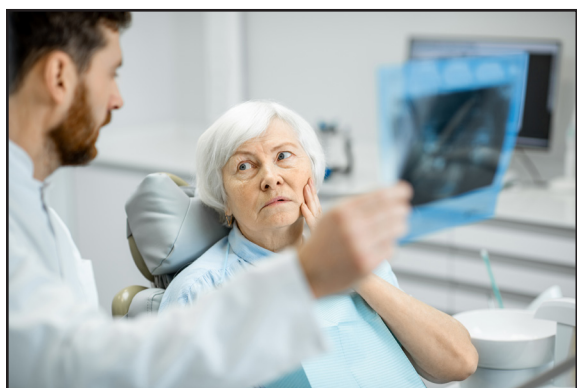


Case Study

Lucy Corr Dental Clinic: Addressing Dental Needs of Uninsured Older Adults

By Patricia B. Bonwell, RDH, BSDH, MS, PhD



Educational Objectives

1. Discuss the critical importance of oral health and the oral-systemic relationship in older adults.
2. Describe how dental insurance determines receipt of dental treatment in older adults.
3. Share how the Lucy Corr Dental Clinic (LCDC) increases access to dental care for uninsured older adults.
4. Describe valuable collaborations with community foundations, the Virginia Dental Association, and Virginia Commonwealth University that enable the success of the LCDC.

Background

A healthy mouth is essential to healthy aging. An

unhealthy mouth adversely affects nutrition, sleep, psychological status, social interactions, and other activities, and is associated with a number of serious chronic conditions, thereby worsening quality of life. This is called the oral-systemic relationship. Having no teeth or unhealthy teeth and gums can contribute to poor nutritional intake and associated health problems. Pain from untreated oral diseases can limit one's activities of daily living, as well healthy sleep patterns. Feeling that the appearance of one's teeth or mouth is unattractive or not socially acceptable can lead to isolation and possible depression.

Evidence supports an oral-systemic relationship between oral disease and chronic diseases, including diabetes, rheumatoid arthritis, cardiovascular disease (CVD), and respiratory conditions (American Academy of Periodontology, n.d.). It is the inflammatory process associated with periodontal (gum) disease that produces the majority of these chronic conditions, for about 70% of adults ages 65 and older have it. Diabetes limits the healing ability of gums and poorly controlled diabetes increases this limitation after dental treatment. Diabetes can also affect the salivary glands leading to a reduction of saliva produced. Bi-directionally, studies show that reducing the inflammation associated with gum disease improves blood sugar levels and healing in diabetics (Corbella, et al., 2013). Reducing the inflammation

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associated with gum disease also reduces arthritic ‘flare-ups’ (Araujo, et al., 2015) and assists with controlling CVD by reducing the production of C-reactive protein associated with CVD (Schenkein, & Loos, 2013). Studies indicate a systemic link between inflammatory gum disease and Alzheimer’s disease, and support implementing oral health preventative measures early that are continued throughout one’s lifespan (Kantarci, et al., 2020). Oral health issues can trigger incidents of acting out in those with Alzheimer’s.

Bacteria in dental plaque/biofilm as well as larger pieces of calculus (calcified plaque) from unclean teeth can be aspirated into the lungs. This increases occurrence of bacterial pneumonia or aspiration pneumonia in less mobile older adults, especially those residing in long-term care (LTC) facilities (Terpenning, et al., 2001). Pneumonia is a common cause of mortality in older adults. Practicing good preventative oral hygiene techniques and receiving routine dental care help to reduce the prevalence of aspirating oral bacteria, preventing hospitalization, thereby reducing medical care costs for older adults (Rife & Luanne, 2018).

Medications prescribed for chronic conditions can display side-effects in the mouth. These can include overgrowth of the gums, burning mouth, ulcers, and limited healing of gingival tissues. However, the main oral side-effect of many medications is xerostomia/dry-mouth (Tan, et al., 2017). Dry mouth is not a normal consequence of aging, and in healthy adults change in saliva production is minimal to nonexistent. Dry mouth can increase tooth decay (cavities), gum irritation, gum infections, chewing and swallowing problems, inhibit taste, limit speech, and limit both comfort and fit of dentures and/or partials.

Oral cancer becomes more prevalent with age. According to the American Cancer Society, the estimated number of new cases of oral and pharyngeal cancer in the U.S for 2020 is 53,000, with the median age of diagnosis being 63. The CDC reports that oral cancer will be responsible for over 10,000 deaths this year with more than half of these occurring among those aged 65 and older. The median age at death is 67. These statistics support the need for routine oral exams/screenings performed by oral health care

providers.

Inadequate Dental Care in Later Life

Maintaining oral health and receiving routine dental care are essential to the overall health and wellbeing of older adults. Practicing proper oral hygiene techniques and routinely visiting a dentist help to address dental needs at an early stage and prevent the exacerbation of chronic conditions, thereby reducing both dental and medical care expenses. However, a survey of older adults found that 54% cited dental care as their most frequent unmet need, second only to transportation (National Association of States United for Aging and Disabilities, 2016). Medicare does not provide any dental coverage and dental coverage in Medicaid plans for adults varies from state to state. According to the 2018 State of Decay Report, eight states cover no dental services through Medicaid and only four states cover the maximum possible dental services in Medicaid (Oral Health America, 2018). The CDC notes that having adequate dental care is closely related to having dental insurance for older adults.

Individuals ages 65 years and older generally have the lowest level of dental insurance coverage, in part due to loss of employer-provided insurance at retirement. Approximately half of all Medicare beneficiaries did not have a dental visit in 2016. In 2017, only 29.2% of adults aged 65 and over had dental insurance. A large number of older adults do not retain employer provided dental benefits after retiring. This lack of coverage leads to their paying for dental care with out-of-pocket resources, which many cannot afford, preventing them from receiving routine dental care. (Allareddy, et al., 2014). Uninsured older adults are often forced to wait until they are experiencing dental pain before seeking treatment, limiting routine oral cancer exams/screenings performed by an oral health care provider. This predicament leads to an increase in high cost Emergency Department (ED) visits to address preventable dental pain. The lack of dental coverage for many older adults contributes to a rise in unnecessary medical costs.

