Volume 31 Number 3 Summer 2016

age in action

Activities in geriatrics and gerontology education and research

Virginia Center on Aging
and
Virginia Department for Aging and Rehabilitative Services

Case Study

Evaluating Commonwealth Coordinated Care: The Experiences of Individuals Dually Eligible for Medicare and Medicaid

by Gerald Craver, PhD
Virginia Department of Medical Assistance Services
Alison Cuellar, PhD, and
Gilbert Gimm, PhD
George Mason University

Objectives

1. To understand Virginia's rationale for implementing the Commonwealth Coordinated Care Program and its approach to evaluating it.
2. To provide a framework for examining the health care experiences of individuals with behavioral health and/or long-term service and support needs who are enrolled in the Commonwealth Coordinated Care Program.
3. To inform policy on future options for improving the quality and health care experiences of similar groups of individuals in Virginia and other states.

Background

In the United States, approximately 10.2 million older adults and others with disabilities are dually eligible for both Medicare and Medicaid benefits (Medicaid and CHIP Payment and Access Commission [MACPAC], 2015). They represent some of the nation's most vulnerable citizens because of their complex mix of medical needs, including acute, primary, behavioral, chronic, and long-term services and supports (LTSS). Although dual eligible individuals have access to a wide range of health and social services, these benefits are generally not well coordinated because they are provided primarily through the traditional fee-for-service (FFS) Medicare and Medicaid programs. The lack of coordination is further complicated by the fact that Medicare and Medicaid operate independently of each another, resulting in conflicting coverage and payment policies, fragmented service delivery systems, and incentives for provider cost shifting. By hindering efforts to improve access and care coordination for dual eligible individuals, this environment promotes unnecessarily high costs and less than optimal patient care and quality of life (Centers for Medicare and Medicaid Services [CMS], 2011).

In response, the federal and state governments are pursuing a number of strategies to improve the quality and delivery of care for this population. One such strategy authorized under the 2010 Patient Protection and Affordable Care Act and administered by CMS is the Financial Alignment Demonstration (FAD), which is testing two new payment reform and service delivery models at the state level: capitation and managed FFS (CMS, 2011). Capitation is a payment arrangement for health care service providers such as physicians or nurse practitioners that pays a set amount for each enrolled person assigned to them, for a given period of time, whether or not that person seeks care. Under the capitated payment model, CMS and 10 states have contracted with over 60 managed care plans to coordinate care for dual eligible individuals, while under the managed FFS model, two states are using their existing infra-

Inside This Issue:

structures to provide individuals with enhanced care coordination (CMS, 2011; MACPAC, 2015; Kaiser Commission on Medicaid and the Uninsured, 2016). Regardless of which model states test, the demonstrations seek to improve quality, access, and health care experiences for dual eligible individuals, while reducing Medicare and Medicaid costs by providing them with services that are more coordinated and person-centered (CMS, 2013).

As part of the FAD initiative, CMS contracted with RTI International to evaluate the demonstrations at the national and state levels. The national evaluation includes site visits to participating states; interviews and focus groups with program staff, stakeholders, and dual eligible individuals; analyses of quality, utilization, and cost outcomes; and calculation of savings attributable to the state demonstrations. While RTI is responsible for the federal evaluation, participating states have the option to evaluate their own demonstrations.

Commonwealth Coordinated Care (CCC)

Virginia implemented its financial alignment demonstration, The Commonwealth Coordinated Care (CCC) Program, on March 1, 2014 for approximately 78,600 dual eligible individuals ages 21 and older who receive full Medicare and Medicaid benefits and reside in one of five geographic regions of the state designated for the program. A unique feature of the CCC Program is that it represents the first time that Virginia has enrolled dual eligible individuals with behavioral health (BH) and/or LTSS needs in a managed care program.

The CCC Program is a capitated model, implemented through a three-way contract among CMS, DMAS, and three managed care plans (Anthem Healthkeepers, Humana, and Virginia Premier), to operate what are called Medicare – Medicaid Plans (MMPs). Initially, the state sent letters to dual eligible individuals encouraging them to select an MMP and actively enroll in CCC. Individuals who did not choose to opt-out of the program were assigned to an MMP and automatically enrolled. (Regardless of how individuals enrolled, CCC participation is entirely voluntary and individuals can disenroll or change MMPs at any time.) Under the terms of the three-way contract, the MMPs provide participants with one membership card (to replace separate Medicare and Medicaid cards), access to a 24-hour nurse call line; and coverage for standard Medicare and Medicaid benefits, as well as additional benefits not typically covered in the FFS programs, such as dental, hearing, and vision services. To ensure that individuals receive appropriate care, the program provides a number of protections, including continuous quality monitoring, continuity of care requirements, a unified appeals and grievances process, and state long-term care ombudsman services, in accord with CMS principles.

These benefits are intended to improve quality, access, and health care experiences for enrolled individuals; but the key benefit of CCC is enhanced care coordination where the MMPs provide individuals with a care coordinator (usually a registered nurse) who is responsible for coordinating various services that meet the person's health and social needs. Coordinators perform several activities to accomplish this, including evaluating individuals to identify gaps in care; developing care plans that address their specific needs and preferences; teaching individuals self-management skills; building relationships with individuals through periodic contact and advocating for their rights when needed; facilitating communication among providers and between individuals and providers; and helping providers and individuals adjust to a new managed care environment (Craver, 2016a).

As of May 2016, approximately 29,374 individuals were enrolled in the CCC Program. Most (23,360, or 80%) were automatically enrolled, while the remainder (6,014, or 20%) voluntarily enrolled. The distribution of individuals was as follows: 12,441 individuals (42%) were with Anthem Healthkeepers, 10,730 (37%) with Humana, and 6,203 (21%) with Virginia Premier. (Additional information on CCC is available online at: www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx.)

CCC Evaluation

Because the CCC Program represents a major effort in state reform, DMAS partnered with George Mason University (Mason) to evaluate it, using both quantitative and qualitative components. Mason faculty members are responsible for the quantitative component, while DMAS staff members are responsi-

ble for the qualitative component. To ensure that both components support each other, the DMAS/Mason evaluation team has met periodically to exchange information since the spring of 2014.

To meet the informational requirements of DMAS management and other stakeholders, the evaluation is examining the program at the beneficiary and population levels. MMP care coordination for individuals with BH and/or LTSS needs is a particular focus for two reasons: 1) care coordination is the CCC Program's hallmark and 2) the program represents the first time that Virginia is enrolling individuals with these needs into a managed care delivery system. (Of the 29,374 enrolled individuals, approximately 21% had BH needs, while 24% had LTSS needs.) As part of the CCC evaluation, DMAS recruited and facilitated an advisory committee to assist the evaluation team with understanding the unique needs and concerns of individuals in the target subpopulations. While having similar research goals as RTI's national evaluation, the DMAS/Mason evaluation is specific to Virginia and includes the use of methods and data that RTI is not using; these include surveys of dual eligible individuals and intensive fieldwork involving observations, interviews, and focus groups.

Quantitative Findings

For the quantitative component, Mason faculty members are surveying individuals over time to examine changes in quality of care, access, and health care satisfaction and experiences. Later phases of the evaluation will be supplemented with Medicaid claims data to examine whether the CCC Program resulted in more appropriate utilization, improved quality, and lower costs at the state population level. Thus far, Mason faculty members have surveyed approximately 1,000 enrolled individuals who were receiving LTSS through DMAS' Elderly or Disabled with Consumer Direction (EDCD) Waiver; 516 individuals responded, representing a 52% response rate. In terms of the experiences of dual eligible individuals, the survey results indicate that the CCC Program is successful and has engendered a high level of satisfaction. In particular, 96% of the 516 individuals responding reported being very satisfied with their care coordinators; 91% reported that the enrollment process was easy to understand; and 74% reported no change in their health care services since enrolling, while 19% reported some improvement in their services since enrolling (Cuellar, Gimm, & Gresenz, 2015). Currently, Mason faculty are compiling results of a survey of individuals in the EDCD Waiver who disenrolled, and are also preparing to survey enrolled individuals with BH needs.

