sustained extensive damages during

Hurricane Michael this fall. The hotel is projecting the need to remain closed through May of 2019. The good news, however, is that SGS will return to this beautiful location for their 43rd annual conference in 2022.

The new meeting hotel is the Sandestin Golf and Beach Resort in Miramar Beach, Florida. The conference dates remain the same, April 9-13, 2019. This resort is reachable by either the Destin-Fort Walton Beach airport (VPS) or the Panama City Beach airport (ECP). Happily, there are a number of different room types available and the rate for a standard room is only \$135 (plus a 12% resort fee).

The conference theme, *Mining the Gems, Investing in Our Future*, reflects SGS's 40th (Ruby) anniversary and continued commitment to bridging research to practice through collaborative partnerships among SGS members, conference attendees, and communities in which SGS hosts its conference. Pointedly, the conference will begin with a day of service within the local communities. All are welcome to join in working with community partners in the Miramar Beach area.

The conference program includes focused tracks on the following topics: Partnerships for Care; Living with Dementia; the Power of Place; Advocacy for and by Older Adults; Wellness, Well-being and Quality of Life; Diversity and Aging; Gerontological Education; and Technology. The program contains nearly 200 presenters, including keynotes by Teepa Snow and Dr. Olivia Clay.

SGS's Florida representatives are planning highly relevant sessions about emergency management and post-natural disaster mitigation and management, as well as sessions on the demise of active advocacy by Florida's "Silver Haired Legislature" and a profile of

the PACE healthcare model, which enables older adults to remain in their communities rather than entering nursing homes.



Conference attendees can anticipate numerous networking activities, such as a round table lunch, a dine-around evening at the Sandestin Wharf, and a fantastic evening of

celebration at the SGS Ruby Anniversary Gala.

Conference registration is at:

<https://southerngerontologicalsociety.org/meeting-registration-info.html> Rates vary based on SGS membership, student, or retiree status. Single daily rates are available. Early bird registration (discounted) is in effect through March 1, 2019. Registration includes all meals, and all daily and evening events.

Reservation for the Sandestin Golf and Beach is at:

<https://southerngerontologicalsociety.org/lodging.html>.

We Eat How Much Added Sugar?

The average American consumes 21 to 28 teaspoons of added sugar each day. For instance, the typical 20-ounce soda contains about 16 teaspoons of sugar, which, by itself is 130 percent of the recommended daily limit for added sugars. But added sugars can hide almost everywhere, from breakfast cereals to three quarters of other packaged foods, like pasta sauce, sports drinks, granola, and yogurt. Consuming added sugars poses a risk for cardiovascular disease.

Find out more at:

<https://www.hopkinsmedicine.org/health/healthy-woman/nutrition-fitness/finding-the-hidden-sugar-in-the-foods-you-eat>

College Students Hack to Develop Tech Solutions to Improve Caregiver Health

by Kim Tarantino, VirginiaNavigator

College students gathered in teams again in Richmond late October for the 2018 edition of the “Caring for the Caregiver Intercollegiate Hack” hosted by VirginiaNavigator’s Lindsay Institute for Innovations in Caregiving. They met to address the often overlooked issues of family caregiver health and wellness.

There are over 65 million family caregivers in the U.S., providing an average of 20-41 hours each week of care to their loved ones, and this number will continue to grow as the nation grows older. “Family caregiving is truly the backbone of long-term care, making up more than 80% of care provided,” said Dr. Richard W. Lindsay, co-founder and namesake of the Lindsay Institute.

“While caring for a loved one can be gratifying, (these caregivers) are likely to be juggling caregiving along with jobs, children, and a host of other responsibilities,” said Adrienne M. Johnson, Gerontologist and executive director of VirginiaNavigator.

This 4th Annual Hack challenged college students to advance the health and improve the lives of family caregivers by creating technological tools such as apps, devices for the home, wearables, or interactive web experiences, through the spirit of friendly competition. Students from each college formed multidisciplinary teams of three to six participants, led by a faculty coach, and aided by a family caregiver who shared his or her experiences and challenges.

Teams from the College of William and Mary, George Mason University, James Madison University, University of Lynchburg, University of Virginia, Virginia Commonwealth University, and Virginia Tech worked competitively over a 24-hour period to create realistic and usable apps or products designed to improve caregiver health. Each team then formally presented its creation. An esteemed panel of judges selected the grand prize, second place, and third place

winners based on the technology's originality, usability, feasibility, and how developed it was at the time of the presentation.