The Lucy Corr Intervention

The Lucy Corr Foundation (LCF) was founded in

2000 with a mission to enhance the lives of Lucy Corr Continuing Care Retirement Community (Lucy Corr) residents, participants, and their families and to help meet the emerging needs of older adults in the community. A central program of the Foundation is the operation of the Lucy Corr Dental Clinic (LCDC), which provides oral health care free of charge to Lucy Corr residents, as well as to eligible uninsured older adults residing in surrounding communities. Community seniors must be ages 65 or over, have no type of dental insurance, and have not been seen by a dentist for a year in order to be eligible to receive care in the LCDC. In addition to screening residents of Lucy Corr, the LCDC volunteers and staff provide offsite screenings to eligible dentally uninsured participants of partnering community geriatric programs, including senior housing and nutrition programs. Participants screened are then scheduled in the dental clinic for treatment based upon needs they presented during their dental screening. For almost 10 years, the LCDC has consistently operated and served as the only safety net provider solely meeting the oral health care needs of eligible dentally uninsured seniors in the region. The LCDC has so far served over 1,300 patients and provided over \$2 million worth of dental services to uninsured older adults.

Grant funds, various fund raisers, and donations have enabled the LCDC to pay part-time staff salaries and purchase dental materials, equipment, and supplies to provide dental treatment free of charge to eligible participants. The Jenkins Foundation, Richmond Memorial Health Foundation, John Randolph Foundation, Rotary of South Richmond, Mary Morton Parsons Foundation, Titmus Foundation, Conduff Memorial Trust, Gwathmey Memorial Trust, Delta Dental of Virginia Foundation, Altria Companies Employee Community Fund, and the Cameron Foundation have provided funds to the LCDC. Services provided by the LCDC include routine exams, prophys (cleanings), restorations (fillings), fluoride treatments, simple extractions, x-rays, new dentures and partials, as well as repairs. Other benefactors to the LCDC are volunteer dentists, dental hygienists, and dental assistants. Their extraordinary donation of time and talent is gratefully received by those to whom they render dental treatment free of charge.

Strong partnerships have helped the LCDC to provide critically important dental care free to uninsured older adults. Through a collaboration with the Virginia Dental Association's Donated Dental Services (DDS) Program, the LCDC has provided over 324 dentures and partials, fabricated free of charge by dental labs that also collaborate with DDS. Once LCDC has determined prosthetic needs, its partnership with the DDS Program enables assistance with making partials with a partnering lab, full dentures if they cannot be made on site, and securing oral surgeons to perform surgical extractions. In turn, DDS reaches out to the LCDC on behalf of community members who have contacted them in need of dental care and dentures. Recipients are grateful for this collaborative effort.

Case Study #1

This case study focuses on two patients in the LCDC. The first is Ms. B, an 88-year old resident of the facility with hypertension, Type 2 diabetes, and COPD. She had been without dentures for a while and was having trouble with eating a diet she desired. She was tired of the soft pureed diet she was on and longed to be able to chew "good food." Her nurses commented that she lost interest in her food and had started to lose weight. She seemed reticent and to be feeling down on herself when she was first seen in the clinic. However, the LCDC staff shared with her that they would be able to make her a new set of dentures on site using the Larell Denture making system. She was delighted to hear this and went cheerfully through the steps and appointments involved in making removable dentures on site. After receiving the dentures and having some adjustments made, her mood improved, she gained weight, and was happy to be able to chew "good food."



Before dentures (left) and after dentures (right).

The second patient, Ms. S., age 82, with hyperten-

sion and restless leg syndrome, came to the LCDC because she was a participant in one of the partnering community geriatric programs. She was in need of surgical extractions of several root tips that were causing her discomfort. In addition, Ms. S. needed to have partial dentures made to replace pulled teeth and improve mastication (chewing). LCDC collaborated with the DDS Program to secure a volunteer oral surgeon for the extractions and a dental lab to assist the LCDC with making upper and lower partial dentures. Her shared “thank you” note supports the scientific findings that being able to chew food more adequately with dentures and partials improves nutritional intake and self-image.



Case Study #2

This case stems from the LCDC serving as a preceptor site for the rotation of dental and dental hygiene students from the Virginia Commonwealth University School of Dentistry. This partnership gives students an opportunity to work with and provide dental treatment to members of the geriatric population that they may not encounter in the dental school clinic environment. With the aging of the population, there is a need to include geriatrics in the educational curriculum of future oral health care providers (Levy, et al., 2013). The LCDC addresses this need by providing oral health care students an on-site training opportunity for the provision of clinical dental treatment to older adults. Students are overseen by licensed volunteers and staff. This collaboration produces two-fold benefits: having students on rotation in the clinic increases the number of providers available to render free oral health care, and more providers increases the number of uninsured older adults who are treated. This experience has had a profound impact on students.

As part of their clinical training curriculum, senior dental and dental hygiene students of the VCU School of Dentistry have various preceptor sites at which they are required to rotate and provide services under the supervision of licensed oral health care providers. After his rotation at the LCDC, B. B., a senior dental student, submitted his reflection piece to the Dental School's Director of Oral Health Promotion and Community Outreach. His words show the impact of the rotation:

“My training as an expeditionary serviceman and a dentist came into contact during the Lucy Corr rotation. I believed that I would go into the clinic, find an operatory, and wait for my patients to appear seeking my specific skill set. This was not to be. For the first part of my rotation I was handed a Rubbermaid tote containing examination gloves and masks and followed the attending dentist, hygienist and assistant as they went out into the nursing home to patient rooms. In this role we provided the service of quick oral exams and prostheses evaluations along with limited treatment planning. This limited treatment plan allows for the patient to be scheduled for an appointment where more definitive treatment can be performed. I was able to be the student and observe the dental treatment rendered. However, the dental portion of this visit was not the only service we provided. We were four humans entering the rooms of strangers, some of whom were mentally aware and some who were not. Regardless of the mental state of the patients, we provided much needed interaction: a smile, a few words, physical touch, even a laugh. It was in one such room that one of the residents continually shouted, “Help us, help us please!” We ensured that she was alright, but her mind was such that she repeated this request, so much that in my memory I can still hear the pitch of her voice, see the height of her bed and the brightness of the light in the room.

