DEMENTIA CARE BEST PRACTICES
IN THE COMMONWEALTH

Report to
Delegate Orrock, Chair
House Committee on Health, Welfare and Institutions

Virginia Department for Aging
and Rehabilitative Services

Commonwealth of Virginia
Richmond
October 1, 2014
October 1, 2014

The Honorable Robert D. "Bobby" Orrock, Sr.
Chair, House Committee on Health, Welfare and Institutions
General Assembly Building
Post Office Box 406
Richmond, VA 23218

Dear Delegate Orrock:

In response to your request of January 29, 2014, DARS has completed a study and review of dementia care best practices in Virginia and ways to encourage and expand such practices across all levels of care and settings.

In preparing this report and its findings, staff at DARS called upon a workgroup comprised of stakeholders representing provider associations, experts and advocates, and state agencies. We are pleased to say that 40 programs from 31 Virginia-based organizations have been identified as best practices that go above and beyond expected practices.

Additionally, upon careful review and consideration, DARS and the stakeholder workgroup developed guiding principles for quality practices and 13 recommendations for encouraging and expanding best practice programs and services. I look forward to adding these recommendations into the agency’s short- and long-term goals and partnerships, and the Virginia Alzheimer’s Disease and Related Disorders Commission has agreed to integrate the findings into the next edition of Virginia’s Dementia State Plan, scheduled for release in October 2015.

If you have any questions, please do not hesitate to contact me.

With best regards, I am

Sincerely,

James A. Rothrock

JAR/ca

cc: Delegate Mark L. Keam
    Delegate John M. O’Bannon, III
    Enclosure
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## I. ACRONYMS

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<th>Acronym</th>
<th>Description</th>
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<tr>
<td>AAA</td>
<td>Area Agency on Aging</td>
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<tr>
<td>ACL</td>
<td>U.S. Administration for Community Living</td>
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<tr>
<td>AD</td>
<td>Alzheimer’s Disease</td>
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<td>ADC</td>
<td>Alzheimer’s Disease Centers</td>
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<td>ADL</td>
<td>Activities of Daily Living (e.g., dressing, feeding, walking, transferring from bed to a chair, bathing, toileting, managing incontinence)</td>
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<tr>
<td>ADSSP</td>
<td>U.S. Alzheimer’s Disease and Supportive Services Program (within ACL)</td>
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<tr>
<td>ARDRAF</td>
<td>Virginia Alzheimer’s and Related Diseases Research Award Fund</td>
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<tr>
<td>BPSD</td>
<td>Behavioral and Psychological Symptoms of Dementia</td>
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<td>BRFSS</td>
<td>Behavioral Risk Factor Surveillance System</td>
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<tr>
<td>CDC</td>
<td>U.S. Centers for Disease Control and Prevention</td>
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<td>CMS</td>
<td>U.S. Centers for Medicare and Medicaid Services</td>
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<td>Commission</td>
<td>Virginia Alzheimer’s Disease and Related Disorders Commission</td>
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<tr>
<td>Council</td>
<td>Virginia Commonwealth Council on Aging</td>
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<td>CSB</td>
<td>Community Services Board/Behavioral Health Authority</td>
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<td>DARS</td>
<td>Virginia Department for Aging and Rehabilitative Services</td>
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<td>DBHDS</td>
<td>Virginia Department of Behavioral Health and Developmental Services</td>
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<td>DMAS</td>
<td>Virginia Department of Medical Assistance Services</td>
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<td>DSC</td>
<td>Dementia Services Coordinator at DARS</td>
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<td>DSS</td>
<td>Virginia Department of Social Services</td>
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<td>ED</td>
<td>Emergency Department</td>
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<td>FTD</td>
<td>Frontotemporal Dementia</td>
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<tr>
<td>IADL</td>
<td>Instrumental Activities of Daily Living (e.g., chores in the home, grocery shopping, transportation, meal preparation, management of finances, scheduling of physician appointments)</td>
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<tr>
<td>LBD</td>
<td>Lewy Body Dementia</td>
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<tr>
<td>LDSS</td>
<td>Local Departments of Social Services</td>
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<tr>
<td>MCI</td>
<td>Mild Cognitive Impairment</td>
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<tr>
<td>NIH</td>
<td>U.S. National Institutes of Health</td>
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<tr>
<td>PDD</td>
<td>Parkinson’s Disease Dementia</td>
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<tr>
<td>TBI</td>
<td>Traumatic Brain Injury</td>
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<td>VaD</td>
<td>Vascular Dementia</td>
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<td>VDH</td>
<td>Virginia Department of Health</td>
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II. DEFINITIONS

**AlzPossible**: A website, [www.AlzPossible.org](http://www.AlzPossible.org), managed by a partnership between DARS, the Commission, Virginia Commonwealth University Department of Gerontology, and World Events Forum, Inc. AlzPossible provides a listing of interdisciplinary memory assessment centers, free training webinars, and data on AD and dementia in Virginia, among other resources.

**Behavioral and Psychological Symptoms of Dementia (BPSD)**: Describes the range of non-cognitive symptoms that often occur or manifest with dementia. These symptoms include, but are not limited to, apathy, verbal and physical aggression, agitation, wandering, decreased inhibition, anxiety, hallucinations and delusions, sleep disturbances, irritability, and depression.

**Behavioral Risk Factor Surveillance System (BRFSS)**: The nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services.

**Best Practices**: Creative or innovative methods, techniques or practices that are consistently shown to have superior results and that are considered to be above and beyond expected practices.

**Dementia Capable**: Tailored to the unique needs of persons with dementia and their caregivers.

**Evidence-Based**: Based on research. Evidence-based programming translates tested program models or interventions into practical, effective programs that can provide proven health benefits to participants. When an evidence-based program is implemented, there is proof that the program works.

**Evidence-Informed**: Reflects the deliberate and systematic use of the best available evidence. This is combined with a distillation of the experience of experts where that evidence is not available, to inform clinical decision-making and evaluation, program development and policy creation.

**Expected Practices**: Practices that are either: (1) required by law, such as those standards outlined in the licensing and regulation of facilities, providers, and professionals, or (2) well-developed and widely accepted practices.

**Formal Caregiver**: Professionals or paraprofessionals who are paid in exchange for providing care.

**Informal Caregiver**: Individuals, usually family members, friends, neighbors or volunteers who provide unpaid care.

**Person-Centered Care**: An approach to service delivery that views the individual with dementia as a person by emphasizing his or her current abilities, rather than focusing on the disease(s) or conditions and the individual’s limitations.

**Pseudodementia**: Disorders that mimic the characteristics and symptoms of dementia but are not actually caused by dementing illnesses. Examples include depression and delirium.
In February 2014, Commissioner James A. Rothrock with the Virginia Department for Aging and Rehabilitative Services (DARS) received a letter from Delegate Robert D. “Bobby” Orrock, Sr. requesting DARS and the Dementia Services Coordinator (DSC) to convene a workgroup to look at dementia care best practices and ways to expand and encourage them across all levels of care and settings. Upon receiving the letter, DARS developed a stakeholder workgroup that was comprised of provider associations, experts, advocates and state agency representatives. DARS also completed a literature review on dementia care, which revealed three overarching themes for implementing best practices: (1) Assessment for Diagnosis and Treatment; (2) Dementia Care; and (3) Formal and Informal Caregiving.

DARS and the stakeholder workgroup approached the study by identifying Virginia entities that are implementing innovative, evidence-based and evidence-informed best practices that go beyond expected dementia care components or standards. In order to do this, DARS and the workgroup defined expected practices as either: (1) those practices that are required by law, such as those standards outlined in the licensing and regulation of facilities, providers, and professionals, or (2) well-developed and widely accepted practices. On the other hand, dementia care best practices were defined as creative or innovative methods, techniques or practices that are consistently shown to have superior results and that are considered to be above and beyond expected practices.