Qualitative Findings

For the qualitative component, DMAS staff members are observing care coordination activities and conducting interviews to understand what the program looks like from the perspective of the dual eligible individuals who are directly involved in it. Since June 2014, DMAS staff members have observed 171 hours of care coordination activities and interviewed 72 individuals (56 who enrolled and 16 who disenrolled) in both group and individual settings across the MMPs and demonstration regions. Staff are also interviewing care coordinators and providers as part of this process.

Staff members have identified several themes that allow for a more in-depth understanding of individual health care experiences. Examples include *Acquiring Perspectives on CCC* (defined as how individuals initially viewed the CCC Program and how their perceptions may vary over time); Engaging in CCC (defined as how individuals became involved in the program and how their involvement may change over time); *Experiencing Meaningful Relationships* (defined as how individuals develop and experience relationships with key individuals as part of their CCC engagement); and *Coordinating Care by Building Associations* (defined as how care coordinators work with providers to support enrolled individuals). The case summaries that follow illustrate these themes by providing insight into how two individuals (the first, an EDCD Waiver participant, and the second, an EDCD Waiver participant who also receives services from a local Community Services Board) initially perceived the CCC Program, became engaged in the program, and experienced meaningful relationships with their coordinators and others involved in their care. The case summaries also provide insight into how MMP care coordinators work with providers to support enrolled individuals.

Case Study 1

Cynthia is 58 years old with several

chronic conditions. In March 2014, she received a letter informing her that the state was implementing a new program for dual eligible individuals that would combine their Medicare and Medicaid benefits under one health plan. Recalling that, Cynthia said, "I [received] a letter saying I had the option to enroll or stay the way I was and I liked the idea of Medicare and Medicaid being together…so I enroll[ed]." Because Cynthia was already in Humana's Medicare Advantage Plan, she was familiar with Humana and selected it as her MMP. Cynthia's enrollment decision was also influenced by the fact that most of her providers were in Humana's network. As Cynthia remarked, "I like to [stay] with people who know me…whether it's the pharmacy or the doctor…"

Soon after enrolling, Carol, a Humana care coordinator, started working with Cynthia. "I like my coordinator, she's always in touch…she and I not only talk [on the phone], but she sees me [in my home]," said Cynthia. When asked about how Carol assists her, Cynthia said, "[Carol] tells me about things that are available, like Silver Sneakers [an exercise program]… she helps me when I do my…[pharmacy] orders…she answers my questions…like when I had to find a dermatologist [and] if I have any problems [with providers or services], she straightens it out." When Cynthia started having mobility issues, Carol ordered a personal emergency response system pendant in case she fell and injured herself. Because Cynthia is in the EDCD Waiver, Carol works with Wendy (a home health agency nurse) to support her at home. Wendy started working with Cynthia in the spring of 2014, and likes the CCC Program because she has a contact person, "I can call [Carol] and I know [my concerns] will be taken care of." This doesn't usually happen with Wendy's FFS members because their case workers change frequently. When comparing her relationships with Carol and Wendy to relationships with other healthcare staff before enrolling in the CCC Program, Cynthia said, "…we have a good relationship…they can tell when something's going on with me whether I say so or not…this is better…I like the one-on-one [contact]…" (Craver, Behrens, & Broughton, 2015).

Case Study 2

Judy is 56 years old and has several chronic conditions and physical limitations. She receives LTSS through the EDCD Waiver and BH services through a local Community Services Board (CSB). In October 2014, she received a letter from the state informing her about a new program to improve care for dual eligible individuals. "It sounded like something I'd like to try," said Judy, so she enrolled with Anthem Healthkeepers in the CCC Program. Soon afterward, Jamie, a care coordinator, came to Judy's home to discuss the program with her and Helen, a CSB case manager. Recalling the encounter, Helen said, "I thought [the program] was very good…I do mental health and [Jamie] helps with the physical part…so [I thought] it [would] help meet all of [Judy's] needs…" During the meeting, Jamie learned that Judy was not satisfied with her service facilitator, so Jamie informed her that she could choose a new facilitator. Jamie said, "…you have the opportunity to switch…we can find you somebody new…we have options that we can look at." Judy was agreeable, so Jamie referred her to a local provider and Marianne became her new service facilitator. (Service facilitators support individuals in the EDCD Waiver by developing and monitoring care plans, providing management training assistance, and completing ongoing review activities as required for their consumer directed personal care and respite services.)

To support Judy, Jamie, as care coordinator, periodically communicates with Helen and Marianne. One issue they've worked on is ensuring that Judy has adequate personal care services. Because Judy lives alone and has physical limitations, she's concerned about having to move into a nursing facility if something happens. Helen said, "...going into a nursing facility… would be very detrimental to Judy's mental health…she would deteriorate quickly…" For this reason, Marianne and Helen have shared information with Jamie in order to ensure that Judy receives adequate personal care services at home. Jamie noted "…getting input from [Marianne and Helen] assists [me] in making sure [Judy's] in the best health she can be emotionally and physically." Marianne added, "…our job is to go to bat for [Judy] to make sure she gets the services she needs…there's a whole team that comes with [Judy]…she knows that she's got a team that fights for her."

When asked how the CCC Program has influenced her quality of care and life, Judy said, "I'm not as anx-

ious about my personal care services as I used to be…I have a lot more support than I ever had…I have people now that care about me as a person, not me as a number or just somebody that it's their job to do this and that. You can tell when a person is really putting their heart into their job or when they're just doing a job. My experience so far has been outstanding. I couldn't ask for a better care team and I wouldn't want to lose them" (Craver, 2016b).

Managed Long-Term Services and Supports

As a four-year demonstration, the CCC Program is scheduled to expire on December 31, 2017, at which time enrolled individuals will transition to a new statewide managed care initiative, known as Managed Long-Term Services and Supports (MLTSS), that will serve approximately 212,000 individuals with complex care needs, including behavioral health, through an integrated managed care delivery system. Building on the CCC Program, MLTSS will focus on improving quality, access, and health care experiences for enrolled individuals, while reducing costs through coordinated, person-centered services. However, MLTSS will differ in that it will incorporate lessons learned from implementing the CCC Program, namely, strengthen requirements for MMP staffing, training, and care coordination activities; use a simplified, two-way contract between the state and participating health plans instead of a three-way contract; require mandatory enrollment for all eligible individuals throughout the state; and require health plans to operate (or obtain approval to operate) as Medicare Dual Special Needs Plans. MLTSS is scheduled for implementation in July 2017. (Additional information on the program is available online at: www.dmas.virginia.gov/Content_pgs/mltss-home.aspx.)

Conclusion

Virginia implemented the CCC Program to both improve the quality of health care experiences of dual eligible individuals and reduce Medicare and Medicaid costs. To measure the impact of the program, the DMAS/Mason evaluation team is employing a mixed-method, longitudinal study design. We believe that using this analytic approach can strengthen findings by allowing the evaluators to assess the program's effectiveness from multiple perspectives at different time points. Virginia's approach to evaluating the CCC Program has received national recognition as a best practice, and, therefore, can provide a framework that other states could use to evaluate similar health care initiatives for complex populations.

To date, the evaluation findings suggest that the CCC Program is improving quality and health care experiences for enrolled individuals. Of course, additional research is needed to draw conclusions about the program's long-term effects on utilization and costs. Nevertheless, as a major public health care reform initiative implemented under the Affordable Care Act for some of the state's most vulnerable citizens, the evaluation findings presented in this case study are important for several reasons. First, the findings can be used for monitoring purposes to ensure that the CCC Program is achieving its objectives. Second, the findings can help inform the development of MLTSS, a new program that will replace CCC and focus on care coordination for dual eligible individuals and others with similar complex care needs. Third, because the dual eligible population will most likely increase in coming years with the aging of America, the evaluation findings can help to inform the development of future programs in Virginia and elsewhere that intend to improve care for this vulnerable population.

Study Questions

1. How is Virginia evaluating the CCC Program and what do evaluation findings thus far indicate?
2. How can one use CCC evaluation findings to develop future programs for similar groups of individuals?
3. Why did Virginia implement the CCC Program and what will happen to the program after it expires in December 2017?

References

Centers for Medicare and Medicaid Services (2011). *Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees*. Retrieved from: https://downloads.cms.gov/cms-gov/archived-downloads/SMDL/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.