After these visits were completed, we returned to the main dental clinic where I was able to practice the dental model to which I am accustomed: those in need come to me. But now a new dental model has been planted in my mind: the expeditionary dentist. Our country has an aging population, a portion of which will utilize nursing homes and assisted living where their ability to seek out dental care might be

limited. This limitation can be coupled with a staff too overwhelmed with the myriad of medical problems to consider dental care for their patients. This is a mission field well suited to the expeditionary dentist. I know of a nursing home not one mile from the office where I will practice in my hometown of Salem, VA. Having now seen a model of this expeditionary nursing home dental care I know I have the resources to either set up a similar clinic or supplement a clinic should one already exist. Perhaps, the one resident's cry of "Help us, help us please!" was meant for me: meant to bring into clarity this need to take dental care where it is needed."

Clearly, the rotation experience at the LCDC was impactful on this future oral health care provider. Follow up correspondence revealed that this dental student did stick to his word after graduating by volunteering at a nursing home facility near him to provide oral health to its residents.

Conclusion

The utilization of routine dental care services is an important component of maintaining oral health. Impaired oral health can adversely affect diet, nutrition, sleep patterns, psychological status, social interaction, and other activities of life in older adults. Research findings support a link between gum disease and systemic chronic conditions prevalent in the older adult population. However, despite these findings and the fact that research also suggests improved oral health may have a positive impact on general health and may delay mortality, dental coverage for older adults in Medicaid is minimal to none in many states and there is no dental benefit included in Medicare at present. There is a nationwide push to add a dental benefit to Medicare and various states have adopted a broader dental benefit to cover adults in their Medicaid plans. However, while policy issues are being addressed, free and charitable clinics, such as the Lucy Corr Dental Clinic, are striving to improve access to dental care for uninsured older adults.

By 2030 the number of US adults aged 65 and older is expected to reach 74 million, 21% of the overall population (Colby & Ortman, 2014). The Baby Boom cohort is a large cohort that may face greater competition for social resources than previous small-

er cohorts. The lack of dental coverage in Medicare and numerous Medicaid programs creates a financial barrier for many Baby Boomers entering later life, limiting their access to dental care. The LCDC, and other similar clinics, present a model for working to address this limited access.

The operation of the LCDC has resulted in positive outcomes for patients seen and students educated. While preparing students to provide dental care after graduation to older adults in need, this clinical educational site rotation improves access to dental care for uninsured older adults. Through collaborative efforts, the LCDC increases access to dental care for these elders while improving knowledge, interpersonal skills, and clinical expertise of future oral health care providers.

Students rotating through the dental clinic add to the number of volunteers providing free oral care. In turn, training future oral health care providers in geriatric oral health care prepares them for what they will confront in practice settings as the overall population grows older. So long as national and state policies limit access to critical oral health care for so many older adults, initiatives like the LCDC offer a meaningful response to this barrier by providing dental treatment free of charge through positive partnerships, training, and productive collaborations.

Study Questions

1. Why is it important to understand how the oral-systemic relationship may affect older adults?
2. What is a good approach for addressing oral side effects of medications?
3. How should the impact of oral health on overall health be shared with older adults and care givers?
4. What are ways to improve access to oral health care for uninsured older adults?

About the Author



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From the Director, Virginia Center on Aging

By Edward F. Ansello, Ph.D.

On wisdom, gerontology, and personal aging: Through a looking glass

A recent, highly readable essay by Arthur Krystal in the *New Yorker* questions what gifts aging brings. He notes that the proposition that later life offers unprecedented opportunity for self-discovery, insight, and wisdom has been growing slowly but incrementally, like the older population itself, since the 1970s. It's time, he says, to question its accuracy and the degree to which we are taking advantage.

I agree, and ask if how and what we teach about aging helps us to achieve these gifts.

Aging demographics themselves are fraught with controversy. For some, like economist Robert Samuelson and columnist George Will, this increase in numbers of older adults is like a tsunami, destructive and presaging economic ruin through age-related entitlement programs that produce intergenerational inequities and an unsustainable economy. For others, like the late Ram Dass and gerontologist Lars Tors-tam, the trend could be likened to a gentler age wave, offering increasing numbers of individuals in late life opportunities for greater self-awareness, spiritual growth, and evaluation of their place in the world through self-transcendence. Wisdom, considered to reflect unbiased judgement, self-knowledge, compassion and understanding, could flow from this trend.

Ageism quickly comes to the fore in discussions on either side: alarms that an ageist preferential treatment of older adults through social insurance entitlements disenfranchises those younger from a stable future versus claims that societal ageism minimizes later life's potential and inhibits contributions to individual self-realization, wisdom, and community good.

What follows is my personal perspective, with no more authority or gravitas than one person's reflections after a career in gerontology.

In English, the principal meaning of "looking glass" is a mirror; it can also mean "counter to common sense or expectations." I hope that my comments

about being an older gerontologist and about the dominant focus of gerontology serve both of these definitions.

Individuation is the name of the game in later life. Life stamps each of us in idiosyncratic ways, from where and how we are born to where and how we pass our days. We each interpret events and people through the lenses of our own previous experiences to create unique perspectives, aptitudes, values, strengths and weaknesses. We grow less like our age-mates in most every way from dexterity to abstract reasoning, from organ functioning to vocabulary. We acquire and lose at our own rate experiences of learning, intimacy, ability, and understanding. I've called this individuating phenomenon the geriatric imperative (Janicki & Ansello, 2000).

From my perspective, so much of the thrust in the field of gerontology is to achieve a "nomothetic" understanding of the processes of aging; that is, to acquire data and descriptive statistics that help to create a generalizable template of the processes of aging. We measure, compare, and publish averages and ranges of scores, be they on problem solving tasks or on numbers of daily interactions with other people in a neighborhood. These normative findings help guide public policy deliberations, public health initiatives, product development decisions, and capture general principles about aging and older adults, a broad but fairly shallow rendering.

Understanding the individual, one's interiority, what a person thinks or feels about matters including one's own aging, can be enormously difficult and requires an "idiographic" approach that does not lend itself to large scale projects and does not, of course, produce generalizable findings. This idiographic, individual approach, seen today in what's called narrative gerontology (de Madeiros, 2013), produces a deeper understanding of the aging person but a narrowed understanding of aging. Inasmuch as generalizability is the grease that lubricates funding support from enterprises like the government, businesses, and

foundations, idiographic studies have limited, almost curated generalizability.