In addition, it was determined that both expected and best practices should reflect guiding principles, which will necessitate ongoing and frequent training and should leverage sustainable partnerships and collaborations:

- The wishes and needs of individuals with dementia and caregivers should be respected.
- Practices should reflect compassionate, ethical, person-centered, and high quality care across the continuum of the disease, from early diagnosis through the end-of-life.
- Practices should respect and incorporate ethnic, cultural, socio-economic, demographic, and geographic diversity.
- Practices should integrate the social and medical needs of individuals living with multiple chronic diseases and disabling conditions, and focus on prevention or mitigation of crisis situations that may arise.
- Care should be provided in the least restrictive environment and with access to a sense of community.

DARS shared information about the study and the request for information about best practices through agency mailings and newsletters. Additionally, members of the stakeholder workgroup were asked to share the study resources, including a submission form, with their contacts in order to collect information about best practice programs in Virginia. A total of 40 programs from 31 organizations, spanning long-term care providers, home and community-based providers, health systems, and nonprofit organizations were identified and included in the final report. Within the three overarching themes, programs spanned a variety of expected practice components, including interdisciplinary diagnosis and assessments; training initiatives for formal
and informal caregivers; interventions not involving medications for dementia care; and innovative partnerships to collaboratively address needs from diagnosis to end-of-life.

While a number of quality programs are recognized in this report, there is still much more Virginia leadership can do to ensure the Commonwealth is dementia capable. After reviewing the findings, 13 recommendations were developed. Specific recommendations were made in the overarching themes of (1) Assessment for Diagnosis and Treatment; (2) Dementia Care; and (3) Formal and Informal Caregiving. Additionally, several cross-cutting recommendations were developed in order to promote and expand both expected and best practices across all three themes. Lastly, DARS and the DSC will work to integrate the findings and recommendations from this report into the Virginia Alzheimer’s Disease and Related Disorders Commission’s Dementia State Plan update, which is scheduled for release in October 2015.
IV. BACKGROUND

OVERVIEW OF REPORT DEVELOPMENT PROCESS

In the 2014 General Assembly session, Delegate Mark Keam introduced House Bill 831 to request the Virginia Department of Health to convene a workgroup to study and make recommendations related to the provision of care for individuals with dementia residing in nursing facilities in the Commonwealth. The bill was tabled in the House Committee on Health, Welfare and Institutions.

In February 2014, Commissioner James A. Rothrock with the Virginia Department for Aging and Rehabilitative Services (DARS) received a letter from Delegate Robert D. “Bobby” Orrock, Sr. requesting DARS and the Dementia Services Coordinator (DSC) to convene a workgroup to look at dementia care best practices and ways to expand and encourage them across all levels of care and settings. The letter is included in Appendix A.

Upon receiving the letter, the DSC developed a stakeholder work group comprised of provider associations, experts, advocates, and state agency representatives. A list of the organizations and representatives in the stakeholder work group can be found in Appendix B. Concurrently, DARS completed a literature review of dementia care best practices. The literature review revealed three overarching themes for expected and best practices: (1) Assessment for Diagnosis and Treatment; (2) Dementia Care; and (3) Formal and Informal Caregiving.

DARS and the stakeholder workgroup determined that it was important to identify best practices that went “above and beyond” expected practices for working with individuals with dementia and their caregivers. In order to do this, expected practice components were defined as either (1) those practices that are required by law, such as those standards outlined in the licensing and regulation of facilities, providers, and professionals, or (2) well-developed and widely accepted practices. For instance, validation therapy is considered an expected standard for meeting individuals with dementia where they are at their level of function. Similarly, avoiding physical restraints in long-term care, providing opportunities for reminiscence (opportunities to enjoy and talk about past memories), and providing support groups for caregivers and those with a diagnosis are common, expected standards for the provision of dementia care.

On the other hand, best practices were defined as creative or innovative methods, techniques or practices that are consistently shown to have superior results and that are considered to be above and beyond expected practices. In the context of integrating information about expected and best practices, DARS and the workgroup wanted to review expected practice components and then subsequently recognize those entities that were implementing best practices. Lastly, DARS and the workgroup wanted to review potential policy options for integrating best practices into other parts of the Commonwealth in various settings.

With the expected practices identified from the literature, DARS began to collect information on best practices in Virginia and code them based on the three overarching themes. As part of this process, DARS developed a submission form that allowed stakeholders and other
interested parties to provide DARS information about programs, services, and techniques that they employ to obtain quality health outcomes for individuals with dementia. The submission form was publicized through a variety of channels, including various e-newsletters and communications, and stakeholders were encouraged to share the information widely.

On June 19, 2014, DARS hosted the first stakeholder workgroup meeting, which was very well attended. In addition to a discussion about some of the submissions that had been received, stakeholders also discussed needs and practices for advance directives, person-centered care, care coordination and planning, a well-trained workforce, access to resources, thorough assessments, and ways to elevate practices through research and study. Additionally, some potential best practices were discussed and shared to provide examples and guidance. The outcomes from the meeting included a stakeholder-approved study development process and study outline.

At the second stakeholder workgroup meeting, held on August 21, 2014, DARS presented stakeholders with a draft of the report and asked for input. The stakeholder workgroup unanimously approved the draft of the report with only minor edits and thoughts for consideration. After the meeting, Appendix C was drafted to provide a full list of organizations with best practices programs included in the report. After DARS made edits to the draft to reflect the consensus of the workgroup, the report was finalized and prepared for submission to Delegate Orrock, Sr.

DEMENTIA AND ITS IMPACT IN VIRGINIA

General Dementia Information

Dementia is a progressive and ultimately fatal collection of neurodegenerative diseases, which affect cognition and memory.\(^1\) Over time dementia can cause changes in memory, thought, navigation, language, behavior, mood and personality.\(^2\) Behavioral changes observed during the onset of dementia can include poor judgment, difficulty with problem solving, the inability to manage finances, misplacing items and disconnection from the date or season.

According to the American Psychiatric Association (APA), dementia can be categorized as mild or major. The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* released in 2013 states that mild dementia involves modest cognitive decline recognized by cognitive testing, which causes the performance of everyday tasks to require greater effort. Major dementia involves substantial cognitive decline recognized by cognitive testing and assistance is required to complete daily activities.\(^3\)

Irreversible forms of dementia can be categorized as cortical or sub-cortical. Cortical dementia involves disorders affecting the cerebral cortex, the outer layers of the brain, and causes impairment in memory and language. Common cortical dementias include Alzheimer’s disease (AD), frontotemporal dementia (FTD), vascular dementia (VaD) and Creutzfeldt-Jakob disease.\(^4\)

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\(^a\) For this report, each in-text citation (1, 2, 3, etc.) uniquely corresponds with one reference as listed on pages 41-44. Some sources are repeated.
disease. AD is the most common form of dementia representing approximately 60 to 80 percent of dementia cases and is the sixth-leading cause of death in the United States. Sub-cortical dementia affects portions of the brain below the cortex causing changes in attention span and personality. Types of sub-cortical dementia include dementia caused by Huntington’s disease, dementia caused by Parkinson’s disease (PDD), alcohol-induced persisting dementia, and Lewy body dementia (LBD). It is not uncommon for individuals to have two or more types of dementia. In fact, in the United States, 75 percent of individuals with dementia aged 75 years and older have mixed pathologies.

Age is the biggest risk factor for AD and is reflected in AD prevalence because of the aging baby boomer generation and longer life expectancies. Between two to ten percent of dementia cases are found among individuals under the age of 65, with prevalence doubling at each five-year increment after the age of 65. Nationally, it is estimated that one-third of individuals aged 85 and older are affected by AD. In 2010, approximately one out of eight Virginians was aged 65 or older and there were approximately 125,000 individuals 85 or older in Virginia.

Lastly, it is important to note that although dementia is generally irreversible, in some instances the cause and symptoms can be reversed. Reversible or pseudodementia can be caused by alcohol consumption, drugs, depression, delirium, medication interactions, tumors, infections, nutritional deficiencies, emotional disorders, eye or ear impairments, and metabolic disorders. A recent meta-analysis of current research indicated that nine percent of individuals with dementia-like symptoms were only mimicking dementia and the symptoms could potentially be reversed.