Centers for Medicare and Medicaid Services (2013). *CMS and Virginia Partner to Coordinate Care for Medicare-Medicaid Enrollees*.

Retrieved from www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-05-21.html.

Craver, G.A. (2016a). *The Beneficiary Experience – June 2016.* Retrieved from www.dmas.virginia.gov/Content_atchs/altc/Beneficairy%20Experience%20June%202016.pdf.

Craver, G. A. (2016b). *The Beneficiary Experience – January 2016.* Retrieved from www.dmas.virginia.gov/Content_atchs/altc/CCC%20Beneficiary%20Experience%20Case%20Study%20January%202016.pdf.

Craver, G.A., Behrens, M., & Broughton, S. (2015). *The Beneficiary Experience – September 2015.* Retrieved from www.dmas.virginia.gov/Content_atchs/altc/CCC%20Beneficiary%20Experience%20%20September%202015.15.pdf.

Cuellar, A., Gimm, G., & Gresenz, C. (2015). *A Survey of EDCD Waiver Participants who were enrolled in the Commonwealth Coordinated Care (CCC) Program for Dual-Eligibles: Early Findings*. Retrieved from www.dmas.virginia.gov/Content_atchs/altc/CCC_Survey%20Findings_Enrollees_15-12-29.pdf.

Department of Medical Assistance Services (2012). *Commonwealth of Virginia's Proposal to the Center for Medicare and Medicaid Innovation State Demonstration to Integrate Care for Dual Eligible Individuals*. Retrieved from www.dmas.virginia.gov/Content_atchs/altc/altc-icp1.pdf.

Kaiser Commission on Medicaid and the Uninsured (2016). *Health Plan Enrolment in the Capitated Financial Alignment Demonstrations for Dual Eligible Beneficiaries.* Retrieved from http://kff.org/medicaid/fact-sheet/health-plan-enrollment-in-the-capitated-financial-alignment-demonstrations-for-dual-eligible-beneficiaries/.

Medicaid and CHIP Payment and Access Commission (MACPAC) (2015). *Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare*. Retrieved from www.macpac.gov/wp-content/uploads/2015/09/Overview-of-Financial-Alignment-Initiative.pdf.

About the Authors

Dr. Gerald Craver is a Senior Policy Analyst in the Policy and Research Division at DMAS and leads the qualitative component of the CCC evaluation. He earned a PhD from Virginia Commonwealth University with expertise in both quantitative and qualitative research methods, and has conducted over 25 evaluation studies for the Commonwealth of Virginia since 1999. His research interests include quality of care, care coordination and integration, and nursing facility work environments. (gerald.craver@dmas.virginia.gov)

Dr. Alison Cuellar is a Professor in the Department of Health Administration Policy at George Mason University and leads the quantitative component of the CCC evaluation. She earned a PhD in economics from the University of California at Berkeley and has research expertise in Medicaid policy, health care delivery systems and organizations, and mental health services for vulnerable populations. (aevanscu@gmu.edu)

Dr. Gilbert Gimm is an Associate Professor in the Department of Health Administration Policy at George Mason University, and is collaborating with Dr. Cuellar on the quantitative component of the CCC evaluation. He earned a PhD in health economics and policy from the University of Pennsylvania and has research expertise in federal and state program evaluations, disability policy and aging, payment reform, and care coordination models. (ggimm@gmu.edu)

Visit Our Websites

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

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

Editorials

From the
Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

Neighborhood Walkability and Health

Environments can foster well-being. We know that built environments can impede or enable participation in work, leisure, and other community activities for individuals with disabilities. A just-published study from Canada gives more evidence that community characteristics called "walkability" can also contribute to physical health, affecting rates of overweight, obesity, and diabetes for populations.

A team of Canadian researchers (Creatore, Glazier, et al.) has published their findings in the *Journal of the American Medical Association* (May 2016) of an elegantly designed study of almost 8,800 neighborhoods in Ontario that they assessed for walkability, correlating these rankings with prevalence of overweight and obesity and incidence (new cases) of diabetes over the 12-year period from 2001-2012. Higher neighborhood walkability was associated with decreased prevalence of overweight and obesity and decreased incidence of type 2 diabetes.

The research team defined walkability using a validated index with standardized scores ranging from 1 to 100, lowest walkability to highest. "The index includes (four) equally weighted components: population density (number of persons per square kilometer), residential density (number of occupied residential dwellings per square kilometer), walkable destinations (number of retail stores, services, e.g., libraries, banks, community centers, and schools within a 10-minute walk), and street connectivity (number of intersections with at least (three) converging roads or pathways)."

They then calculated baseline walkability scores for "dissemination areas" within the study region. "Dissemination areas are the smallest geographic unit for which Canadian census data are available and are relatively uniform in terms of population size (approximately 400-700 persons). Dissemination areas are generally composed of several adjacent city blocks…. Only residential areas that were developed before 2001 and classified by Statistics Canada as urban areas (which includes suburban areas) were included in this study. Fringe areas on the outskirts of a city that were largely rural or undeveloped were excluded."

The researchers assigned these dissemination areas to one of five quintiles according to their walkability rankings, from 1 (least walkable) to 5 (most walkable). There were about 1750 dissemination areas (neighborhoods) in each quintile, with similar population numbers in each neighborhood (513-561 residents). Neighborhoods were similar in such varied characteristics as ability to speak English or French, percent of youth with less than high school education, and age distribution.

The researchers accessed robust self-reported health data of 30-64 year old residents available in Canada's universal health care system databases; these contained annual provincial health care surveys of about three million individuals/year and the biennial Canadian Community Health Survey of about 5,500 individuals/cycle. Data from these surveys included such health-related behaviors as smoking, daily consumption of fruits and vegetables, levels of activity during leisure times, and transportation modalities. They correlated these data with the annual prevalence of overweight and obesity, and incidence of diabetes in the various neighborhoods indexed for walkability, while adjusting for age, sex, income, and ethnicity.

The results are instructive. The median walkability index was 16.8, ranging from 10.1 in quintile 1 to 35.2 in quintile 5. Resident characteristics were similar across neighborhoods, but poverty rates were higher in the higher walkability areas. In 2001, the adjusted prevalence of overweight and obesity was substantial everywhere but still lower in quintile 5 than in quintile 1 (43.3% vs 53.5%; $P < .001$). Between 2001 and 2012, the prevalence of overweight and obesity increased in the three less walkable neighborhoods (5.4% change in quintile 1, 6.7% in quintile 2, and 9.2% in quintile 3), but did not change significantly in the two areas of higher walkability (2.8% in quintile 4 and 2.1% in quintile 5). In 2001, the adjusted diabetes incidence was lower in quintile 5 than in other quintiles, declining by 2012 from 7.7 to 6.2 per 1000 persons in quintile 5 and from 8.7 to 7.6 in quintile 4. In contrast,

diabetes incidence did not change significantly in the less walkable areas (−0.65 in quintile 1; −0.5 in quintile 2; and −0.9 in quintile 3.)

Rates of walking or cycling and public transit use were significantly higher and that of automobile use lower in quintile 5 than in quintile 1 at each time point, although daily walking and cycling frequencies increased only modestly from 2001 to 2011 in highly walkable areas.

The authors are scrupulous in assessing their findings. Among their comments:

"This study found that urban neighborhoods that were characterized by more walkable urban design were associated with a stable prevalence of overweight and obesity and declining diabetes incidence during a 12-year period. By 2012, rates of each of these conditions were significantly lower in these highly walkable neighborhoods compared with less walkable areas, in which levels of obesity continued to increase.

The observed patterns are not easily explained by other confounders. The analysis accounted for differences in the ethnic composition and socioeconomic characteristics of each residential area. There was no indication that highly walkable areas were undergoing rapid shifts in wealth compared with less walkable neighborhoods, although there was a modest decrease in poverty in these areas, with a concomitant increase in education level. Although there is evidence that low-income neighborhoods have higher levels of obesity and diabetes, the changes in poverty observed during this period were likely too small to explain a decline in diabetes incidence of this magnitude. Furthermore, poverty levels remained 9% higher in the most vs least walkable areas at the end of the study period, and changes in socioeconomic status were accounted for in the analysis.