There are terms to describe these different analyses and their different results. In Jungian psychology, persona is the outer garment of who we are. Soul is the inner self. We develop a persona in the course of our growing older. Our environment, social position, birth order, education, friends, work experiences, gender, and other lived conditions help shape and encourage us to adopt a persona or outward manifestation of who we are: parent, nurse, travel agent, teacher, whatever. For some of us, what we do becomes who we are. We may wear this persona for decades without asking ourselves: Is this who I really am? And this is perfectly fine. The persona is protective; it offers security and self-identity. So it's easy for later life to become Mid-Life, Part Two.

Understanding one's true self, one's soul, is not undertaken lightly and rarely is completed in a lifetime. Most of us don't even think to begin, while some take small steps and are content. This simply reflects the basic fundament of growing older: individuation.

Soul-searching has been well described in Rick Moody and David Carroll's *Five Stages of the Soul* (1997). The stages begin with hearing an internal "Call" to discern our purpose. Many of us don't have this progenitor experience. Disengagement may be central to attaining self-insight and wisdom but our society prizes engagement, activity, and productivity. Torstam noted this early on in an issue of *Generations* (1999-2000) when he described the challenges to his theory of self-transcendence in later life.

Self-appraisal was an integral part of the pre-retirement seminars that I gave for about 25 years for the FBI, IBM, NIH, and other acronyms. I was part of comprehensive, separate four-day programs with both the FBI and the International Broadcasting Bureau at the Department of State where I emphasized reflection while other presenters discussed second careers, finances, and the like. Some pre-retirees related to the message, many did not. This is as to be expected with the process of individuation. Plus, the omnipresence of social media and other intrusions in daily life (emails, assignments, etc.) mitigate against introspection or metacognition, which is the aware-

ness of one's own knowledge, what one does and doesn't know.

There are various models for later life, including Successful Aging (Rowe & Kahn, 1988), Productive Aging (Butler & Gleason, 1985), Creative Aging (Cohen, 2001) and various taxonomies of developmental tasks, from Havighurst to Erickson. While each has dimensions that are external (e.g., public attitudes) and internal (e.g., personal development), each also has its strengths and weaknesses and its adherents. Not surprisingly, given the primacy of individuation, each may be germane and helpful for some individuals and not others.

Dealing with losses and forces over which one has no control. To some degree, I think this is emblematic of later life. When younger, one has the illusion, at least, of being able to overcome or confront these forces. In my case, the forces include a recent change of higher administration that fixed what wasn't broken and diminished my roles and responsibilities within the university; happening at the end of my career, it inserted an unfortunate note to my persona but I see it as typical of so many later lives. Times, values, and worth are transitory and what endures must be an honest self-appraisal rather than the opinions of others.

Conscious aging and gerotranscendence, as well as some elements of Cumming & Henry's disengagement theory (withdrawal and reflection, awareness of finitude, and making room for those younger), have more relevance to me now, even though I have advocated these models for more than 40 years in my humanities-related gerontological work.

My daily routine upon awaking is something different from what it was 20 years ago and quite frankly something I could not have anticipated then. First thing each morning, I appraise the levels of pain in my back, my feet, my knees, and whatever loss might be causing psychological pain. One thing that older gerontologists do is older gerontologists die. As we grow older, the deaths of friends and colleagues seem a too frequent routine. Again, something unknown to me 20 years ago. But, as with a screen-saver, one moves beyond this appraisal to open up apps or platforms of one's life and the screen-saver "disappears"

into the background, present but not primary. Another piece of self-awareness. As stated in Ecclesiastes, “In much wisdom is much grief: and he that increaseth knowledge increaseth sorrow. . . .”

I don’t think that we gerontologists overall do an adequate job of teaching about interiority and self-reflection. We overly subscribe to models that advocate the worth of older adults as a group (e.g., productive aging) and we rely upon the more readily accessible and generalizable descriptive statistical approach to research and teaching, one that, in turn, helps to produce the numbers of scholarly publications necessary for promotion within higher education. Relatedly, our curricula still tend to rely upon the triumvirate of the social aspects of aging, bio-physical aspects of aging, and psychological aspects of aging, with scant attention to how the humanities and the arts (literature, music, poetry, philosophy, etc.) can contribute to interiority and a

sensitivity to what it *means* to grow old.

Critical gerontology maintains that there is no objective meaning to growing old. As Ronald Blythe noted four decades ago in *The View in Winter* after collecting oral histories of older adults, old age is full of life and full of death, full of promise and full of disaster, full of individual lives lived in their own different ways.

Late life offers us an opportunity, nothing more. Whether we undertake self-appraisal and grow in wisdom is an option during the added years of our lives. How widespread are these options being exercised? Has the election of older national candidates produced leaders with wisdom?

On the other hand, can a broader, humanities-infused gerontology help develop broader self-awareness and incipient wisdom?

From the Commissioner, Virginia Department for Aging and Rehabilitative Services

By Nickolas Slentz, Human Services Coordinator, and Elizabeth White, VLRVP Coordinator
DARS, Division for Community Living-Office for Aging Services

Virginia Lifespan Respite Voucher Program

The Virginia Department for Aging and Rehabilitative Services (DARS), with grant funding from the federal Administration for Community Living (ACL), and in partnership with the Virginia Caregiver Coalition, created the Virginia Lifespan Respite Voucher Program (VLRVP) to address the need for respite support services across the Commonwealth.

The program’s goal is to assist caregivers by providing a temporary break from caregiving duties in order to reduce the risk of burnout associated with the long-term stress of caring for a loved one with a disability or serious health condition. This includes family members providing unpaid care to individuals with disabilities across the lifespan. The program provides a one-time reimbursement of up to \$400 for respite care services to allow a family caregiver to take a break from caregiving to relax and recharge.

The caregiver and care recipient must reside full-time in Virginia at the same address in order to be eligible.

Caregiving duties can become taxing and cause high levels of stress, which are known to affect emotional, mental, and physical health negatively. Respite care is one solution to avoid caregiver fatigue and give caregivers some well-deserved relief from the responsibilities and strain of caring for loved ones.