"I'm always moved by the love and generosity family caregivers so willingly bring to a job that can be all-consuming emotionally, physically, and even financially," said Dr. Catherine Alicia Georges, National Volunteer President, AARP Board of Directors, and a panel judge. "To ease the challenges they can face, technology offers tremendous promise. And, as we see each year at the Caregiver Hack event, finding ways for the generations to put their heads together has proved to be a joy and a benefit to all."



The team representing Virginia Commonwealth University was awarded the competition's \$3,500 Grand Prize, for "Hummingbird", an app dedicated to connecting care aides and family caregivers for

scheduling, continuity of care, and training. Relieving the family caregiver of multiple paper trails and calendars, Hummingbird allows for seamless scheduling and uploading availability of new training experiences for care aides.

Additional teams and technologies developed at the Hack event include:

University of Virginia (2nd place and \$2,000 cash prize): "Circ" is an app designed to help the LatinX family caregiver connect with medical resources for their family members, addressing the specific trends in LatinX care and the care of those in other minority demographics.

George Mason University (3rd place and \$500 cash prize): "WriteMind" is a social media app designed to improve the caregiver's lifestyle through journaling. The journaling app will recognize key words to detect the caregiver's mood and recommend specialized resources based upon that information.

The other teams produced the following: • College of William and Mary: "Carepath: A Personally Curated Caregiving Resource" is an app that takes a holistic

approach to connect caregivers, offering curated content and combining knowledge to combat isolation.

- James Madison University: "Caregiver to Caregiver (C2C)" is an app designed to connect, encourage, train on medical equipment, and offer resources that are easily accessible, based on the condition of the family caregiver's loved one. This app is geared to combat the isolation and depression that 40-70% of family caregivers feel.
- University of Lynchburg: "True to Me" is an app designed specifically to the needs of the child caregiver. Loaded with games and incentives, the app focuses on fun for the child.
- Virginia Tech: "Mobius" is an app to capture lasting memories of your loved ones. Mobius is a living journal only shared with loved ones; it connects those family members who cannot be a part of the care of their family member.

At the conclusion of the event, the judges agreed that several of the concepts developed and presented by the student teams have great potential to become viable and useful tools and products in the market to help family caregivers stay healthy.

With the teams retaining ownership of their ideas, there were several surprises announced at the conclusion of the Hack weekend. The grand prize winning team from Virginia Commonwealth University (VCU) will have the opportunity to pitch their new technology tool to leadership at Startup Virginia, an incubator that supports entrepreneurs and high-growth companies, for a chance to secure a summer residency at Startup Virginia's office; here the team will have mentors and education to help them refine and pursue further development of their tech tool.

In addition, each of the six students comprising the VCU team was awarded a \$1,000 scholarship from Hack Platinum Sponsor, Genworth. Representatives from Genworth also extended an invitation for the student participants from all seven teams to spend an afternoon with Genworth's President and CEO, Tom McInerney, and the company's senior leadership team.

For more information on the Lindsay Institute for Innovations in Caregiving or this Hack event, please visit www.Caregivinginnovations.org.

Interestingly, even though essentially all these increasingly used mood-stabilizers are FDA approved as anti-epileptic drugs, the diagnosis of seizure-epilepsy is actually decreasing in Virginia nursing homes. In fact, all of the increases in mood-stabilizing antiepileptic drugs in Virginia are in long-stay patients without a seizure diagnosis. Long-stay patients with a seizure-epilepsy diagnosis are prescribed very different antiepileptic medications than long-stay patients without a seizure-epilepsy diagnosis.

The majority of residents with seizure are prescribed antiepileptics without a mood-stabilizing benefit; over the last five years, this has changed to become predominantly new drugs like Keprra and Vimpat rather than older drugs like Dilantin and phenobarbital, while patients without a seizure diagnosis are overwhelmingly prescribing a mood-stabilizing antiepileptic. Long-stay residents who are prescribed a mood-stabilizer, whether an antipsychotic type or a non-antipsychotic type, were more likely to be male and African-American.