Although residents living in more walkable areas may be expected to be more health conscious, they reported that they were no more likely to engage in leisure-time physical activity, nor did they report having a better-quality diet or smoking less. There were also no significant differences across quintiles with respect to access to parks, fitness clubs, or health care. Recent studies suggest that individuals who regularly engage in walking and cycling or who use public transit may be more likely to achieve the 30 or more recommended minutes of moderate to vigorous physical activity per day. In contrast, driving has been linked to a higher likelihood of obesity, similar to other sedentary behaviors. However, although the relationships observed are plausible from an etiologic perspective, rates of walking or cycling increased only modestly during the study. Thus, it is not possible to directly ascribe population-level changes in overweight, obesity, and diabetes to transportation choices. Further research is needed to understand whether the relationship between walkability and obesity-related outcomes is causal and, if so, whether transportation patterns mediate such effects."

This study is notable for several reasons, not the least of which are its very large sample size, being population based, and the consistency of findings using different data sources.

Of course, in self-reported data we tend to enhance our levels of "good" behaviors. But one can assume that amounts of over-reporting were likely similar across all five quintiles. Population level interventions may also be playing a role in the findings. Media campaigns have been promoting more walking, physical exercise, and cycling. There are reports from the National Health and Nutrition Examination Survey (NHANES) in the United States and some European studies that the rises in obesity are slowing. Public awareness initiatives from sources as diverse as the First Lady in the White House to Major League Baseball have pushed more active daily lifestyles.

Finally, two observations: First, we should note that percentages of overweight and obese residents were high to begin with, in all five quintiles. This, unfortunately, reflects today's developed societies but the apparent benefit of neighborhood walkability suggests that it may be an important health-related consideration in the lives of everyday people. Second, it remains to be determined if the "walkability" benefits fully require actual walking; most of the elements in the walkability index reflect components in the environment, so these may be relevant across the continuum of impairments, meaning that walkable neighborhoods themselves may have positive impact on the daily lives of people with physical or intellectual disabilities.

Editorials

From the
Commissioner, Virginia Department for Aging and Rehabilitative Services

Jim Rothrock
with Amy Marschean, JD,
Senior Policy Analyst and
Devin Bowers, Dementia
Services Coordinator

As summer simmers after the wettest May ever, we have time to review some of the highlights of the past year at DARS and note summer projects.

We are busy using new state funds to move hundreds of Virginians needing **public guardianship** services off our waiting lists and are working with the court system to align them with a new qualified guardian.

Our **No Wrong Door** expansion continues, now based on a more robust public/private partnership that more promptly and simply fosters coordinated community based services to those needing long term supportive services.

Our Adult Services unit is engaged in a study of **adult financial exploitation** generated by legislation patroned by Delegate Chris Peace from Hanover. The participation and support of financial institutions bode well for the success of this effort.

With a successful **Governor's Conference on Aging** in May, our team is already planning the follow-up conference targeted for next May, likely in Roanoke, to focus on policy and budgetary recommendations for Governor McAuliffe and the candidates for our top elected offices in the campaign in 2017. If the success of the next conference equals our most recent effort, we will be able to shape our own future!

There are two additional initiatives to share with you.

WINGS

As our readers know, **guardianship** serves some of society's most vulnerable populations, namely, older adults and those with disabilities who need assistance in making decisions about their health, lives, and finances and who may be at risk of abuse, neglect, or exploitation. In recent years, the Virginia Public Guardian and Conservator Advisory Board has seen an increased demand for public guardians, as Virginia undergoes a demographic shift in its aging and disability populations. Also, more public guardians have been needed for both incapacitated persons leaving state training centers under the Department of Justice Settlement Agreement and persons reentering the community after years in prison.

While Virginia's guardian and public guardianship laws are effective, there is room for improvement in several areas, including court oversight, collection of adult guardianship data, and training for all stakeholders. In 2011, the National Guardianship Network (NGN), in its Third National Summit, recommended the creation of state groups to advance adult guardianship reform. The **Working Interdisciplinary Networks of Guardianship Stakeholders (WINGS)** model of court-community partnerships was the result. WINGS are broad-based, interdisciplinary working groups that include judges, the aging and disabilities networks, advocates, and others. In 2013, with funding from the State Justice Institute (SJI), NGN selected four states to receive technical assistance and support in creating and sustaining their own WINGS groups (NY, OR, TX, and UT); and in 2015, with SJI and supplemental funding from the Borchard Foundation Center on Law and Aging and others, NGN named six additional WINGS states (DC, IN, MN, MS, WA, and WI). Based on all of these experiences, NGN published **Wings Tips: State Replication Guide for Working Interdisciplinary Networks of Guardianship Stakeholders**. (Visit the NGN website for details, including an informative video: www.naela.org/NGN/WINGS).

The movement is growing across the country to develop WINGS to provide a continuing forum for evaluation of strengths and weaknesses, prioritization of needs, and collaborative action through consensus-building partnerships. WINGS initiatives are reforming state guardianship systems and establishing best practices so guardianship can be a safe option in the fight against elder exploitation.

Last fall in its biennial report to the Virginia General Assembly, the Virginia Public Guardian and Conservator Advisory Board recommended that a WINGS initiative be established in Virginia to improve judicial processes, enhance

services, and, most importantly, protect individual rights and promote accountability for all guardianships. Also, the Commonwealth Council on Aging recommended in its 2015 Annual Report to the Governor and General Assembly support for monitoring and training programs for all guardians. Moreover, a goal in Virginia's State Plan for Aging Services 2015-2019 is to strengthen adult protection by partnering with the judiciary to develop a uniform procedure for guardianship monitoring and complaints for guardianships.

Later this summer, the Virginia Supreme Court will convene a WINGS group to develop court and community partnerships aimed at evaluating and improving the guardianship and conservatorship process in Virginia. We believe such an initiative could significantly protect the health and well-being of our most vulnerable population and DARS embraces the opportunity to participate in WINGS.

The Longest Day

June 20th, the summer solstice, marks the longest day of the year in the Northern Hemisphere. The Alzheimer's Association has designated this longest day as a special occasion to recognize and support persons living with dementia, their families, and friends. The Alzheimer's Association annually now sponsors "The Longest Day" to generate awareness and raise funds to provide care and support, and drive research and advocacy. Teams spend the 16-hour day participating in activities to honor a loved one and acknowledge their challenging journey living with dementia or providing care. As we transition into summer, let's acknowledge some important accomplishments affecting the lives of Virginians living with dementia and their caregivers: over 100 caregivers have been enrolled in a counseling program to assist in developing their support networks; 23 persons newly diagnosed with dementia are participating in a specialized care coordination program to help them navigate their healthcare and provide connections to supportive services in the community; over 20 staff members at our Area Agencies on Aging have completed training in dementia capability; and approximately 250 first responders have participated in dementia training developed by the International Association of Chiefs of Police to prepare them for interacting with individuals experiencing cognitive impairment.

As always, the DARS team is busily engaged in leadership and support of our Commonwealth's aging network and service system.

2016 DARS Meeting Calendar

Commonwealth Council on Aging
September 21

Alzheimer's Disease and Related Disorders Commission
August 30, December 6

Public Guardian and Conservator Advisory Board
September 15, November 17

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

Including People with Disabilities: Public Health Workforce Competencies

People with disabilities are at a higher risk for poor health outcomes like hypertension, obesity, and depression. Knowledge about their health status and public health needs is essential to address them. However, most public health training programs do not include curricula on people with disabilities and methods for including them in core public health efforts. A new training program aims to build a stronger public health workforce skilled in ways to include people with disabilities in all public health efforts.

Including People with Disabilities: Public Health Workforce Competencies, made possible by funding from the Association of Teachers of Maternal and Child Health (ATMCH), and the Association of University Centers on Disabilities (AUCD), outlines recent advances in knowledge and practice skills that public health professionals need in order to include people with disabilities in the core public health functions: Assessment, Policy Development and Assurance.

See the competencies and training modules at https://disabilityinpublichealth.org.