One in five Virginians is a primary caregiver to an individual with a disability and/or serious health condition, including dementia. Some 458,000 caregivers in Virginia provide assistance to someone with Alzheimer’s disease or a related dementia. These caregivers provide an estimated 521 million hours of unpaid care to their loved ones, thereby saving the Commonwealth over \$6 billion annually. Nearly 18% of

Virginia caregivers provide more than 40 hours of care per week.

It is estimated that 14% of caregivers care for a child with special needs. Over 65,000 children, ages 18 and younger, live with at least one disability. In Virginia, there are almost 134,000 children who live with and are cared for by their grandparents. Additionally, there are nearly 41,000 children who live with and are cared for by other relatives. Research has shown that children are more well-adjusted, with fewer placement changes, when living with a caregiver who is a relative. In order to maintain the benefits of familial caregivers, it is important that they are allowed time off from the emotional and physical demands of caregiving.

The objective of the VLRVP is to continue to expand and increase Virginia's ability to provide affordable and accessible lifespan respite support. The program is increasing its outreach to inform more caregivers about this opportunity, specifically targeting those caring for adults with dementia, grandparents caring for a grandchild under age 18 with a disability, and other relative caregivers caring for an adult, ages 19-59, with a severe disability. The VLRVP is looking to expand funding, increase caregiver participation, and partner with other programs with similar target

populations in the hopes of increasing outreach.

DARS received its first of three lifespan respite grants from the ACL in 2012. Since then, the program has provided 1,417 families with a reimbursement for a temporary short-term respite break. Since 2012, the VLRVP has provided an average reimbursement of \$338.65 to family caregivers, with disbursements totaling nearly \$500,000. From 2014 through 2020, the VLRVP provided caregivers with 40,350 respite hours, averaging 44.3 hours per family.

The VLRVP has been able to get a glimpse of what Virginia caregivers and their loved ones look like. The average caregiver is 55.8 years old. The youngest has been 23 years old and the oldest was 92. Some 28% of caregivers are spouses, 43% are parents, 20% adult children, 3% grandparents, and the remaining 6% other relative caregivers (siblings, grandchildren, aunts).

Notably, 29% of individuals are caring for someone with a form of dementia, 21% are caring for someone with autism, 5% for someone with a mental health disorder, 5% for someone with a developmental or intellectual disability, and the remaining 39% for someone with another diagnosis, such as Parkinson's, rare genetic disorders, cerebral palsy, traumatic brain injury, renal failure, etc. About 8% of caregivers are caring for a veteran. The youngest care recipient was 2 years old and the oldest was 98; 55% of care recipients are male; 39% of care recipients are African American, 1% Asian, 49% Caucasian, 5% Hispanic/Latino, 5% multiracial and 1% other.

Caregivers who have used this program have described what respite has allowed them to do:

"My husband and I were able to take a short trip with our grandchildren- something we have not been able to do since caring for my 94 year-old mother at our home. The funding for this type of break from caregiving is critical to our marriage and mental health."

"This program helped me obtain care for my mom during COVID. The financial assistance allowed me to get someone I trusted to care for my mom and I was able to get rest and enjoy fun-time with my

DARS 2021 Meeting Calendar

The DARS advisory boards meet quarterly and are open to the public. For information, call (804) 662-9333 or visit vda.virginia.gov/boardsandcouncils.htm.

Commonwealth Council on Aging
January 27, April 28, July 28, September 22

**Alzheimer's Disease and Related
Disorders Commission**
March 9, June 8, September 14, December 14

**Virginia Public Guardian and
Conservator Advisory Board**
March 16, June 22, November 9

spouse at home.”

“This program is needed. As a caregiver, we need to take time for ourselves. This was the first vacation I have taken in 4 years. Just keep doing what you are currently doing - Thank you.”

The hope for the future of the program is to increase

utilization and find a sustainable funding source for this invaluable service. The program continues to have a positive impact within the Virginia community of caregivers. Caregivers are essential to the Commonwealth and this program is a way to recognize their contributions and offer a much needed break to allow them to maintain their health so they can continue to care for their loved ones.

In Memoriam: Gale Davis and Joan Wood

By Bert Waters, Associate Director, VCoA

Both Gale Davis and Joan Wood died last month. Their passing was dutifully noted in the *Richmond Times Dispatch*, but they deserve a special recognition from the Virginia Center on Aging. I am grateful for their mentorship and leadership qualities that shaped my professional life as a gerontologist. Both Gale and Joan were recipients of Master’s Degrees in Gerontology from VCU, and Joan then completed a PhD in Psychology. Both were tireless advocates for our older adult population, and both will be sorely missed.

Gale was teaching the course “The Business of Geriatric Care Management” for the Department of Gerontology, when Connie Coogle recruited her in 2005 to work with VCoA on a Richmond Memorial Health Foundation grant entitled “Employed Caregiver Initiative, Workplace Partners for Eldercare – Awareness, Education and Support.” VCoA partnered with Senior Connections, The Capital Area Agency on Aging, on this project to help businesses offer support to employers who were current or potential caregivers. I knew Gale because we had been volunteering for two regional coalitions since the early 2000s, the Central Virginia Coalition for Quality End-of-Life and the Virginia Culture Change Coalition. She was someone who would never say “no” when a family member needed help with navigating the aging network. Gale later joined the VCU Health System as the geriatric social worker in Geriatric Medicine’s House Calls program.

Joan was the Associate Director for the Virginia Geriatric Education Center (VGEC) when I first met her in 1998. I was initially struck by how her mannerisms

were so similar to my own mother’s. When I later found out Joan had taught high school in Dinwiddie County, where my mom grew up, and I told her that I am from the Glass clan, she said, “I know your mom. She is the prettiest woman in all of Dinwiddie.” When I mentioned this to my mom, she didn’t bat an eye, and said “Oh, I know Joan Wood. She is the smartest person in all of Dinwiddie.”

Joan moved on to become Director of the Northern California Geriatric Education Center at the University of California at San Francisco School of Medicine. She moved back to Richmond when she retired in 2007. In early 2009, an interprofessional group, led by VCoA, started meeting regularly every other Wednesday to prepare for a Geriatric Education Center call for proposals. This group became the VGEC Plenary, which continues to meet twice a month on Wednesdays. Joan helped lead this group, and was instrumental in developing the VGEC’s Faculty Development Program (FDP), modeled after the FDP she led in San Francisco. The VGEC FDP became the cornerstone of our many VGEC initiatives. When the VGEC received initial funding in 2010, Joan joined our Plenary as an adjunct faculty for the next four years, before retiring for a second time in 2014.