In conclusion, mandatorily reported ‘inappropriate’ antipsychotic mood-stabilizer prescribing is decreasing in Virginia nursing homes, as it is nationally. However, unreported mood-stabilizer prescribing is on the rise. This is due to increases in both ‘appropriate’ (and therefore unreported) antipsychotic prescribing and escalating non-antipsychotic mood-stabilizer use. If pharmacologic approaches to Behavioral and Psychological Symptoms of Dementia (BPSD) management are evolving nationally with risky and ineffective, but unreported, medications being used more, while at the same time medications mandatorily reported to CMS are being used less, this has impact on clinical guidelines and policies; this has direct relevance to all stakeholders in dementia care, including patients, providers, specialty groups, payers, patient advocates, and policy makers. Harms could be increasing with no clinical or safety benefit, jeopardizing the health and safety of the 1.5 million American older adults currently in nursing homes. CMS should be cautious in permitting exclusions to any of their quality metrics. Mood-stabilizing antiepileptic drugs should be added to the list of psychoactive medications that must be reported to the CMS. *Dr. Winter may be contacted at (540) 631-3700, jwinter@valleyhealthlink.com*

Request for ARDRAF Applications

Funding: The size of awards is limited to \$45,000 each. Number of awards is contingent upon available funds. The funding period begins July 1, 2019 and projects must be completed by June 30, 2020. Award decisions will be announced by June 24, 2019.

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.

Letter of Intent: By **February 15, 2019** prospective applicants are required to submit a non-binding letter of intent that includes a tentative project title, contact information for the principal investigator, the identities of other personnel and participating institutions, a non-technical abstract, and a 4-5 sentence description of the project in common, everyday language. Letters on letterhead with signature affixed must be uploaded to www.bit.ly/ardraf-loi.

Applications: Applications will be accepted through the close of business **March 15, 2019**. Significant changes to the application form and guidelines were instituted in 2018. Application forms, guidelines, and further information may be found at www.go.vcu.edu/ardraf or by contacting the Award Fund administrator, Constance L. Coogle, Ph.D. (804-828-1525 or ccoogle@vcu.edu).

MIND Diet May Slow Cognitive Decline

(The following is adapted from an article by Nancy Difiore, Media Relations, Rush University Medical Center)

A diet created by researchers at Rush University Medical Center may help substantially slow cognitive decline in stroke survivors, according to preliminary research presented last year at the American Stroke Association's International Stroke Conference in Los Angeles. The findings are significant because stroke survivors are twice as likely to develop dementia compared to the general population.

The diet, known as the MIND diet, is short for Mediterranean-DA_SH Intervention for Neurodegenerative Delay. The diet is a hybrid of the Mediterranean and DASH (Dietary Approaches to Stop Hypertension) diets. Both have been found to reduce the risk of cardiovascular conditions such as hypertension, heart attack, and stroke.

“The foods that promote brain health, including vegetables, berries, fish and olive oil, are included in the MIND diet,” said Dr. Laurel Cherian, a vascular neurologist and assistant professor in Rush's Department of Neurological Sciences, and (the diet) “has the potential to help slow cognitive decline in stroke survivors.” The diet has been associated with reduced Alzheimer's risk in older adults who adhered to its recommendations. Even people who moderately adhered had reduced risk of AD and cognitive decline.

The MIND diet has 15 dietary components, including 10 “brain-healthy food groups” (whole grains, leafy greens, berries, nuts, beans, vegetables, wine, fish, poultry, and olive oil) and five “unhealthy groups” (red meat, butter, cheese, pastries and sweets, and fried or fast food).

To adhere to and benefit from the MIND diet, a person would need to eat at least three servings of whole grains, a green leafy vegetable and one other vegetable every day, along with a glass of wine, snack most days on nuts, have beans every other day or so, eat poultry and berries at least twice a week, and fish at least once a week. A person would also need to limit

intake of the designated unhealthy foods, limiting butter to less than 1 1/2 teaspoons a day and eating less than a serving a week of sweets and pastries, whole fat cheese, and fried or fast food.

From 2004 to 2017, Cherian and colleagues studied 106 participants of the Rush Memory and Aging Project who had a history of stroke, and watched for cognitive decline, including decline in one's ability to think, reason, and remember. They assessed people in the study every year until their deaths or the study's conclusion, for an average of 5.9 years, and monitored patients' eating habits using food journals.

The researchers grouped participants into those who were highly adherent to the MIND diet, moderately adherent and least adherent. They also looked at additional factors that are known to affect cognitive performance, including age, gender, education level, participation in cognitively stimulating activities, physical activity, smoking and genetics.

The study participants with the highest MIND diet score had a substantially slower rate of cognitive decline than those who scored lowest. The estimated effect of the diet remained strong even after taking into account participants' level of education and participation in cognitive and physical activities. In contrast to the results of slower decline with higher MIND diet score, stroke survivors who scored high on just the Mediterranean and the DASH diets did not have significant slowing in their cognitive abilities.