Dementia in Virginia

In Virginia, an estimated 130,000 older adults aged 65 and older are currently affected by AD, with an expected increase to 190,000 by 2025. Further, according to data from the Centers for Medicare and Medicaid Services (CMS), 91,517 Medicare beneficiaries in Virginia had received a clinical diagnosis of AD or a related dementia in 2012. Recognizing that anywhere from 29 to 76 percent of individuals in the community have not received a clinical diagnosis and that not all of those who receive a clinical diagnosis of AD or a related dementia are enrolled in Medicare, experts expect that the figure is much higher, thus accounting for the differences between 91,517 clinically diagnosed Virginians and 130,000 estimated Virginians with dementia. For more details on this data, including the prevalence rates for Medicare beneficiaries within cities and counties in Virginia, please visit www.AlzPossible.org.

In 2012 and 2013, the optional Cognitive Impairment Module was included in the annual Behavioral Risk Factor Surveillance System (BRFSS), allowing the Commonwealth to get an idea of widespread cognitive issues as reported by Virginians for the first time ever. The results provide state Health and Human Resource agencies a deeper perspective of cognitive impairment issues and how they may interfere with functioning. Among the findings are: in 2012, 12.5 percent of adults age 45 and older surveyed by VDH reported having experienced increased confusion or memory loss in the last 12 months. Of those adults, 30 percent have given up household activities or chores that they used to do and 33 percent reported that confusion or memory loss interfered with their ability to work, volunteer or engage in social activities.
Perhaps most troublesome, however, is the finding that of those who reported confusion or memory loss, only 25 percent had talked about it with a health care professional.9

It is important to note the specific needs of women and minority Virginians as well as those living in rural areas. Virginia is ethnically diverse with one in every ten residents having been born in another country.10 The proportion of Hispanic Virginians almost doubled during the decade of 2000 to 2010. As of 2011, 2.4 percent of the 60 and older population was Hispanic.11 For African Americans, this figure was 15.3 percent.10 Comparing prevalence between ethnicities, aging Hispanics are one and one-half times more likely and African Americans are twice as likely to be diagnosed with AD in comparison to Caucasians.1 In addition, there were 123.3 women per 100 men aged 60 and over living in Virginia as of 2011 and approximately two thirds of AD patients are women.1,10 Older adults living in rural areas of Virginia also represent a population vulnerable to the impacts of dementia; they often have decreased access to specialists, community supports, and educational resources, which impede diagnosis and treatment.12 In 2010 there were 1.4 million Virginians aged 60 and older living in rural areas of the state.10

Given the debilitating nature of dementia, caregiving is generally required in both an informal and formal setting. Caregivers in Virginia, estimated to be around 447,000 individuals in 2013, provided 509 million hours of unpaid care valued at $6.3 billion in 2013 to individuals with AD or another form of dementia.1 By the age of 80, 75 percent of individuals with AD have been transferred to a nursing facility.13

Funding or coverage for services that provide dementia assessment, diagnosis, and ongoing care and supports for individuals with dementia and their caregivers come predominantly from five areas: Medicare; Medicaid; public federal and state grants; third party payers, such as health insurance and long-term care insurance; and private sources, such as an individual’s own financial resources, donations, scholarships, in-kind resources, volunteer commitments, etc.

GUIDING PRINCIPLES FOR BEST PRACTICES IN DEMENTIA

The following reflect guiding principles for dementia care expected and best practices that necessitate ongoing and frequent training and that should leverage sustainable partnerships and collaborations:

- The wishes and needs of individuals with dementia and caregivers should be respected.
- Practices should reflect compassionate, ethical, person-centered, and high quality care across the continuum of the disease, from early diagnosis through the end-of-life.
- Practices should respect and incorporate ethnic, cultural, socio-economic, demographic, and geographic diversity.
- Practices should integrate the social and medical needs of individuals living with multiple chronic diseases and disabling conditions, and focus on prevention or mitigation of crisis situations that may arise.
- Care should be provided in the least restrictive environment and with access to a sense of community.
INFLUENCING FACTORS IN VIRGINIA

There are dozens of state and local contributors that enhance and strengthen Virginia’s dementia capability. The following agencies and organizations play a particular key role in dementia initiatives, activities, and oversight.

- **Virginia Department for Aging and Rehabilitative Services (DARS):** In 2012, DARS intensified its focus on individuals with dementia and their caregivers. In July 2013, DARS hired Virginia’s first DSC. Since that time, DARS and the DSC have been implementing Virginia’s Dementia State Plan on a day-to-day basis, including reviewing memory assessment centers and training for first responders, and working with the state agencies to identify and inventory dementia data collected across agency programs. DARS has made dementia and caregiving a focus of its Four-Year State Plan on Aging Services, which will be updated next year. DARS’ network of contracted Virginia’s Area Agencies on Aging (AAAs) have proven to be great resources and practitioners for individuals and families dealing with a dementia diagnosis. Furthermore, DARS is now home to the State Long-Term Care Ombudsman, which frequently assists individuals with dementia, and the Adult Protective Services Division, which oversees the adult services delivery system within the local departments of social services (LDSS) across Virginia. DARS also has a wealth of knowledge and experience in assistive technology devices, some of which can be adapted to support the independence of those living with a cognitive impairment.

- **Virginia’s Area Agencies on Aging (AAAs):** Virginia has 25 Area Agencies on Aging serving every county and city. The AAAs provide many services for persons with dementia and their caregivers to include Home Delivered Meals, Care Coordination, Respite Care, Information and Assistance, Options Counseling, Long Term Care Ombudsman, Medicare Counseling, and Referrals for Services. The AAAs also serve as advocates on behalf of persons with dementia and their family caregivers to promote beneficial systemic changes for Virginia’s LTSS system.

- **Virginia Alzheimer’s Disease and Related Disorders Commission (Commission; advisory board within DARS):** Formed in 1982, the Commission has long served as an advisory board to the Governor and General Assembly on statewide issues related to AD, dementias, and caregiving. Working for several decades now to examine cognitive and caregiving needs in the Commonwealth and to identify solutions, the Commission develops and submits an annual report on activities with policy recommendations for consideration. Coinciding with other state efforts to develop a coordinated plan for responding to dementia, the Commission published Virginia’s first Dementia State Plan in December 2011. Since its publication, the Dementia State Plan has served as a road map for the Commission to advocate for policies and programs that ensure Virginia’s dementia capability. In 2013, a major objective of the Dementia State Plan was realized when DARS hired the first DSC, a position that focuses on identifying duplication and gaps in dementia care, and working with statewide organizations to improve services.
  - Much of the work and accomplishments of the Commission and the DSC can be found at [www.AlzPossible.org](http://www.AlzPossible.org), the Commission’s virtual platform in partnership.
with Virginia Commonwealth University (VCU) Department of Gerontology and World Events Forum, Inc. that offers free webinars on dementia and caregiving, information on memory assessment center services, a listing of available data sets for researchers, and many other Virginia-specific resources.

- **The Commonwealth Council on Aging (Council; advisory board within DARS):** The Council’s annual Best Practices Awards have highlighted several dementia care best practices, including caregiver programs and cultural activities for persons with dementia.

- **Virginia Department of Social Services (DSS):** DSS supervises the local departments of social services (LDSS) that administer and provide a wide variety of social services. DSS also serves as the state licensing agency for adult day services and assisted living facilities, two programs that frequently serve individuals with AD and dementia.

- **Local Departments of Social Services (LDSS):** The local departments of social services serve as a key component on the frontline of service need identification and delivery. The local departments serve as part of the pre-admission screening team that conducts eligibility determinations for nursing facility placement and benefit programs such as food stamps, Medicaid and assistance with heating and cooling expenses. LDSS also provide and link clients to home-based adult services, conduct adult protective service investigations, and provide information and referrals for additional programs serving older adults and those with dementia and their caregivers.