Many organizations experienced loss in the 2020 pandemic. The Virginia Center on Aging is no exception. With the losses, first of Bob Schneider in September and then of Gale Davis and Joan Wood in December, we move forward, honoring their legacies, and continue to advocate for Virginia’s older adult population.

Commonwealth of Virginia

Alzheimer's and Related Diseases Research Award Fund

Request for Applications

- Purpose:** The Commonwealth of Virginia established the Award Fund in 1982 to promote research into Alzheimer's and related diseases. Because of a commitment to program balance, the Fund encourages scientifically rigorous applications from a broad spectrum of disciplines. Studies may involve:
- (1) the underlying causes, epidemiology, diagnosis, or treatment of Alzheimer's and related diseases;
 - (2) policies, programs, and financing for care and support of those affected by Alzheimer's and related diseases; or
 - (3) the social and psychological impacts of Alzheimer's and related diseases upon the individual, family, and community.
- Funding:** The size of awards varies, but is limited to \$45,000 each. Number of awards is contingent upon available funds.
- Eligibility:** Applicants must be affiliated with colleges or universities, research institutes, or other not-for-profit organizations located in Virginia. The Fund encourages partnerships between community-based agencies/facilities and academic institutions in Virginia.
- Schedule:** Letter of Intent: By **February 4, 2021** 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 key personnel and participating institutions, a non-technical abstract, the specific aims, and a 4-5 sentence description of the project in common, everyday language for press release purposes. Letters on letterhead with signature affixed must be uploaded to go.vcu.edu/ardraf-loi. Potential applicants will be contacted if LOIs are deemed inappropriate.
- Applications: Applications, emailed on or before the due date, will be accepted through the close of business **March 11, 2021**. NOTE: significant changes to the application form and guidelines were instituted in 2018.
- Announcement of Awards: Award decisions will be announced by June 21, 2021.
- Funding Period: The funding period begins July 1, 2021 and projects must be completed by June 30, 2022.
- Review:** Three qualified technical reviewers, one of whom is identified by the applicant, will review proposals for scientific merit. The Awards Committee will make the final funding decision.
- Application:** Application forms, guidelines, and further information may be found at go.vcu.edu/ardraf or by contacting the Award Fund administrator: Constance L. Coogle, Ph.D., ccoogle@vcu.edu.

VCU Students Address Social Isolation in Older Adults

A group of health professional students from VCU is making a difference in the lives of socially isolated older adults in the Richmond area. Social Calling with Older Adults is a collaboration between faculty from VCU's Division of Geriatric Medicine and leaders from the American Geriatrics Society (AGS) Student Chapter. Led by the students, a system has been developed that connects students with older adults living in assisted living facilities and senior apartment complexes. The purpose is purely social: an opportunity to connect with someone who may be feeling more isolated than normal in the pandemic. There are about 40 student volunteers making weekly phone or video calls to provide support and friendship.

According to Chuck Alexander, Education Administrator for the VCU School of Medicine, "The Social Calls program is of immense, and unexpected, importance for many health sciences students. These learners come from a range of educational backgrounds; medicine, nursing, pharmacy, PT, OT, gerontology, and other health science disciplines. Each participating learner has had an opportunity to develop a friendship with an older adult in the community, providing a social outlet for their loneliness, depression, and isolation. In cultivating these relationships, the learners are improving the health and wellness of older adults throughout our region. I could not be more proud of their dedication and accomplishments achieved with this program."



Miranda Savioli and Joan Kerby meet in-person for the first time in November 2020. Photo originally seen on wric.com.

A poster with an orange background. At the top, it says "DON'T LET SOCIAL DISTANCING KEEP YOU FROM STAYING CONNECTED" in large, bold, black letters. Below this, there is a blue telephone handset icon on the left and a smartphone icon on the right. In the center, there is a paragraph of text: "Social isolation can make us all feel lonely and stressed. But being physically distant does not mean being socially distant - connect with our volunteers to help you stay happy and healthy!". Below this, there is another paragraph: "Whether you're looking for conversation or companionship, VCU students are here to provide support and friendship during these difficult times." Below that, it says "CONTACT THE VCU STUDENT SENIOR HOTLINE" followed by the phone number "804-362-7865" in large, bold, black letters. Below the phone number, it lists the "HOURS OF SERVICE": "MON - FRI 3:00 PM - 9:00 PM", "SAT 9:00 AM - 5:00 PM", and "SUN 9:00 AM - 5:00 PM". At the bottom left, there is a VCU logo and the text "VCU American Geriatrics Society Student Chapter" and "vcugeriatics@gmail.com". At the bottom right, there is an illustration of two women, one younger and one older, standing together and talking.

This unique program was recently featured on WRIC 8News Richmond in a story by reporter Delaney Hall. The story focused on the relationship that has formed between VCU medical student Miranda Savioli and retiree Joan Kerby. The two women met through the Social Calling with Older Adults program and developed a friendship through their weekly phone calls. Eventually, they were able to have an in-person meeting. To view the full story, visit www.wric.com/community/lifelong-friendship.

For more information about this program, and other community service initiatives, visit the VCU AGS Student Chapter website or email vcugeriatics@gmail.com. To connect an older adult with a student volunteer, please call the VCU Student Senior Hotline at (804) 362-7865.

Substance Misuse in Older Adults

There's a new and valuable resource on substance misuse in older adults, thanks in large part to Dr. Frederic Blow, Professor of Psychiatry and Director of the University of Michigan Addiction Center. The product is *Treating Substance Use Disorder in Older Adults: SAMHSA Treatment Improvement Protocol (TIP) 26*.

It's been quite some time since publication of the last *Treatment Improvement Protocol (TIP)*, but the wait has been worth it. TIP 26, as the publication is being called, is useful for healthcare providers, psychologists and social workers, older adults, family caregivers, and others who may interact with older adults. TIP 26 has nine chapters, some of which aim specifically for adults and families. Conveniently, it's available free online at [SAMHSA.GOV](https://www.samhsa.gov).