Transportation and Mobility Needs in Focus at Local Global Startup Search

by Catherine MacDonald
Network Integration and Outreach, Greater Richmond Age Wave & No Wrong Door, Senior Connections, The Capital Area on Aging

An app called Uzurv that expands the utility of on-demand transportation services and a mobility device called Handizap, whose prototype emerged from a Ring Pop, were the winning ideas pitched at the kickoff event for the Aging2.0 Global Startup Search.

Focused on connectedness, engagement, and active aging, 100 people gathered at Genworth Financial in Richmond to see the latest and most creative applications. Attendees included gerontologists, local government representatives, service providers, business leaders, and students. They heard pitches from nine teams comprising local entrepreneurs and university students from Virginia schools.

The Richmond chapter of Aging2.0, an international organization with a mission to reshape technology in aging, hosted this very first event in the global competition. The local chapter is "raising the bar," says the San Francisco-based headquarters team, and has leveraged movement in the community by being housed in the Greater Richmond Age Wave's Business for Life work group, which includes a diverse network of advocates and leaders. Trish Fitzpatrick, vice president of corporate outreach for Uzurv, pitched the company as a way to connect older adults with transportation network services such as Uber and Lyft through advance reservations. Users can develop relationships with drivers and schedule rides to and from rural areas that might not usually receive service, aspects that Fitzpatrick hopes will appeal to older customers. Anyone in the world will be able to vote for Uzurv in the final round of the competition; voting takes place from July 18th to August 19th.

Handizap won the People's Choice Award at the event. Founder Josh Smith started the company after looking for a way to manipulate touch screens with limited hand mobility, taking the idea from a Ring Pop. After a successful crowdfunding campaign, Smith now offers the tool for sale.

Ninety-eight-year-old advocate Guy Kinman remarked on the "wonderful, practical event." A resident of Brookdale Imperial Plaza, he said the pitch event has since created a buzz among other residents, "So the ideas have legs."

The Greater Richmond Age Wave thanks Genworth and Richmond Memorial Health Foundation for sponsoring the Aging2.0 Pitch Event, as well as fellow philanthropic partners The Community Foundation, United Way of Greater Richmond & Petersburg, and Bon Secours.

To engage in our next Aging2.0 pitch and expo on September 30th, e-mail Richmond@aging2.com.

Forever Young Revisited

Bob Dylan turned 75 this spring. Many of us, from older Americans to Baby Boomers, will identify him with our youth. Indeed, he is still writing and performing. Five years ago we noted Dylan's turning 70 under the editorial *Forever Young*. This birthday calls for a re-visit.

The author of ballads about failed loves and moving on and of protest songs against war and the human tendency of failing to learn lessons from past failures, Dylan was also, from many accounts, a loving father to a step daughter, three sons, and a daughter during these times. Five years ago, we noted one of his more misunderstood songs, *Forever Young*. Its message continues to deserve attention.

Forever Young is not a screed against growing older, not a wish for eternal youth. Rather, it is a timeless message, lovingly delivered to his children, of the values that never grow old. The lines include:

May you always know the truth
And see the lights surrounding you.
May you always be courageous,
Stand upright and be strong,
May you stay forever young…

May you have a strong foundation
When the winds of changes shift.
May your heart always be joyful,
May your song always be sung,
May you stay forever young,
Forever young, forever young,
May you stay forever young.

For the full 2011 editorial and others, visit www.vcu.edu/vcoa.

COMMONWEALTH OF VIRGINIA

Alzheimer's and Related Diseases Research Award Fund

2016-2017 ALZHEIMER'S RESEARCH AWARD FUND RECIPIENTS ANNOUNCED

The Alzheimer's and Related Diseases Research Award Fund (ARDRAF) was established by the Virginia General Assembly in 1982 to stimulate innovative investigations into Alzheimer's disease and related disorders along a variety of avenues, such as the causes, epidemiology, diagnosis, and treatment of the disorder; public policy and the financing of care, and the social and psychological impacts of the disease upon the individual, family, and community. The awards this year have been enhanced by a $25,000 donation from Mrs. Russell Sullivan of Fredericksburg, in memory of her husband who died of dementia. Sullivan awards are indicated by an asterisk (*). The ARDRAF competition is administered by the Virginia Center on Aging in the School of Allied Health Professions at Virginia Commonwealth University. Questions about the projects may be directed to the investigators or the ARDRAF administrator, Dr. Constance Coogle (ccoogle@vcu.edu).

UVA Matthew J. Barrett, MD, MSc, Jason Druzgal, MD, PhD, and Scott Sperling, PsyD
Nucleus Basalis of Meynert Degeneration in Parkinson Disease Cognition

Dementia in Parkinson disease (PD) is a major source of morbidity. Degeneration of neurons in the nucleus basalis of Meynert contributes to dementia in PD. For this reason the nucleus basalis of Meynert has been identified as a potential intervention point to treat dementia in PD, and deep brain stimulation has been proposed as a potential therapy. As a preliminary step toward testing this procedure in PD, the investigators will determine whether Magnetic Resonance Imaging measures of nucleus basalis of Meynert volume correlates with cognition in PD. This is critically important to identify PD patients that would most likely benefit from an intervention. They will also investigate whether specific genetic factors are associated with reduced nucleus basalis of Meynert volume in PD. Determining factors associated with nucleus of basalis Meynert degeneration would allow treatment to be targeted to more vulnerable PD patients. This research will provide important information for the future study of deep brain stimulation of the nucleus basalis of Meynert to treat dementia in PD. *(Dr. Barrett may be contacted at (434) 243-2012, mjb5t@virginia.edu; Dr. Druzgal may be contacted at (434) 982-1736, tjd4m@virginia.edu; Dr. Sperling may be contacted at (434) 982-1012, sas7yr@virginia.edu.)*

VCU Jennifer Inker, MBA, MS, Tracey Gendron, PhD, and J. James Cotter, PhD*
Use of Antipsychotic Medications by Residents with Dementia in Assisted Living Facilities

This research will deliver Virginia's first comprehensive effort to: 1) establish a baseline rate of antipsychotic medication use in residents with dementia in Virginia's assisted living facilities (ALFs); 2) explore what ALF characteristics correlate with the use of antipsychotic medications; and 3) investigate reasons why antipsychotic medications are used in ALF residents with dementia. With the expertise and guidance of an interdisciplinary, interagency research advisory committee, VCU will use a use a mixed methods approach with two phases. Phase one will employ a self-administered survey of licensed ALFs in Virginia to identify facility characteristics (rural/urban, chain/independent, staffing, etc.), followed by aggregate data on the rate of administration to ALF residents with dementia of the four most widely used antipsychotic medications. Phase two, which will be informed by the findings of phase one, will include three case studies of ALFs, with one each from below, at, and above the median rate of antipsychotic medication use as determined in the quantitative phase. The findings of this critical research will be used to inform policy and practice. *(Ms. Inker may be contacted at (804) 828-1565, inkerjl@vcu.edu; Dr. Gendron may be contacted at (804) 828-1565, tlgendro@vcu.edu; Dr. Cotter may be contacted at (804) 828-1565, jcotter@vcu.edu.)*

College of William and Mary **Oliver Kerscher, PhD and Munira Basrai, PhD***

STUbL-dependent clearance of transcriptionally-active, aggregate-prone proteins from the nucleus

Patients suffering from Huntington's disease experience a wide-range of degenerative symptoms from short-term memory loss to motor function. On the cellular level, the patient's brain atrophies due to the accumulation of a toxic huntingtin protein that, at least in part, disrupts the transcriptional program of specific neurons. The investigators determined that human RNF4, an enzyme involved in targeted protein degradation, prevents the abnormal transcriptional activity associated with a mutant, aggregation-prone fragment of huntingtin. This study aims to identify and study the proteins that counteract the transcriptional aberrations that plague neuronal cells affected by huntingtin and other aggregation-prone proteins. The research will also determine whether RNF4 reduces the transcriptional activity of mutant huntingtin protein in a tissue culture model of Huntington's disease, and establish the role that RNF4 plays in stripping transcriptionally-active huntingtin on a genome-wide scale.
(Dr. Kerscher may be contacted at (757) 221-2229, opkers@wm.edu; Dr. Basrai may be contacted at (301) 402-2552, basraim@nih.gov.)