- **Virginia Department of Medical Assistance Services (DMAS):** Individuals with AD and other dementias often receive long-term care services in nursing facilities, and some are covered through traditional Medicaid. Since 2004, some individuals with AD and dementia have also received personal care services while living in assisted living facilities through their enrollment and coverage under the Alzheimer’s Assisted Living waiver. Individuals with AD and dementia are also enrolled in the Program for All-Inclusive Care for the Elderly (PACE), a Medicaid state plan option which provides comprehensive, coordinated, community-based care for individuals aged 55 and older who are typically Medicaid and Medicare eligible and have been assessed to meet nursing facility level of functional care criteria. In 2013, participants in PACE had an average of six chronic conditions per participant, and 565 of the 1322, or 43%, of individuals had a clinical diagnosis of AD or dementia. Additionally, as of 2014, some individuals with AD and dementia are being enrolled in the Commonwealth Coordinated Care (CCC) program, which blends Medicare and Medicaid benefits for Virginians who are receiving both services. Under the CCC program, individuals with dementia have access to better coordination that can improve their health outcomes and reduce the burden that caregivers frequently experience when it comes to arranging various services.

- **Virginia Department of Behavioral Health and Developmental Services (DBHDS):** Originally the home of the Commission until it moved to DARS in 2003, DBHDS continues to serve individuals with serious mental illness and dementia through its State Hospitals, particularly Piedmont Geriatric Hospital, and through its contracted network of Community Services Boards (CSBs).
• **Community Services Boards (CSBs):** Select local CSBs operate programs and interventions directed specifically at older adults and those with dementia, especially individuals displaying behavioral and psychological symptoms of dementia (BPSD).

• **Virginia Department of Health (VDH):** VDH included an optional Cognitive Impairment Module into the annual BRFSS in 2012 and 2013, allowing Virginia to collect widespread data like never before. VDH serves as the Commonwealth’s State Survey Agency for Medicare and oversees the state licensing of nursing facilities, home health care, hospice, and other facilities in which individuals with dementia are frequently served. Staff at VDH participate in the Healthy Aging Council of the National Association of Chronic Disease Directors, which recently focused a funding opportunity on brain health and caregiving needs. In addition, at the local level, health districts serve on the pre-admission screening for individuals seeking nursing facility placement and waiver services under contract with DMAS and in partnership with the LDSS. Local health departments also respond to reports of communicable disease and provide communicable disease/outbreak management support and direction for all long-term care facilities; provide training for long-term care staff on communicable disease control as requested; respond to requests to meet with groups to discuss issues related to older adults; refer caregivers to community based support groups; and evaluate community health improvement opportunities.

• **Virginia Department of Health Professions (DHP):** The mission of DHP is to “ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to health care practitioners and the public.” DHP regulates professionals in medicine, nursing, pharmacy, physical therapy, social work and long-term care administration, among others. These professions frequently treat and work with individuals with dementia, including AD, and their caregivers.

• **The Virginia Alzheimer’s Association** chapters provide significant support to individuals with dementia and have proven to be invaluable resources for state agency staff as they implement statewide programs and services. The four Alzheimer’s Association chapters (Central and Western Virginia, Greater Richmond, National Capital Area, and Southeastern) have provided decades of support to individuals with dementia and their caregivers across the Commonwealth. The Alzheimer’s Association chapters consistently offer quality information and resources on dementia, support groups, respite care, education, training and presentations for both informal caregivers and formal caregivers, and coordinated national efforts to fund research and advocate for dementia capable programs, policies and systems. The Alzheimer’s Association chapters are key partners in Virginia’s efforts to ensure dementia-capability and the provision of high-quality services.

• **Alzheimer’s and Related Diseases Research Award Fund (ARDRAF):** In 1982, the Virginia General Assembly established ARDRAF, a competitive seed research grant program that is administered by the Virginia Center on Aging at Virginia Commonwealth University. ARDRAF grants seed money to researchers in Virginia to stimulate innovative research into biomedical, clinical, and psychosocial aspects of dementia,
including cell biology, caregiving, and animal modeling. Since 1982, ARDRAF has supported over 150 pilot studies with small grants totaling over $3.3 million and has assisted in the development of evidence-informed and evidence-based practices. ARDRAF summary reports provided by awardees can be found on AlzPossible.

- **SeniorNavigator:** For the past 13 years, SeniorNavigator has been utilized by hundreds of thousands of seniors, caregivers and families each year, with over 1.2 million visits in 2013. The site gives users access to information about 26,000+ community programs and services, 800+ informative and topic-based articles, 1,000+ links, and features like “Ask an Expert”. Over 700 “Navigator Centers” developed through partnerships with senior centers, libraries, hospitals, police stations and churches serve as community access points for Virginians. Helpful information focused on AD includes: detailed information and streamlined access to over 500 community-based AD or dementia-related programs and services searchable by zip code or city/county; a library of helpful educational articles separated by category; ten experts ready to answer AD related questions; and the new Institute for Innovations in Caregiving, which is highlighted on page 36.

- Further and of particular note, the **national Alzheimer’s Association** has developed and published three documents that outline evidence-based practice recommendations for general dementia care, end-of-life care in assisted living facilities and nursing facilities, and for professionals working in the home environment. These person-centered, comprehensive documents, identified below, outline both expected practices and best practices spanning various topics, including: home safety, falls and wandering; decision-making and care planning; staff training; pain management; personal care; and nutrition.


Together, these efforts represent Virginia’s responses, informed by national efforts and programs, to dementia and caregiving needs. These partners and leaders in dementia, as well as others, will be vital to ensure Virginia is prepared and equipped to provide quality care and support until such time as we have eliminated dementia, including AD.
V. FINDINGS

Recognizing that AD and dementia research is constantly evolving, this report summarizes, to the extent possible, the best treatments and the latest research available at the time of drafting. With time, the science will surely evolve beyond what is understood about dementia today. The statements of expected practice components were adapted from the 2014 *Health Affairs* article series titled “The Long Reach of Alzheimer’s Disease”\(^\text{14}\) with feedback from the stakeholder workgroup. DARS and the stakeholder workgroup chose to review expected practice components, which are either (1) those practices that are required by law, such as those standards outlined in the licensing and regulation of facilities, providers, and professionals, or (2) well-developed and widely accepted practices. These could include, but are not limited to, validation therapy, avoiding physical restraints, reminiscence, and providing support groups for caregivers and those with a diagnosis. DARS and the workgroup also chose to identify programs and services deemed best practices as well as the organizations or providers implementing them. DARS and the stakeholder workgroup worked diligently to ensure organizations had opportunities to submit potential practices. This report does not serve as an exhaustive or comprehensive review. Providers are encouraged to further study expected practice components and best practices as well as the evidence that is referenced.

**ASSESSMENT FOR DIAGNOSIS AND TREATMENT:**

**EXPECTED PRACTICE COMPONENTS**

Make a formal diagnosis using a standardized instrument and with input from a family member or friend.

There are a variety of instruments and tools designed to assess cognitive function, with many of them available at no cost and in multiple languages. The United States Preventive Services Task Force (UPSTF) reports that the Mini-Mental State Examination (MMSE) is clinically useful for identifying dementia and is an appropriate screening tool for the primary care setting.\(^\text{15}\) Clinicians can use the MMSE to screen for cognitive decline, however the test is held under copyright by Psychological Assessment Resources, Inc. and a fee is required for each use.\(^\text{16}\) As alternatives to the MMSE, the Alzheimer’s Association recommends using the General Practitioner Assessment of Cognition (GPCOG), Mini-Cog or Memory Impairment Screen (MIS). Although these screening tools are under copyright, clinicians are allowed to use them for free. The Alzheimer’s Association advocates the use of these tools because they require five minutes or less to administer, have been validated in primary care or community settings, can easily be administered by a medical or nursing staff member, and are reasonably unaffected by educational, language or cultural bias.\(^\text{16}\) Research has also shown that the Montreal Cognitive Assessment (MoCA) is better at detecting cognitive impairment among patients at a higher risk of developing dementia and differentiating between mild cognitive impairment (MCI) and AD, in comparison to the MMSE.\(^\text{17,18}\) Of particular note, since 2011, Medicare beneficiaries are now entitled to an Annual Wellness Visit that includes an assessment (no specific tool is named) to detect cognitive impairment.\(^\text{16}\)
If performance on a screening tool indicates potential cognitive decline, further evaluation is necessary. Such evaluation can be conducted by the individual’s primary care provider or by referral to a specialist, such as a geriatrician, geriatric psychiatrist, neurologist or neuropsychologist, or to an interdisciplinary memory assessment center.\textsuperscript{19} A formal diagnosis can be best made after a thorough evaluation, which should include:

- A thorough history obtained from the patient and informants, such as family members or friends that details the areas of cognition that have been affected, how the symptoms have progressed, changes in ability to perform activities of daily living (ADLs; \textit{e.g.}, dressing, feeding, walking, transferring from bed to a chair, bathing, toileting, managing incontinence) and instrumental activities of daily living (IADLs; \textit{e.g.}, chores in the home, grocery shopping, transportation, meal preparation, management of finances, scheduling of doctors appointments), and other symptoms.\textsuperscript{19}
- Identification and assessment of co-morbidities, previous medical issues, family history and educational history, as well as prescription medications, non-prescription or over-the-counter medications and nutritional supplements.\textsuperscript{19}
- Hearing and vision screenings since deficits can influence mental status and neurological evaluations.\textsuperscript{20}
- Laboratory tests and examinations to screen for depression, vitamin B12, folate, thyroid-stimulating hormone, calcium, glucose, complete blood cell count, renal and liver function abnormalities, all of which may rule out reversible causes of dementia.\textsuperscript{20}
- Lastly, a comprehensive dementia evaluation may also include either magnetic resonance imaging (MRI) or computed tomography (CT). Brain imaging is particularly useful if there was a recent onset or rapid progression of symptoms, onset occurs under the age of 65, there is a history of head trauma, or neurologic symptoms are present.\textsuperscript{19}

**Evaluate the patient for treatable causes of cognitive impairment or disability.**

Reversible causes of dementia are often treatable and can be recognized using the mnemonic depression/delirium, emotional disorders, metabolic disorders, eye and ear impairments, nutrition, tumors, infections and alcohol/drugs/medication interactions, which spells dementia.\textsuperscript{2} Depression, a treatable pseudodementia, is the most common cause of reversible dementia. It has a rapid onset and individuals typically verbalize their distress.\textsuperscript{2,19} Other pseudodementia causes include organ failure, hypothyroidism, B12 deficiency, electrolyte imbalance, lack of oxygen to the brain due to cardiac or pulmonary issues, space-occupying lesions, and normal pressure hydrocephalus.\textsuperscript{2,21}

Delirium should also be considered before diagnosing an older adult with dementia, especially if the cause of the delirium is potentially deadly. Delirium leads to an acute period of confusion, which can be initiated by a variety of factors.\textsuperscript{2} Causes of delirium include certain medical conditions, including diseases of the heart, vascular system, renal system and lungs, as well as electrolyte disorders, metabolic disorders, glucose imbalance, hyperthyroidism and hypothyroidism.\textsuperscript{2,21} Similarly, use of substances, legal or illicit, and prescribed medications in combination, known as polypharmacy, or alone can cause delirium.\textsuperscript{2} Medications often implicated in these instances include diuretics, sedative-hypnotics, antihypertensives and beta-blockers.\textsuperscript{22} As a general rule, a period of delirium can last one week for every decade the individual has been alive and is only reversed if the cause is identified and effectively treated.\textsuperscript{2}
Conduct a comprehensive and holistic periodic assessment that addresses cognitive, medical, affective, social, economic, environmental, spiritual and functional status.

Below are issues to consider when identifying and addressing key components for quality of life. While not listed here, there are many available tools and scales with proven validity and reliability that providers can use to ensure a thorough assessment.

- **Cognitive**: For information on suitable cognitive assessments, please refer to page 13, which details different tools to use for the formal diagnosis of dementia.

- **Medical**: The well-being of individuals with dementia can affect independence, health status, and the burden placed upon their caregivers. Consistent monitoring of nutrition, hydration, oral health, exercise, and performance on ADLs, as well as sleep, bowel and bladder routines, dental hygiene, and vaccinations is very important. Assessments for co-morbidities as well as acute and chronic conditions should be conducted regularly. Interventions using medications and those without should be continually assessed to ensure continued benefits and adjustments should be made when necessary.

- **Affective**: Apathy or a lack of expressing emotions is a common symptom of dementia. As a result of a decline in ability to portray emotions and communicate, there is immense importance placed on conducting assessments to monitor factors, such as pain, depression and mistreatment, that may affect the emotional health of individuals with dementia.

- **Social**: Social support can be informal (family, friends, neighbors, coworkers or clergy) or formal (assistance from paid individuals). After an individual’s social support network is identified, gaps can be filled with other available resources. Of particular note, if abuse or neglect is suspected, Adult Protective Services should be contacted.

- **Economic**: As cognitive decline progresses, individuals with dementia should be assessed on their ability to manage finances. There are many expenses associated with dementia, including the cost of medications, personal care supplies, adult day services, in-home care, and long-term care. Individuals with dementia and their caregivers should be referred for financial and legal advising to help manage such activities.

- **Environmental**: The home should be assessed for factors such as excessive stimulation, which include noise, clutter and the number of people, as well as under stimulation, which can be caused by lack of objects for touch or viewing and inadequate lighting. Additionally, room temperature can be an issue that may cause discomfort and navigating to the bathroom, bedroom and kitchen can cause frustration.

- **Spiritual**: Spirituality has been shown to significantly affect how older adults and those with dementia cope with hardships as they age. Assessing and understanding an individual’s spirituality can assist clinicians in providing support and relieving distress.

- **Functional**: Functionality can be assessed in a variety of ways and cover many activities. Functional assessments are frequently informed by a caregiver and may include: paying bills, shopping alone, working on a hobby, turning off a stove, preparing a balanced meal, keeping track of current events, and traveling out of the neighborhood.

Consider referral to a specialty interdisciplinary memory care practice.

The National Institute on Aging provides funding to Alzheimer’s Disease Centers (ADCs), which operate at medical institutions and teaching hospitals across the United States. ADCs work to translate research into improvements for diagnosis and care of individuals with dementia.
AD. They also conduct research aimed at preventing AD and finding a cure.\textsuperscript{1} For individuals with AD, ADCs offer diagnostic services, medical management, disease information along with available services and opportunities to participate in support groups, and drug trials or clinical research. Virginia is home to a satellite center for the University of Pittsburgh, the Memory and Aging Care Clinic at the University of Virginia (UVA), which is housed within the Department of Neurology Memory Disorders Clinic (MDC) at the UVA Health Sciences Center.\textsuperscript{28}

The Commission has identified nine interdisciplinary memory assessment clinics, including the MDC at UVA, with six in Virginia, two in neighboring states, and one in Washington, D.C. These clinics have multi-disciplinary teams that provide a comprehensive dementia assessment and diagnosis, continuing care for individuals diagnosed with dementia, access to support groups, and opportunities to join clinical trials. Below shows the map of the locations of the memory centers in Virginia. AlzPossible hosts the full listing of interdisciplinary memory centers as well as detailed information about their services and how to contact them.

\begin{center}
\textbf{Virginia}

CMS Chronic Conditions:
Percentage of all Medicare beneficiaries
diagnosed with Alzheimer’s disease and dementia, 2012
\end{center}

\begin{tabular}{|c|c|}
\hline
Percentage & Color \\
\hline
0-7.44 & \cellcolor{#00b300} \\
7.45-8.22 & \cellcolor{#008000} \\
8.23-9.14 & \cellcolor{#006000} \\
9.15-10.33 & \cellcolor{#003300} \\
10.34-14.34 & \cellcolor{#000000} \\
\hline
\end{tabular}

\textbullet\ Centers are also located in:
\begin{itemize}
\item\ Morgantown, WV;
\item\ Washington, D.C., and
\item\ Chapel Hill, N.C.
\end{itemize}

Consider cognition enhancing drugs.

Providers and caregivers are encouraged to discuss potential medications with medical and pharmacy staff to ensure that they are appropriate for the individual with dementia. Medications with the ability to stop dementia have not yet to be developed, but the U.S. Food
and Drug Administration has approved several prescription drugs to assist with some of the symptoms throughout the stages of the disease. Cognition enhancing drugs have been shown to mildly improve cognition, behavior and daily function. The National Institute on Aging has published a factsheet providing information about the drug treatments currently available, appropriate dosages and possible side effects. It is important to have a thorough and clear diagnosis since medications are not universal for all dementias, with some potentially causing negative side effects. National and international research continues to focus on developing medications that may treat or eliminate the symptoms of dementia.