“Substance” may include alcohol, prescribed medications, illicit or, increasingly, legally marketed drugs and products, and more. Substance misuse can remain relatively invisible among older adults, partially because symptoms may be misinterpreted as signs of physical or cognitive decline. Moreover, people may have more limited interactions with older adults who no longer work or who drive and socialize less frequently, thereby missing signs of functional impairment caused by substance misuse.

Released by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) in September 2020, TIP 26 offers the most current guidance on how to identify, manage, and prevent substance misuse in older adults.

The content in TIP 26 reflects input from subject matter experts, best practices, and evidence-based research. It is likely to become THE definitive guide for practitioners in identifying and treating substance use disorders (SUD) among older adults. Each chapter has Key Messages, Key Terms, and resources such as screening tools; in addition, there are large print handouts to help patients or clients.

TIP 26 takes a person-centered team approach to substance misuse among older adults, encouraging healthcare providers and other professionals to learn

how to approach screening, assessment, treatment, and education/support for family members and caregivers. Social support for the older adult is critical to achieving and maintaining success.

Each of the nine chapters is labeled for its intended audience, and begins with a chapter summary and key learning points. Some chapters contain screening tools, e.g., for alcohol, medication, mental health, or cognitive functioning. There are over 1,500 key references and resources in TIP 26.

Here's an overview of each chapter, with intended audiences and key points:

1. Older Adults and Substance (All Audiences)

Rates of substance misuse in older adults vary widely, and are under-recognized and undertreated. Substances affect older adults differently than younger adults, and smaller amounts of substances can have greater and more dangerous impacts. It is never too late to stop misusing substances, no matter one's age.

2. Principles of Care for Older Adults (Providers, Supervisors, Administrators)

It's important to recognize the difference between early- and late-onset SUDs among older adults. Emphasize client education, early identification, screening, and brief treatment. Engage in health risk reduction practices. Provide person-centered care. Age-sensitive and age-specific treatment practices increase engagement and retention in treatment for older adults. Recognize and address diversity and health disparity issues related to culture, ethnicity, and race in the diverse among older adults. Interprofessional collaboration among service providers is essential, especially for those with co-occurring medical conditions and mental disorders.

3. Identifying, Screening for, and Assessing Substance Misuse in Older Adults (Providers)

How to screen for substance misuse in older adults. Behavioral health service and healthcare providers in any setting should screen older clients for substance misuse. The main reason for screening and assessment is to help you decide whether, where,

and how to address substance misuse. Substance misuse affects older adults differently than it does middle-aged and younger adults. Providers across settings should be trained in giving age-appropriate care. They also need to have the skills to recognize substance misuse in older clients.

4. Treating Alcohol Misuse in Older Adults (Providers)

Screening and assessment tools and treatment options should be tailored to older adults. Educating older adults about low-risk levels of alcohol use and about alcohol–drug interactions can be a powerful brief intervention. Offering many different treatment choices based on the individual’s symptoms and needs can increase the chances of success; address all co-occurring health conditions using a stepped-care approach to the management of referrals and ongoing coordination of care.

5. Treating Drug Use and Prescription Medication Misuse in Older Adults (Providers)

How to identify, screen, and assess for drug use disorders in older adults. The majority of older clients who use illicit drugs or misuse prescription medication do not need care from programs or providers that specialize in substance use disorder (SUD) treatment. Education and brief interventions are often enough to help older adults prevent, reduce, or stop drug use and prescription medication misuse. Age-specific and age-sensitive treatments are useful in reducing drug use and prescription medication misuse and related health risks.

6. Substance Misuse and Cognitive Impairment (Providers)

How to educate clients about the relationship between cognitive impairment and substance misuse. How to work with and help caregivers. It is important to screen for mental disorders that co-occur with substance misuse that can negatively affect cognition. Doing such screening will help you quickly get older adults the substance use disorder (SUD) treatment, mental health services, and medical evaluation they need. Treatment should address the person’s substance misuse and co-occurring mental conditions, including depression, anxiety, and cognitive impairment.

7. Social Support and Other Wellness Strategies for Older Adults (Providers)

Strong social networks support older adults in achieving and maintaining recovery from substance misuse, and providers can help older adults to develop and maintain these. Older adults have to increase their health literacy to maintain recovery and prevent relapse. Providers need to engage older adults in illness management and relapse prevention activities specific to substance misuse with a focus on health and wellness. Providers can help older adults feel more empowered by understanding the normal developmental challenges of aging and age-specific strategies that promote resilience and setting goals. Providers should instruct family members to visit the older adult when he or she is not misusing substances, rather than visiting only during times of crisis, and recommend that they attend family support groups such as Al-Anon.

8. Drinking as an Older Adult: What Do I Need To Know? (Older Adults, Caregivers, and Family Members)

The messages are for older adults who drink (including those who have questions about how much they should drink), their families, and their caregivers. Provides information about how alcohol can affect older adults’ changing bodies, health, and life circumstances. Includes drinking guidelines, tips and cautions for self-assessment, treatment options, and helpful resources. Includes information for caregivers, families and friends about alcohol misuse, and how they can help the older adult quit or cut back on drinking. Encourages people to have hope, for many older adults are able to change their drinking habits to improve health and well-being.

9. Resources for Treating Substance Use Disorder in Older Adults (All Audiences)

Contains scores of resources, organized by audience and topic, addressing substance misuse, recovery, and related health and wellness issues among older adults. Contains numerous facts and figures, referral, treatment and support group locators for providers, older adults, and families.

The University of Michigan Addiction Center’s website is: umaddictioncenter.org.

Duties and Responsibilities of a Representative Payee

By Emily A. Martin, Esq. Hook Law Center

Does My Loved One Need a Representative Payee?

If you have a friend or family member who receives Social Security benefits but no longer has the capacity to manage these benefits, you may be wondering how you can help them. Many people think that if they are appointed as someone's Agent under a General Durable Power of Attorney, they will be able to help their loved one manage their Social Security benefits. Unfortunately, the Social Security Administration (SSA) does not recognize powers of attorney or other similar documents. If you need to assist someone with managing their Social Security benefits, you will need to apply to become their representative payee through the SSA.

How Do I Become a Representative Payee?

In order to apply to become a Representative Payee, you will need to complete form SSA-11 (Request to be selected as payee), make an appointment with your local Social Security office, and bring supporting documents such as your license and social security card to verify your identity.