VCU **Rory McQuiston, PhD***

AAV-Induced Tau Pathophysiology in Interneurons of the Mouse Hippocampus

Tau proteins are important for normal brain cell molecular trafficking, but when pathological tau begins to misfold and aggregate, the result is dysfunctional synaptic signaling and eventual cell death. One of the first regions of the brain to display tau pathology in Alzheimer's disease (AD) is the entorhinal cortex (EC). EC neurons innervate the hippocampus, but little is known about how early tau pathology affects specific types of hippocampal inhibitory neurons or how it disturbs the synaptic connections between these regions. This study will employ a mouse model that has a highly aggressive form of the human tau protein to investigate how tau affects these cells using state-of-the art physiological and immunochemical techniques. Greater understanding of changes in inhibitory neuron function may lead to novel therapies to treat early Alzheimer's disease and other neurodegenerative disorders. *(Dr. McQuiston may be contacted at (804) 828-1573, amcquiston@vcu.edu.)*

UVA **Andrés Norambuena, PhD***

Amyloid Beta Peptides, Nutrient Signaling and Mitochondria Dysfunction: An Unholy Triad in Alzheimer's Disease

Normal mitochondrial functions allow the proper delivery of nutrient-derived energy in the form of ATP, providing timely clearance of reactive oxygen species and buffering of calcium. These functions are fundamental for maintaining proper synaptic activity, but how neurons coordinate nutrient signaling with mitochondrial activity and how its dysregulation promotes AD needs to be investigated further. Oligomeric forms of the amyloid-ß peptide (AßOs) initiate signaling pathways leading to loss of dendritic function, changes in mitochondrial dynamics, insulin signaling disruption, and cell death. While these studies have provided valuable information about the molecular players involved in AD pathogenesis, the molecular mechanisms involved are poorly understood. The investigator has developed a two-photon fluorescence lifetime imaging assay which allows for the detection of changes in mitochondrial activity in live cortical neurons in culture. The results mechanistically link insulin resistance to mitochondrial dysfunction and AD. This new funded study is intended to move basic findings closer to being translated into clinical applications by using a newly developed human-derived neural cell model grown on three dimensional cultures. *(Dr. Norambuena may be contacted at (434) 982-5809, an2r@virginia.edu.)*

VA Tech **Jyoti S. Savla, PhD, Karen A. Roberto, PhD, and Rosemary Blieszner, PhD***

Families in Rural Appalachia Caring for Older Relatives with Dementia

The purpose of this research is to increase understanding of how families in Appalachia manage care for older relatives with Alzheimer's disease or other dementias. Specifically, the primary aim is to learn from families in Appalachia about their approaches to caregiving and uncover whether they need and use community services currently, as well as their views of formal service use in the future. The research is based on a guiding model of caregiving stress and influences on service use, and incorporates multiple pieces of information about both individual and community factors that affect care needs and service use. The research employs multiple strategies to gather information. Ten family caregivers will be invited to participate in an in-depth in-person interview to provide insight about their caregiving situation, and their needs and difficulties in receiving informal and formal help services. Guided by the themes and patterns of these interviews, 60 family caregivers will respond to an in-depth telephone survey followed by brief calls about daily events for 7 days. This combination of using open-ended questions, and then asking specific questions to a larger group of participants is very effective for generalizing and validating the qualitative findings. Qualitative interviews will be summarized by grouping similar answers and identifying the different perspectives in the interviews. Statistical methods will be used to identify groups and trends in the survey and daily events data. The findings from this project will reveal the diverse approaches to caregiving for persons with Alzheimer's disease living in Appalachian Virginia. *(Dr. Savla may be contacted at (540) 231-2348, jsavla@vt.edu; Dr. Roberto may be contacted at (540) 231-7657, kroberto@vt.edu; Dr. Blieszner may be contacted at (540) 231-5437, rmb@vt.edu.)*

Christopher Newport University **Lisa S. Webb, PhD and Darlene A. Mitrano, PhD**

Comparative Biochemical and Behavioral Analysis of the 3xTg-AD Mouse Model of Alzheimer's Disease

The investigators will use bioanalytical techniques and behavioral measures to characterize blood lipid profiles and olfactory abilities in the triple transgenic mouse model of Alzheimer's Disease (3xTg-AD). They will test the mice at three month intervals over the course of a year and compare results from the 3xTg-AD mice to age- and sex-matched mice without AD to pinpoint when blood lipid profiles are altered and when the declines in olfactory abilities become statistically different. The results of this study will better define the biochemical and behavioral phenotype of the 3xTg-AD mice, an important model used to illuminate how AD develops in humans. *(Dr. Webb may be contacted at (757) 594-7056, lwebb@cnu.edu; Dr. Mitrano may be contacted at (757) 594-8093, darlene.mitrano@cnu.edu.)*

2016-2017 ARDRAF Awards Committee

Paul Aravich, PhD
Eastern Virginia Medical School
Frank J. Castora, PhD
Eastern Virginia Medical School
Randolph Coleman, PhD
College of William & Mary
Christianne Fowler, DNP, RN, GNP-BC
Old Dominion University
Kathleen Fuchs, PhD
University of Virginia
Linda Phillips, PhD
Virginia Commonwealth University
Beverly A. Rzigalinski, PhD
Via College of Osteopathic Medicine
Webster L. Santos, PhD
Virginia Tech
Patricia W. Slattum, PharmD, PhD
Virginia Commonwealth University
Shirley M. Taylor, PhD
Virginia Commonwealth University
Patricia A. Trimmer, PhD
Virginia Commonwealth University
Gregorio Valdez, PhD
Virginia Tech Carilion Research Institute
Bin Xu, PhD
Virginia Tech
Ning Zhang, PhD
Virginia Commonwealth University

2016 ARDRAF Reviewers

The Alzheimer's and Related Diseases Research Award Fund (ARDRAF) has been enabling promising lines of research into dementing illnesses since 1982 and has emerged as the most productive and cost-effective state-funded pilot grant program for research on dementia in the country. Its success depends in large measure on the careful scrutiny that the ARDRAF review panel gives each grant application. Experts in bio-chemical, physiological, and psycho-social aspects of dementia, family caregiving, clinical practice, and other relevant areas volunteer their time and talent to the review process.

Pictured clockwise from top are the members of this year's review panel in session: Constance Coogle, PhD, (chair), Paul Aravich, PhD, Randolph Coleman, PhD, Frank Castora, PhD, Toni Coe, PhD (recorder), Gregorio Valdez, PhD, Patty Slattum, PharmD, PhD, Patricia Trimmer, PhD, Beverly Rzigalinski, PhD, Shirley Taylor, PhD, Linda Phillips, PhD, Natalie Wheeler, PhD (recorder), Webster Santos, PhD, Kathleen Fuchs, PhD, Christianne Fowler, DNP, Ning Zhang, PhD, and Bin Xu, PhD.

VGEC Faculty Development Program June Graduates

The Virginia Geriatric Education Center (VGEC), a consortium of faculty from VCU, Eastern Virginia Medical School, and the University of Virginia, annually conducts a 200-hour Faculty Development Program (FDP), September through June. FDP Scholars commit to this interprofessional geriatrics training program with the expectation of passing their training to colleagues in order to maximize the impact of their training. Our 2015-16 FDP Scholars celebrated the conclusion of their training year on June 17, 2016.

Pictured (Back Row): Emily Sperlazza, MSN, RN, CHPN; Karen Mittura, RN, MSN, CCRN, CNE; Beth Tremblay, MSN, RN; Donna Jarrell, MS; Patricia Ottavio, PT, MPH.

(Front Row): Paula Smith, PT, MAS, DPT; Susan Murray, RN, MSN, ANP; Ann Marie Kopitzke, BBA, MPA, PhD; Nancy Prince, RN, MBA, LNHA; Joanne Iannitto, DNP, ANP-BC, GNP-BC; Sujatha Kemler, RPh.

(Not Pictured): Susan Scharpf, MD, FAAFP

Would You Like to Receive *Age in Action* Electronically?