Regularly reassess the side effects of prescription and nonprescription medications, nutritional supplements, and alcohol and other substances.

The role of medications in aging is best identified along two categories: pharmacokinetic changes and pharmacodynamic changes. Pharmacokinetic changes occur as a consequence of aging, affecting the clearance of fat and water-soluble drugs caused by a decrease in liver and kidney function. Aging also causes an increase in sensitivity to certain categories of drugs such as anticoagulants, cardiovascular and psychotropic drugs, known as pharmacodynamic change.

As a result of this understanding, the Beers Criteria was developed and serves as a list of medications not advised for use among older adults. The Beers Criteria recommends avoiding prescribing anticholinergics, benzodiazepines, H₂-receptor antagonists, Zolpidem (brand name: Ambien) and antipsychotics, including first (conventional) and second (atypical) generations, for individuals with dementia when possible. Specifically, anticholinergic drugs, including antihistamines, antidepressants, medications for urinary incontinence, anti-Parkinson agents, antipsychotics, antispasmodics, and skeletal muscle relaxants have been known to cause side effects such as seizures, delirium, agitation, hallucinations, cardiac arrhythmias, cognitive impairment, and urinary retention. Further, the use of antipsychotics, conventional and atypical, can lead to tardive dyskinesia, which involves behavioral side effects such as uncontrolled chewing, lip smacking, jaw clenching, grimacing, and eye blinking. While the Beers Criteria is widely recognized in health care, inappropriate prescribing still occurs. In order to prevent side effects, prescription medications, non-prescription medications, and nutritional supplements should be reviewed for appropriateness, dosage and adherence.

Of particular note, over the past two years and in line with a national initiative from CMS to improve dementia care in nursing facilities, Virginia has achieved a 14.7 percent reduction in the use of antipsychotics among long-term stay residents in nursing facilities and a 23.1 percent reduction among short-term stay residents.

Detect and treat vascular risk factors.

Vascular risk factors associated with the development of dementia include high blood pressure, diabetes, cerebrovascular and cardiovascular disease, high body mass index (BMI), elevated cholesterol, consumption of saturated fats, smoking cigarettes, drinking alcohol, and traumatic brain injury (TBI). The presence of multiple vascular risk factors causes a collective effect and increases risk of dementia with the addition of each new issue.
• Diabetes is commonly associated with VaD, AD and other dementias. Pre-diabetes and impaired glucose tolerance among older adults may increase risk for dementias.39
• Cerebrovascular and cardiovascular diseases linked to dementia and AD include stroke, silent infarcts, peripheral arterial disease, atrial fibrillation and heart failure.38
• Obesity or a high BMI in mid-life significantly increases risk of developing a form of dementia later in life. Abdominal obesity has been identified as an important risk factor for dementia. A drastic decrease in BMI among older adults has been connected to an increased risk of developing AD within the next five to six years.38
• Smoking cigarettes causes an increased risk of developing AD especially among individuals with a genetic predisposition.39
• Alcohol abuse can lead to an increased risk of developing dementia.39
• Moderate TBI can cause a two-fold increase and severe TBI can lead to a 4.5-fold increase in risk of developing AD and other dementias.1

Manage the patient’s co-morbid conditions in the context of dementia.

It is not uncommon for individuals with AD or dementia to have multiple co-morbid or chronic conditions. In fact, one study examined co-morbid conditions across Medicare beneficiaries with AD or dementia.32 Out of 5,400 participants with a clinical diagnosis of AD or VaD, 19 percent also had cancer, 22 percent had diabetes, 25 percent had osteoarthritis, 26 percent had chronic obstructive pulmonary disease (COPD) and 28 had congestive heart failure. The AARP Public Policy Institute recently released a paper with results from a national survey, which indicates that caregivers are receiving little to no guidance on how to care for persons with cognitive impairment who are also affected by other chronic medical conditions.40

Changes in functional status can be inappropriately attributed to the progression of dementia when the cause may actually be related to a co-morbid condition. Further cognitive decline, functional deterioration, and delirium are potential signs that a new medical issue has developed or a pre-existing co-morbid condition has worsened. Individuals with dementia require close monitoring of signs and symptoms such as behavioral changes, weight loss and drowsiness.31 Management of co-morbid conditions at diagnosis and throughout the disease course may improve cognitive function among individuals with AD.19 Hospital admissions and emergency department visits can be caused by poor management of chronic conditions among individuals diagnosed with dementia.41

Similarly, it is vital to recognize and treat acute and chronic pain and depression. Individuals may not always report pain because of an inability to communicate, and when reported, the presence of pain is not always taken seriously.32 Moreover, new research provides evidence that depression may occur in response to cognitive decline and the manifestation of late-onset depression possibly serves as a precursor to the onset of dementia.42
Evidence-Based Best Practices

**Department of Neurology Memory Disorders Clinic (MDC)  
University of Virginia**

The Department of Neurology Memory Disorders Clinic (MDC) at the University of Virginia Health Sciences Center has been in operation since 1997 and over 2000 patients have been assessed since inception. As a satellite clinic of the University of Pittsburgh’s Alzheimer’s Disease Center (ADC), the MDC is a multi-disciplinary clinic with active on-site participation by four neurologists, three neuropsychologists, a geriatric psychiatrist, a social worker, a nurse practitioner, a nurse coordinator, and a representative from the local Alzheimer’s Association chapter. The clinic serves as both a primary facility for the diagnosis and management of dementing disorders and as a consultative resource for patients who will be followed by their primary care physicians. The MDC offers comprehensive services to patients and their families, and conducts clinical trials of medications for treatment of AD. The clinic maintains close ties to the community through educational programs for the Alzheimer’s Association and the Jefferson Area Board on Aging, and often provides in-service programs for area nursing facilities and assisted living facilities. MDC is focused on serving underserved populations and rural minority individuals. In 2013, the MDC saw over 200 new patients; 82 percent were from rural counties outside of Charlottesville and 14 percent were African-American.

**Geriatric Assessment Center (GAC)  
Riverside Center for Excellence in Aging and Lifelong Health (CEALH)**

The GAC at CEALH offers comprehensive, interdisciplinary evaluations to older adults who are concerned about their ability to remain independent or are suffering from common geriatric syndromes like dementia, memory loss, falls, frailty, etc. More than 85 percent of assessments involve a patient with cognitive loss. The assessment is provided by a geriatric interdisciplinary team comprised of a board certified geriatrician (MD), Registered Nurse, Counselor, and Physical Therapist. The assessment distinguishes geriatric syndromes from normal aging and provides information to physicians regarding recommendations to their older adult patients to enable them to remain healthy and independent for as long as possible. This service also provides valuable caregiver support and education to include resources and referrals to other programs and agencies. The GAC has been in operation since 2009 and serves the eastern part of Virginia but also routinely sees patients from around Virginia and other states.

**Senior Adult Mental Health (SAMH)  
Arlington County Community Services Board**

The SAMH program provides multidisciplinary mental health treatment to individuals 60 and older with a serious mental illness and dementia, and individuals 18 and older with an intellectual or developmental disability and mental health needs. Intensive community-based support is provided by staff to prevent premature institutional placements, ensure safety in the home, and foster full participation for individuals in the community. Staffing includes a program supervisor, a clinical coordinator, three full time and two part-time mental health therapists, a part-time psychiatric nurse, and three contract psychiatrists. The following services are provided
for individuals with dementia: screening and diagnostic intake assessments; person-centered treatment planning; medication management; individual, group and family therapy; case management services; psycho-educational services; and consultation and collaboration.