What Are the Responsibilities of a Representative Payee?

Once you are appointed someone's representative payee, you are in a fiduciary relationship with that person. This means that you must manage their Social Security payments and use those funds to meet their needs. You must keep clear and accurate records of your actions as Representative Payee – the SSA requires that you file annual reports with them so they can verify that you are acting in the best interests of the person you are assisting.

Representative Payees cannot use the funds in the payee's account to cover their own personal expenses or deplete the funds in a way that would leave the beneficiary without enough money for food, housing, medical care, or other essential items or services. As Representative Payee, you also cannot commingle the payee's funds with your own funds or with someone else's funds.

If you would like more information about what it means to be a Representative Payee, you can review the Social Security Administration's publication, *A Guide for Representative Payees*, at <https://www.ssa.gov/pubs/EN-05-10076.pdf>.

The Hook Law Center publishes articles and conducts webinars periodically. You can reach Emily Martin at emartin@hooklawcenter.com

Lifelong Learning Institute in Chesterfield



The LLI is a member-supported, nonprofit organization with a mission to provide lifelong learning opportunities for midlife and older adults through education, fitness, and social activities. Since April 2020, LLI has adapted to the pandemic by providing hundreds of live, online courses, providing its members with social connections, lively discussions, thought-provoking lectures, and learning for the love of learning from the comfort and safety of their own homes.

LLI welcomes new members. Annual membership is \$150, which provides access to unlimited courses for one full year. New online sessions will be kicking off in January. For more information, email info@LLIChesterfield.org or call (804) 347-5096.

If you would like to support the work of the LLI, please [consider making a tax-deductible donation](#).

Foundations in Longevity and Aging



**Presented by the
Department of Gerontology in the VCU
College of Health Professions**

Specialized knowledge of aging and older adults is crucial, especially in certain professions. With the onset of COVID-19, this is apparent now more than ever.

This nine-part series anchors concepts of gerontology relating to longevity and aging, all set within the context of the current pandemic and with hands-on strategies, tools and case studies. No prerequisites are needed to complete modules.

This online curricula series is designed for:

- Health Professionals
- Recareering health professionals
- Emerging health professionals
- Anyone who desires rigorous, evidence-based continuing education

Participants in this series can earn individual badges for completing each module and a micro-certificate for completing the entire series.

Individual Badges

Online modules are priced at \$60 each. Badges will be awarded for the completion of each module. A badge is an industry credential that verifies and describes your qualifications in specific professional content areas. [Visit here for a full list of modules and to register.](#)

Micro-Certificate

To earn a micro-certificate in "Foundations in Longevity and Aging," all nine modules listed above and a self-reflection exercise must be completed. Those enrolling in the entire series receive a 10% discount off the per module charge.

[Visit here to register for the full micro-certificate at the discounted rate.](#)

For more information, contact:
Kim Ivey
ksivey@vcu.edu



VCU

College of Health
Professions

Calendar of Events

January 26, 2021

[*Dementia Friends Virtual Training*](#). “Dementia Friends” is a growing movement with the goal of creating awareness in communities about what dementia is, the many ways it is manifested, and how people can respond and help when they encounter someone who seems confused. 10:30 a.m. - 11:30 a.m. Webinar is free; registration required.

January 27, 2021

[*Virginia Center on Aging's 35th Annual Legislative Breakfast \(Virtual\)*](#). For more information, email eansello@vcu.edu or ksivey@vcu.edu.

February 16-18, 2021

[*2021 Health Datapalooza and National Health Policy Conference*](#). A virtual gathering for health data and policy innovation. Presented by AcademyHealth.

March 1-3, 2021

[*Virginia Assisted Living Annual Spring Conference*](#). The Hotel Roanoke, Roanoke.

March 23-26, 2021

[*Times of Change: Educational Scholarship During Major Transition*](#). 2021 Virtual Health Sciences Education Symposium. Presented by VCU's School of Medicine.

March 24, 2021

[*Envisioning the Future: Exploring Lessons Learned*](#). Symposium presented by the Pioneer Network.

April 6-15, 2021

[*On Aging*](#). Annual Conference of the American Society on Aging (Virtual).

April 20-23, 2021

[*Aging Better Together: Building an Inclusive Aging Community*](#). Virtual Annual Meeting and Conference of the Southern Gerontological Society.

April 27-29, 2021

[*Virtual Aging Policy and Advocacy Summit*](#). Presented by the National Association of Area Agencies on Aging.

May 13-15, 2021

[*American Geriatrics Society's 2021 Virtual Annual Scientific Meeting*](#).

May 17-18, 2021

[*Virginia Governor's Conference on Aging*](#). Richmond Marriott, Richmond.

May 24-26, 2021

[*2021 Quality Summit*](#). Presented by the American Health Care Association and the National Center for Assisted Living. Grapevine, TX.

June 7-10, 2021

[*Age+Action 2021 Virtual Conference*](#). Presented by the National Council on Aging.

July 19-22, 2021

[*National Association of Area Agencies on Aging's 46th Virtual Annual Conference and Tradeshow*](#).

August 25-27, 2021

[*Solving the Puzzle: Joining Together to Protect Elder Virginians*](#). Annual Conference of the Virginia Coalition for the Prevention of Elder Abuse. Kingsmill Resort and Conference Center, Williamsburg.

November 10-14, 2021

[*Disruption to Transformation: Aging in the "New Normal"*](#). Gerontological Society of America's Annual Scientific Meeting. Phoenix, AZ. **Call for Abstracts will open from February 1 - March 11, 2021.**

Age in Action

Volume 36 Number 1: Winter 2021

Edward F. Ansello, PhD, Director, VCoA
Kathryn Hayfield, Commissioner, DARS
Kimberly 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 2021 Issue Deadline for Submissions:
March 15, 2021**



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Aging Better Together: Building an Inclusive Aging Community

The Southern Gerontological Society's 42nd Annual Meeting and Conference
Virtual Conference
April 20-23, 2021

SGS is revisiting this important theme, Aging Better Together: Building an Inclusive Aging Community, from the cancelled 2020 conference.



Visit the [SGS Website](#) to register.
For questions about SGS, call Lee Ann Ferguson at
(866) 920-4660 or [send her an email](#).

age
in action

Thanks for reading our Winter 2021 issue!



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.