We currently publish *Age in Action* in identical print and PDF verions. *Age in Action* will be transitioning over time to an electronic version only. You can subscribe at no cost. Simply e-mail us and include your first and last names and your best e-mail address. If you now receive hard copies by postal mail, please consider switching to e-mail distribution. Send an e-mail listing your present postal address and best e-mail address for future deliveries. Send requests to Ed Ansello at eansello@vcu.edu.

Road Scholar and the Modern Traveler

by Jeffrey Ruggles,
Road Scholar Program
Administrator, VCoA

Road Scholar, the celebrated educational travel program for older adults, is non-profit, yet it must still compete in the marketplace for attention and enrollments. It remains subject to many of the same factors that affect the travel industry as a whole. A key challenge for Road Scholar is to be pro-active and keep up with the times.

In the travel world, the interests that motivate folks to go places shift over time. What attracts people is not the same in each era. Virginia places such as Buckroe Beach, Ocean View, and Colonial Beach were once "the cat's meow." Today, historic houses and battlefields don't draw as they once did, whereas, the wild landscapes of the American West continue to attract visitors. The largest Road Scholar tour provider is Northern Arizona University, with programs that go to the Grand Canyon and southern Utah. New opportunities arise, too: Road Scholar is currently one of the top providers of travel to Cuba.

For Road Scholar programs in Virginia, such as those offered by VCU, history remains important. Overall, there is probably more historical tourism today than ever, but it is spread out, with the spectrum of historical attractions having become broader. Sites where something important took place or where an important person lived remain valuable but people today like history in many flavors. For the modern traveler, the historical is often one component of a larger package: part of an ambience, perhaps, such as a preserved urban area that is full of both older architecture and modern life.

For many attending VCU's programs in Staunton, the small Shenandoah Valley city is as much of an attraction as the program topic. The downtown sits on a hillside surrounded by other hills that create a defined space. There is a large enough proportion of late 19th and early 20th century structures, many with idiosyncratic decorative features, to give the town a "look," topped by an amiable skyline of cupolas, clock towers, steeples, and a gilt statue on the courthouse. Along the main street, Beverley, and the cross streets, the majority of shops are distinctive in their specialties; a good number could be called unusual or quirky.

At the lower end of downtown Staunton, by the "Wharf" and the railroad station, the architecture is 19th century commercial and houses eateries, brewers, and craft-makers. A cluster of textile shops occupy the old freight station. In Staunton's case, the historical is wrapped in with creative entrepreneurial, with a big dollop of handmade, to make a fun and intriguing place that people like to explore.

Another Virginia city that similarly has made preservation a main component of its downtown development is Fredericksburg. Compared to Staunton, it is an older settlement, not as hilly, and its close-by river, the Rappahannock, is substantially bigger. What is similar is the spirit of imaginative entrepreneurs populating historic buildings. The Tidewater town has a different mix than in the Valley, as probably should be expected. In common, both cities have used bookstores, a brewery, a college, and a trolley.

Fredericksburg would seem, therefore, to have the qualities to make it an attractive location for a Road Scholar program. VCU has designed one titled "George Washington's Virginia." There's plenty around the city for a Civil War theme but the downtown tends toward an earlier period. Washington himself grew up at Ferry Farm across the Rappahannock and archaeological investigation at the site is learning what was there, although the location of the proverbial cherry tree remains undetermined. Other Washington family sites in Fredericksburg include his mother Mary's house, the estate Kenmore where his sister lived, the Rising Sun tavern originally built by his brother, and Chatham, where the claim that "Washington slept here" is based on the General's own journals. In addition, an officer who served on Washington's staff, James Monroe, after the Revolution opened shop as a lawyer in Fredericksburg, and his office is preserved as a museum.

A mix of historic redevelopment and creative entrepreneurship may not be enough by itself to attract a traveler to a place, but as a setting to explore interesting subjects in Road Scholar educational programs, it might be enough to establish a niche in the world of travel.

Discard Unused Rx Drugs Safely

As we age, we sometimes receive prescriptions for medications for pain, heart problems, and other conditions. Subsequently, our health care provider may change the medication, leaving us with left-over drugs. Some of these, like opioids for pain (*Demerol, Oxycontin, Percocet, Vicodin*, etc.), are powerful and potentially dangerous if taken by others accidentally or on purpose. Indeed, most any prescription drug can be harmful in the wrong hands.

How should we dispose of unused prescription medications?

First, do not flush them in the toilet. This may cause environmental damage. We can empty the pills into a sealable bag, mix in coffee grounds or kitty litter to make everything unappealing, then seal and put into the trash. Better yet, go to an Authorized Collector nearby. The Office of Diversion Control of the federal Drug Enforcement Administration (DEA) has identified sites, such as retail, hospital or clinic pharmacies, and law enforcement locations, which will take and dispose safely of our unused medications. Some offer mail-back programs or collection receptacles ("drop-boxes"). Visit the DEA's website below or call (800) 882-9539 for more information and to find an authorized collector in your community.

www.deadiversion.usdoj.gov/drug_disposal/index.html

Guidance to Long-Term Care Facilities to Enhance Community Integration for Residents

The U.S. Department of Health and Human Services' Office for Civil Rights (OCR) has issued guidance to help long term care facilities comply with their civil rights obligations. They can do this by administering the Minimum Data Set (MDS) appropriately so that their residents receive services in the most integrated setting appropriate to their needs.

The following are excerpts from this new guidance.

The MDS, a mandated quarterly assessment administered to all nursing home residents, has questions that can connect long term care residents with opportunities to live in the most integrated setting and assist the state in meeting its nondiscrimination requirements under Section 504 of the Rehabilitation Act and the Americans with Disabilities Act. Specifically, Section Q of the MDS provides a process that, if followed correctly, gives the resident a direct voice in expressing preference and gives the facility means to assist residents in locating and transitioning to the most integrated setting.

OCR has found that many long term care facilities are misinterpreting the requirements of Section Q of the MDS. This misinterpretation can prevent residents from learning about opportunities to transition from the facility into the most integrated setting.

All long term care facilities should know their Local Contact Agency and have a working relationship with it. A Local Contact Agency is a local community organization responsible for providing counseling to nursing facility residents on community support options. Long term care facilities must make referrals to the Local Contact Agency whenever a resident would like more information about community living or alternative living situations to the facility.

When the long term care facility makes a referral to a Local Contact Agency, OCR recommends that a facility representative serve as a liaison to the Local Contact Agency staff member and maintain regular communication with the Local Contact Agency regarding the resident. The Facility must in no way impede the assessment, planning, and transitioning process triggered by the referral to a Local Contact Agency.

OCR also recommends that the facility invite the Local Contact Agency to provide seminars/presentations to residents and staff on a regular basis (e.g., every six months), about the services it provides, community-based settings in which residents can choose to receive services, and the residents' opportunity to seek a referral regarding potential transition to the community.

The six-page guidance document offers guidelines for administering questions in the MDS and provides, as well, a list of helpful resources on MDS training. It can be accessed at: www.hhs.gov/sites/default/files/mds-guidance-2016.pdf.

Calendar of Events

July 24-28, 2016
41st Annual Conference and Tradeshow of the National Association of Area Agencies on Aging. Sheraton San Diego Hotel and Marina, San Diego, CA. For information, visit www.n4a.org.

August 17, 2016
The Second Annual Senior Safety Day. Presented by the Senior Center of Greater Richmond, Office of the Attorney General Mark Herring, and First Baptist Church of Richmond. 9:00 a.m. - 3:00 p.m. First Baptist Church, Richmond. For information, call (804) 353-3171 or visit www.SeniorCenterOfGreaterRichmond.org.

August 19, 2016
Fall Classes at the Lifelong Learning Institute (LLI). Fall Catalog to be released on site and online. For information, visit www.LLIChesterfield.org.

August 29-31, 2016
Protect / Prevent / Empower. 27th Annual Conference of the National Adult Protective Services Association. Philadelphia, PA. For information, visit www.napsa-now.org/about-napsa/annual-conference.

September 8-9, 2016
Elder Care Conference. Presented by the Geriatric Collaborative of Central Virginia. Westminster Canterbury of the Blue Ridge, Charlottesville. For information, visit http://corporation.tjpdc.org/gccv/elder-care-conference.