**Regional Older Adult Facilities Mental Health Support Team (RAFT)**  
Arlington County Community Services Board

RAFT began in 2007 and is funded by a state and federal grant. RAFT serves individuals aged 65 and older who have serious mental illness and/or dementia with BPSD and who live in nursing facilities or assisted living facilities. The program is managed by Arlington County and works in contracted facilities in Alexandria, Arlington, Fairfax, Loudoun, and Prince William. RAFT’s mission is to provide mental health care to elders in their home communities in the least restrictive environment. This objective is implemented by partnering with state hospitals and long-term care facilities when individuals from the area are ready for discharge back to their communities. Staff includes three mental health therapists, a psychiatrist who specializes in geriatrics, a psychiatric nurse, and a program manager who deliver frequent, intensive services to help clients remain stable and out of psychiatric hospitals. RAFT provides assessment and ongoing evaluation, case management, psychotherapy, staff training, family support, and crises intervention. The program is successful; in 2014, 96 percent of clients were maintained in the community without having to be re-hospitalized in a state hospital.

**Evidence-Informed Best Practices**

**ClearPath**  
City of Williamsburg and areas of the Peninsula, Middle Peninsula, Northern Neck and Eastern Shore, VA

Riverside Health System

Riverside Health System’s ClearPath Memory Care is a program designed to provide all the information, resources and services individuals with cognitive impairment and their caregivers need to manage a memory-related condition. ClearPath’s services include a complete continuum of care. ClearPath is supported by Lifelong Health & Aging Related Services, a division of the Riverside Health System. The point of entry for ClearPath is Riverside Senior Care Navigation, a free service designed to provide information and referrals based on individual and specific needs, with services varying by geographic location.

**Webinar Trainings: Various Topics**  
Statewide

Geriatric Mental Health Partnership (GMHP)

The GMHP is a statewide, informal, voluntary group of diverse stakeholders that focuses on geriatric mental and behavioral health care in the Commonwealth. A primary focus of the group has been BPSD and training staff to more quickly identify and address such issues before the individual’s condition declines further or the situation escalates to possibly become dangerous. This initiative has developed nine free one-hour webinars over the past three years, including topics such as “Behavioral Disturbances of Dementia: Interventions to Reduce the Use of Psychotropic Medications” and “Pre-Admission Screening of Older Adults with Cognitive Impairment”. The webinars are archived to be available for staff to view 24/7 at their convenience (visit www.AlzPossible.org). The live webinars have been viewed by more than 2,600 people from 26 states, with many more presumably having accessed the archived
webinars. The webinars are consistently evaluated as Very Good to Excellent, and for the most recent webinar, 99.41 percent of respondents indicated that they would recommend the webinar to a colleague. The webinars were funded with Virginia Geriatric Training and Education (GTE) funds, administered by the Virginia Center on Aging, and were produced by a partnership involving the GMHP, CEALH, and VCU.

**Webinar Training: Differentiating Dementia and Depression**

Virginia Commonwealth University (VCU) Department of Gerontology

Developed in 2012 by Drs. Andrew Heck, Clinical Director at Piedmont Geriatric Hospital, and Tracey Gendron, Assistant Professor and Director of Research with the VCU Department of Gerontology, this 1.5 hour webinar focuses on evaluating Depression and Dementia in older adults. Over the course of the webinar presentation, attendees are provided a thorough review and discussion on the symptoms of depression in older adults, the symptoms of dementia in older adults, and the similarities and differences to ensure a thorough differential diagnosis in practice. The webinar is archived on the AlzPossible website and an expanded 6 hour curriculum titled “Dementia: It’s Not Just Alzheimer’s” can be made available to organizations by contacting the VCU Department of Gerontology.

**Other Best Practices**

No submissions received.

**DEMENTIA CARE:**

**EXPECTED PRACTICE COMPONENTS**

Educate the individual with dementia and their caregiver about dementia, potential care goals, and care options from diagnosis through end-of-life, and refer them to relevant community supports.

Individuals with dementia and their caregivers should receive education about the diagnosis, treatment, and management of dementia as well as information about care options, such as respite care, adult day services, long-term care, home care, palliative and hospice care, among others. Many educational needs can be met by referral to community-based resources. The Alzheimer’s Association and the Alzheimer’s Disease Education and Referral Center (ADEAR) can provide information about dementia and connections to numerous resources. Local AAAs and Alzheimer’s Association chapters can assist individuals and their caregivers in developing a care plan and obtaining needed supports. Individuals diagnosed with dementia and their caregivers should be referred to support groups, which can be located by contacting local Alzheimer’s Association chapters, community organizations, religious groups, and hospitals. Individuals with dementia and their caregivers should be encouraged to contact care managers or social workers, home health agencies, cleaning services, transportation programs, financial planners and elder law specialists, social service agencies, and therapists, as needs arise.
Develop and implement coordinated care planning and advance directives that respect and are guided by the individual and his or her caregiver.

Individuals with dementia receive medical care in a variety of environments, including outpatient clinics, hospitals and emergency departments, behavioral health settings, their homes, and nursing facilities. In comparison to older adults not diagnosed with dementia, these individuals experience more care transitions each year and receive services from hospitals, nursing facilities and home health agencies with greater frequency. Complex care needs result in added opportunities for errors to occur, but several pilot studies have demonstrated that care management can better coordinate transitions, provide access to community-based resources, and support informal caregivers. Advanced care planning has been shown to improve quality of life for individuals with dementia while decreasing care costs. These approaches have the ability to improve advance care planning, manage neuropsychiatric complications, reduce ED visits, avoid the trauma of involuntary commitment for behavioral disturbances, reduce caregiver strain and stress, and increase hospice utilization.

Research indicates that advance care planning has beneficial effects for older adults and their caregivers; however, the prevalence of advance directives is low. Advance directives provide individuals with dementia the opportunity to clearly express their health care, including medical, behavioral health, and end-of-life care, wishes before they become incapacitated. Individuals with dementia commonly receive end-of-life care in a nursing facility and around 90 percent of individuals with dementia will be institutionalized before they die. While nursing facility residents involved in advance care planning experience a reduction in rates of hospitalization and an increase in the use of hospice, almost half of all nursing facility residents do not have an advance directive.

Facilitate regular cognitive, physical and social activities, including interventions not involving medications (sensory therapy, activity therapy, behavior therapy, ADL and environmental modifications, social contact, medical or nursing interventions).

Non-pharmacological interventions, therapies not involving medication, have been successfully implemented to improve quality of life for individuals with dementia. Interventions not involving medications provide individuals with dementia opportunities to participate in cognitive, physical and social activities, which result in a reduction of the symptoms associated with dementia. In addition to validation therapies (meeting the individual where they are at their level of function) and reminiscence therapy, these interventions can involve music, art, dance, physical activity, aromatherapy, interactions with animals, and many other activities, which have documented positive outcomes. **Music:** A review of studies involving music therapy among individuals with dementia determined that levels of agitation have been reduced and mood as well as socialization skills have been positively impacted by these interventions. A program called Music & Memory, which has been implemented in dementia care facilities in the United States and Canada, provides individuals with an iPod containing a playlist of their favorite music. **Arts:** The Alzheimer’s Association of Greater Cincinnati created a program called Memories in the Making. Individuals with dementia were recruited from adult day centers and participated in the program encouraging self-expression through the creation of artwork, which resulted in an increase in interest, attention spans, enjoyment, self-esteem, and normality.
Dance: Dance and movement therapy has been evaluated among nursing facility residents with dementia, with slight increases in MMSE scores and significant improvements with the Clock Drawing Test. Exercise: A review of interventions involving physical activity, including exercise involving aerobics, balancing, flexibility and strength, have improved physical functioning such as walking and have found a positive impact on depression and increased quality of life for individuals with dementia. Aromatherapy: Aromatherapy involving lavender oil and other essential oils have improved cognition, augmented the ability to perform ADLs, reduced BPSD, and increased quality of life. Animals: Having dogs and their handlers visit nursing facilities with dementia residents has been shown to be an effective method for inducing engagement. New research involving interactions between attendees of an adult day health center and horses, such as grooming, leading, bathing and feeding, has led to lower levels of disruptive behaviors afterwards. Culture Change: Many nursing facilities are now employing the Household and Green House Models, both of which are examples of the application of the Eden Philosophy that advocates for improved quality of life for older adults. Both models aim to make residents feel more comfortable with smaller living areas and a home-like set up rather than long corridors. Residents frequently experience lower rates of depression and higher emotional well-being.

Track the patient’s outcomes and adjust goals of care as appropriate.