“The Mediterranean and DASH diets have been shown to be protective against coronary artery disease and stroke, but it seems the nutrients emphasized in the MIND diet may be better suited to overall brain health and preserving cognition,” Cherian said.

According to Cherian, studies have found that folate, vitamin E, omega-3 fatty acids, carotenoids and flavonoids are associated with slower rates of cognitive decline, while substances such as saturated and hydrogenated fats have been associated with dementia.

This was a preliminary, observational study and subsequent studies need to confirm these most promising findings.

Joyful Voices with Dementia



Joyful Voices, a community chorus, capitalizes on the functional reality that the amygdala, a seat of emotional and musical memories in the brain, is one of the sturdiest fortresses against dementia. It often resists decay well into the advances of Alzheimer's disease and other dementing illnesses.

As is common with many brain structures, there are two amygdalae, located in the frontal portion of the temporal lobe, each close to the hippocampus, which is thought to be central for forming, storing, and retrieving memory. While the hippocampus is affected early in dementia, the emotional resources of the amygdalae tend to endure. Enter Joyful Voices.

Joyful Voices is, so far, a small nationwide movement where adults with dementia, their caregivers, and community volunteers gather together in chorus to sing and "elevate the spirit." There is a chorus just outside Richmond, VA, at Salisbury Presbyterian Church in Midlothian.

Members of the Joyful Voices Chorus gather on Thursday mornings at this church for rehearsals, but they often experience quite a bit more. Laughter, fellowship, and the warm memories that singing familiar melodies can bring. Music is increasingly becoming recognized for its beneficial roles in dementia care, such as stimulating positive emotions and having a calming influence.

Joanne Sherman, Artistic Director of the Chorus, engages the 40 or so chorus members during these rehearsals to contribute what they can. The result can seem greater than the sum of these parts.

Recently, the Joyful Voices Chorus held its debut performance at the church. Chorus co-founders Mark

Patterson, Laura Miles, and Joanne Sherman welcomed a large audience. The chorus sang a dozen songs, most being from the earlier days of the older adults, such as *Over the Rainbow* and *This Land Is Your Land*; this set included three well-known melodies for audience sing-along. And sing they did.

By the concert's conclusion, it was apparent the chorus and audience thoroughly enjoyed the experience. Caregivers and volunteers can obtain more information about Joyful Voices by contacting Joanne Sherman at JoyfulVoicesSherman@gmail.com.

Management of Later Life Pain: Free Webinar Series

The Translational Research Institute on Pain in Later Life (TRIPLL) offers a web-based training resource for health professionals, researchers, and others with interest (or working) in the aging field. Beginning in February, there will be a free series presented by Cornell University's Edward R. Roybal Center and University of Florida's Pain Research and Intervention Center of Excellence entitled *Mechanisms and Management of Later Life Pain*. The dates and specific topics of the first webinars are:

February 25, 2019, 1:00 p.m. - 2:00 p.m. EST
Presenter: Robert D. Kerns, PhD, Yale School of Medicine, *Psychological Therapies for Pain*

March 18, 2019, 1:00 p.m. - 2:00 p.m. EST
Presenter: Fadel Zeidan, PhD, University of California San Diego School of Medicine, *Mechanisms Supporting Mindfulness Based Pain Relief*

April 29, 2019, 1:00 p.m. - 2:00 p.m. EST
Presenter: Lynn Martire, MD, Penn State College of Health and Human Development, *Close relationships and Chronic Pain Self-Management*

May 20, 2019, 1:00 p.m. - 2:00 p.m. EST
Presenter: Joseph Riley, PhD, University of Florida, *Assessment of Pain Modulation in Older Adults*

Please visit the TRIPLL website at www.tripll.org for more information.

Calendar of Events

January 23, 2019

Virginia Center on Aging's 33rd Annual Legislative Breakfast. Patrick Henry Building, 1111 E. Broad Street, Richmond. 7:30 a.m. - 9:00 a.m. For information, call (804) 828-1525 or email eansello@vcu.edu.

February 2, 2019

Seventh Annual Emswiler Interprofessional Symposium. Presented by the VCU Center for Interprofessional Education and Collaborative Care. For information, visit <https://ipe.vcu.edu/symposium>.

March 5, 2019

Residential Care/Assisted Living Exam Prep Course. Provided by the VCU Department of Gerontology. Westerre Conference Center, Richmond. 9:00 a.m. - 4:00 p.m. For information, call (804) 828-1565 or email agingstudies@vcu.edu.