September 13, 2016
Conference on Dementia: The Art of Engagement: Innovative Care Practices for People Living with Dementia. Presented by the Alzheimer's Association of Greater Richmond. Keynote Speaker: Paul Raia, PhD. 8:00 a.m. - 5:00 p.m. The Westin Richmond. For information, call (804) 967-2580 or visit www.alz.org/grva.

September 20-21, 2016
Virginia Assisted Living Annual Fall Conference and Trade Show. Marriott City Center, Newport News. For information, visit www.valainfo.org.

September 26, 2016
2nd Annual Bon Secours Richmond Successful Aging Forum. Keynote address by Emily Kimball, "The Aging Adventurer." Lewis Ginter Botanical Gardens, Richmond. 10:00 a.m. - 2:30 p.m. For information and to register, call (804) 287- 7700 or visit www.bsvaf.org/successfulagingforum.

October 5, 2016
13th Annual Empty Plate Luncheon. Benefit event for Senior Connections, The Capital Area Agency on Aging. Trinity Family Life Center, Richmond. 11:30 a.m. - 1:00 p.m. For information, contact Angie Phelon at (804) 343-3045 or aphelon@youraaa.org.

October 16-19, 2016
67th Annual Convention and Expo of the American Healthcare Association and the National Center for Assisted Living. Nashville, TN. For information, visit www.eventscribe.com/2016/ahcancal/index.asp.

November 10, 2016
Conference on Dementia: Enhancing Quality of Life in Dementia Care. Presented by Alzheimer's Association Central and Western Virginia Chapter. 8:00 a.m. - 5:00 p.m. Holiday Inn Valley View, Roanoke. For information, call (434) 973-6122 ext. 103 or visit www.alz.org/cwva.

November 10, 2016
The Art of Healthy Aging Forum and Expo: The Joys and Challenges of Caregiving. Presented by Senior Services of Southeastern Virginia. Virginia Beach Convention Center. 9:00 a.m. - 2:00 p.m. For information, visit www.ssseva.org.

November 15-16, 2016
33rd Annual Conference and Trade Show of The Virginia Association for Home Care and Hospice. Marriott City Center, Newport News. For information, visit www.vahc.org.

Age in Action
Volume 31 Number 3
Summer 2016

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

James A. Rothrock
Commissioner, DARS

Kimberly S. Ivey, M.S.
Editor

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

Fall 2016 Issue Deadline: September 15, 2016

Virginia Center on Aging

at Virginia Commonwealth University, Richmond, Virginia
www.sahp.vcu.edu/vcoa

Staff:

Director
Edward F. Ansello, PhD

Elderhostel Coordinators
Catherine Dodson, MS - Richmond
Barbara Wright - Natural Bridge and Staunton

Associate Director for Research
Constance L. Coogle, PhD

Elderhostel/Road Scholar Program Administrator
Jeffrey Ruggles, MFA

Project Director
Paula Knapp Kupstas, PhD

Lifelong Learning Institute
Rachel Ramirez

Assistant Director, Virginia Geriatric Education Center
Bert Waters, PhD

Project Coordinators
Courtney O'Hara, MEd
Ruth Anne Young, MEd

Research Associates
Toni Coe, PharmD, PhD
Sung Hong, PhD
Myra G. Owens, PhD

Research Assistant
Jenni Mathews

Administrative Assistant
Devanee Beckett

Editor, *Age in Action*
Kimberly S. Ivey, MS

Advisory Committee:
Paul F. Aravich, PhD
Frank Baskind, PhD
Russell H. Davis, PhD
Cecil Drain, PhD
Jonathan Evans, MD
James Hinterlong, PhD
Paul G. Izzo, JD
Christine Jensen, PhD
Adrienne Johnson, MS
Richard W. Lindsay, MD
Christopher M. McCarthy, Esq
Hon. Jennifer L. McClellan
Kenneth J. Newell, MS
Hon. John O'Bannon
Sherry Peterson
Saundra C. Rollins, MSSW
Jim Rothrock
David Sadowski
Robert L. Schneider, PhD, *Chairman*
Ralph E. Small, PharmD
Beverley Soble
Thelma Bland Watson, PhD

Virginia Department for Aging and Rehabilitative Services

www.dars.virginia.gov

Staff:

Commissioner: Jim Rothrock
Devin Bowers, Dementia Services Coordinator
Tanya Brinkley, Service Referral / Administrative Assistant
Tim Catherman, MHA, Director, Aging Operations
Brenda Cooper, Program and Compliance Analyst
Leonard Eshmont, PMP, Director, Information Technology
Jacqueline Freeze, External Aging Services Auditor
Bet Gray, ASAPS Program
Elizabeth Havenner, MSW, Program Coordinator
April Holmes, MS Ed, Prevention Program for Older Adults
David Hominik, Legal Services Developer
Janet James, Esq., Public Guardian Program Coordinator
Nicole Keeney, RD, LDN, Nutrition Program Coordinator
Georgie Lewis, Customer Service Specialist
Nancy Lo, MSW, GrandDriver Coordinator
Amy Marschean, JD, Senior Policy Analyst
Christy Miller, PMP, CSTE, NWD IT/Business Analyst
Kathy Miller, RN, MS, MSHA, Director of Programs
Carolyn Mines, No Wrong Door Help Desk
Katie Roeper, Assistant Commissioner
Annette Sherman, Systems Analyst
Cecily Slasor, Administrative Program Specialist
Pam Smith, VICAP Director
Anita Squire, Commonwealth Coordinated Care Educator
Mary Strawderman, Lifespan Respite Voucher Grant Assistant
Kathleen Vaughan, MA, No Wrong Door Coordinator
Erika Yssel, No Wrong Door

Commonwealth Council on Aging:

Members
Kyle R. Allen, DO, AGSF
Beth Barber, Chair
Robert B. Blancato
Mitchell Patrick Davis
David M. Farnum
Arthur R. Giesen
Joni C. Goldwasser
Carter Harrison
Valerie L'Herrou, JD
Richard W. Lindsay, MD
Shewling Moy
Brenda A. Kelley Nelum
Valerie Price, Vice-Chair
Roberto Quinones
Stephen G. Reardon, Esq
Kathryn B. Reid
Vernon Wildy
Veronica Williams
Sandra Williamson-Ashe, EdD

Ex Officio Members
The Hon. William A. Hazel, Jr., MD , *Secretary of Health and Human Resources*
William Massey, *VAAAA*
James A. Rothrock, *DARS*
Terry A. Smith, *DMAS*
Lynne Williams, *VDSS*

Virginia Commonwealth University
Age in Action
Virginia Center on Aging
P.O. Box 980229
Richmond, VA 23298-0229

Return Service Requested

Nonprofit Organization
U.S. POSTAGE PAID
Permit No. 869
RICHMOND, VIRGINIA

2016 Walk to End Alzheimer's

Walk to End Alzheimer's is the Alzheimer's Association's signature nationwide fundraising event. Each fall, tens of thousands of people walk together to help make a difference in the lives of people affected by Alzheimer's and to increase awareness of the disease. Become part of the group of individuals, corporations, and organizations that are proud to lead the fight against Alzheimer's disease!

Central and Western Virginia Chapter Register for walks in this area at www.alz.org/cwva.	Waynesboro, September 10 Culpeper, September 17 Danville, September 24 Roanoke, October 1 Charlottesville, October 8 Lynchburg, October 15 Harrisonburg, October 22 Blacksburg, October 29	
Greater Richmond Chapter Register for walks in this area at www.alz.org/grva.	Middle Peninsula/Northern Neck, October 8 Fredericksburg (Univ. of Mary Washington), October 15 Richmond (Innsbrook), November 5th	
National Capital Area Chapter Register for walks in this area at www.alz.org/nca.	LaPlata, MD, September 17 Solomons, MD, September 17 Bowie, MD, September 24 Reston, September 25	Washington, DC, October 8 Manassas, October 15 Winchester, October 29
Southeastern Virginia Chapter Register for walks in this area at www.alz.org/seva.	Suffolk, September 17 Virginia Beach, September 24 Newport News, October 15	Farmville, October 20 Williamsburg, October 22 Onancock, October 29