March 26-27, 2019

Virginia Assisted Living Annual Spring Conference. The Hotel Roanoke and Conference Center, Roanoke. For information, visit www.valainfo.org.

April 9-13, 2019

Mining the Gems: Investing in Our Future. 40th Annual SGS Conference. Sandestin Golf and Beach Resort, Miramar Beach, FL. For information, visit www.southerngerontologicalsociety.org.

April 15-18, 2019

2019 Aging in America Conference. Annual Conference of the American Society on Aging. Hyatt Regency, New Orleans, LA. For information, visit www.asaging.org.

April 26-28, 2019

30th Annual Virginia Geriatrics Society Conference. Hilton Richmond Hotel, Short Pump. For information, visit www.vgsconference.org.

May 29-31, 2019

Breaking Barriers: Empowering Older Virginians. 25th Annual Conference of the Virginia Coalition for the Prevention of Elder Abuse. Kingsmill Resort and Conference Center, Williamsburg. For information, visit www.vcpea.org.

June 5-7, 2019

LeadingAge Virginia Annual Conference and Expo. Registration will open April 1, 2019. Norfolk Waterside Marriott, Norfolk. For information, visit leadingagevirginia.site-ym.com/default.aspx.

June 17-20, 2019

Age+Action Conference. Presented by the National Council on Aging. This conference will bring together the National Institute of Senior Centers, Center for Healthy Aging partners, and Benefit Enrollment Centers from across the country. Renaissance Washington, DC Downtown Hotel, Washington, DC. For information, visit <https://www.ncoa.org/event/ageaction>.

July 27-31, 2019

National Association of Area Agencies on Aging's 44th Annual Conference and Tradeshow. Registration opens March 29, 2019. Hilton New Orleans Riverside, New Orleans, LA. For information, visit www.n4aconference.org.

November 12, 2019

Virginia Association for Home Care and Hospice Annual Conference. The Westin Virginia Beach Town Center, Virginia Beach. For information, visit www.vahc.org.

November 13-17, 2019

Strength in Age: Harnessing the Power of Networks. Gerontological Society of America's Annual Scientific Meeting. Austin, TX. The call for abstracts will open February 1, 2019 and close on March 18, 2019. For information, visit www.geron.org.

Age in Action

Volume 34 Number 1: Winter 2019

Edward F. Ansello, PhD, Director, VCoA
Kathryn Hayfield, Commissioner, DARS
Kimberly S. Ivey, MS, Editor

Age in Action is published quarterly (January, April, July, October). Submissions and comments are invited, and may be published in a future issue. Send submissions to ksivey@vcu.edu.

**Spring 2019 Issue Deadline for Submissions:
March 15, 2019**



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Breaking Barriers: Empowering Older Virginians

25th Annual Conference of the Virginia Coalition for the Prevention of Elder Abuse

May 29-31, 2019

Kingsmill Resort and Conference Center, Williamsburg

Since 1993, The Virginia Coalition for the Prevention of Elder Abuse (VCPEA) has been a leader in promoting awareness and training on behalf of Virginia's abused, neglected, and exploited adults. We are a coalition of individuals and agency representatives committed to improving the lives of adults in Virginia who are older or have a disability. VCPEA hosts the only statewide conference focusing on adult abuse.

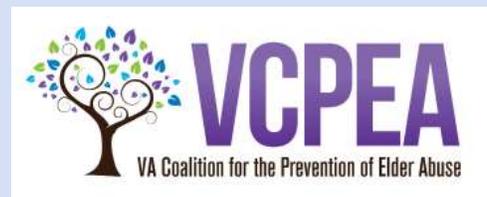
The conference is open to professionals in a variety of disciplines who provide services to older adults, and are interested in increasing their awareness of the issues of adult abuse, neglect, and exploitation.

Online registration for the conference will begin January 15, 2019 as follows:

Early Bird Registration (1/15/19 - 2/15/19): \$300

General Registration (2/16/19 - 4/15/19): \$350

Late Registration (4/16/19 - Sell Out): \$450



Membership to VCPEA is included for all those who register for the conference.

For more information, or to register, visit www.vcpea.org.

Virginia Commonwealth University is an equal opportunity/affirmative action institution and does not discriminate on the basis of race, gender, age, religion, ethnic origin, or disability. If special accommodations are needed, please contact Dr. Edward F. Ansello, VCoA, at (804) 828-1525.