Individuals with dementia receive care in a variety of settings and because of the progressive nature of the disease, continual and frequent assessments are needed to monitor the effectiveness of their care plan and make adjustments as symptoms change. Health care professionals should perform periodic assessments to ensure the continued benefits of both interventions that use medications and those that do not. If interventions are losing effectiveness or a different approach is required, ongoing supervision will inform caregivers and may lead to adjustments in the care plan, particularly when it comes to managing BPSD.

Recommendations and requirements for assessments of care plans, including those for individuals with dementia, vary depending upon the care provider. It is not uncommon for regulations to require assessments prior to or during admission or start of service delivery, quarterly, and when there is a change in the individual’s condition. Providers should adhere to the minimum standards outlined in licensing and certification regulations. Additionally, while regulated practices may suffice for meeting older adult care needs, the frequency of these assessments may need to be increased to support the complex issues associated with dementia.

DEMENTIA CARE:
BEST PRACTICE EXAMPLES IN VIRGINIA

Evidence-Based Best Practices

Montessori-Based Program for Later Stages of Dementia
Circle Center Adult Day Services
Richmond, VA
The Montessori-Based Program for Later Stages of Dementia at the Circle Center focuses on increasing engagement and satisfaction and controlling BPSD in adult day participants who are
less able to engage in usual group activities. Implemented by a Certified Therapeutic Recreation Specialist in small groups and occasionally with 1:1 interventions, the Montessori-based program targets participants with 30 to 60 minutes of specific activities keyed to their abilities. In place since 2002, the program has been found to significantly increase engagement from a few minutes to as long as an hour in otherwise distracted individuals. It reduces BPSD and increases positive behavior (smiling, eager participation, and verbalization) in the majority served. The Montessori approach is based on the principles of retrogenesis, use of longer-sustained procedural memory and use of familiar objects and everyday activities for programming, use of developmentally sequenced activities, and emphasis on concrete tasks not requiring declarative memory. The impact on family caregivers is also a benefit; they are able to see specific ways to constructively engage their relatives, which can lead to successful experiences and improved self-esteem.

**Insight Memory Care Center**

**Fairfax, VA**

Adult Day Health and Resource Center

Insight Memory Care Center (IMCC) is a nonprofit adult day health and resource center providing specialized care, support and education for individuals with AD and other memory impairments, their families, caregivers and the community. IMCC offers the Music & Memory program, which is a personalized music system that provides therapeutic benefits to participants by providing an individualized playlist on an iPod. Musical memory is profoundly linked to emotions with memories stored deep in the brain. When individuals with dementia hear a melody connected with a meaningful memory, they can reawaken through the use of their personalized playlist. IMCC combines Music & Memory with other interventions not involving medication, including touch therapy, a multi-sensory environment, art therapy and physical programming.

**Snoezelen**

**Richmond, VA**

Circle Center Adult Day Services

The Snoezelen program aims to provide person-centered sensory stimulation and increase opportunities for engagement for withdrawn or regressed participants with AD or dementia. More specifically, Snoezelen, which is under copyright and can only be used by approved facilities, provides intense sensory stimulation (lights, sounds, aromas, tastes and tactile sensations) in a failure-free therapeutic environment. There is a protocol for engagement and maximization of senses, which compensates for sensory deprivation, and offers pleasure, recreation and social interaction. Circle Center has a dedicated room with multi-sensory activities and equipment that is staffed by a Certified Therapeutic Recreation Specialist. At Circle Center, Snoezelen is provided to individuals whose dementia is late stage with screening based on observation and a decision made in collaboration with the multi-disciplinary team. Studies have found that Snoezelen is equally or more effective than psychotropic medications for reducing anxiety and equally or more effective than reminiscence therapy in increasing positive behaviors, attention and relaxation, and reducing fear and agitation. Further, Snoezelen can decrease agitation and aggression, decrease anxiety, decrease blood pressure and pulse rate, decrease physical pain, decrease wandering, lethargy and boredom, and decrease apathy.

**Household Model**

**Warsaw, VA**

The Memory Support Household Model at The Orchard and Riverside Health System creates a home-like atmosphere for residents through various changes by deinstitutionalizing the staff and the environment. Several components of the program are: self-rising and going to bed when
desired; personalized medication system—medications are administered from the medicine cabinet in the resident’s room and medications are consolidated to diminish the need to wake residents in the middle of the night; residents assist in cooking their meals and doing laundry; breakfast is made to order when the resident rises; food is accessible 24/7; staff perform a variety of duties; and residents are self-governed. Households are created to mimic a home by including a dining room, living room and kitchen. Staff at The Orchard work 12-hour shifts, which has resulted in decreased sun-downing since there is no change of shift at 3:00 pm when sun-downing tends to occur and staff also have been able to decrease medications without observing an increase in BPSD, believed to be as a result of the relaxed, home-like environment. In fact, the facility has seen residents make significant improvements once transitioned into the Household Model. The Memory Support Household Model at the Riverside Health System permanently assigns a versatile team of staff to each household to support the residents. This approach recognizes and fosters important values such as dignity, respect, love and privacy.

Evidence-Informed Best Practices

**Health Care Advance Directives**

*University of Virginia, Institute of Law, Psychiatry, and Public Policy (UVA-ILPPP)*

While an individual with dementia experiences decreased cognition, his or her health care needs increase, requiring more caregiver-based decision-making. For instance, behavioral disturbances may arise and require psychiatric hospital care through involuntary commitment. Virginia laws now allow an individual’s agent to consent to outpatient and inpatient behavioral health care and, if authorized by the individual’s advance directive, to consent to such care even though the individual (incapacitated by dementia) objects. The UVA-ILPPP program seeks to integrate advance directives into dementia care through a program of research and implementation on the advance care planning needs of individuals with dementia, their caregivers, health care providers and systems, and other professionals. The dementia-specific element of this program is informed by four years of experience with implementing advance directives for those with severe mental illness. UVA-ILPPP collaborates with relevant agencies as the DARS, AAAs, inpatient and outpatient facilities/clinics, etc. The program seeks to demonstrate the full potential of advance directives as tools for improving care and avoiding the traumatic experiences that can arise from unplanned-for psychiatric crises and unwanted care transitions.

**Arts Fusion**

*Alzheimer’s Association Central and Western Virginia Chapter (AACWVA)*

Arts Fusion provides persons with a diagnosis of AD or dementia and caregivers the opportunity for creative expression through the arts, including art viewing, art making, music, dance, theater, horticulture, and more. The program, which is modeled after the evidence-based, Meet Me At the MoMA program, promotes meaningful engagement, verbal expression, creativity, enjoyment, and social interaction. The program has now been active at the AACWVA for three years and partners include museums, art associations, adult day centers, arts specialists, and facilities in the central Virginia region. The first evaluation of this specific program is being conducted during the 2014 summer through a qualitative study. However, anecdotal stories, quotes, and videos highlight the success of the program in achieving the goals of meaningful engagement and enjoyment as well as of reaching people even in advanced stages of the disease.
**GHArts Festival**
Alexandria, VA

Goodwin House Alexandria, a Continuing Care Retirement Community

The GHArts Festival, which has been held annually for the last six years in June at Goodwin House in Alexandria, Virginia, is a community wide creative arts celebration that is at the heart of all programming for residents. Residents living with neuro-cognitive disorders are provided a wide range of programs each week that offer opportunities for individual expression as well as collaborative creative processes. Programs include painting, sculpture, storytelling and composition, poetry writing, music appreciation, music performance (vocal and instrumental), music composition, drama, dance, and gardening. The GHArts Festival brings all residents, family members and friends, administrators and caregivers together on a single day to share creative accomplishments. Residents with cognitive impairment not only gain the many benefits of creative exploration and self-actualization in daily programming, but experience a sense of belonging. For instance, in June 2014, the Goodwin House memory unit residents led the community in a group singing and drumming circle during the celebration.

**Linked Senior**
Alexandria, VA

Mt. Vernon Nursing & Rehabilitation Center

Mt. Vernon Nursing & Rehabilitation Center uses Linked Senior technology to provide custom, personalized and interactive experiences through touch-screen interfaces and a web based platform. The touch-screen kiosks are installed in common areas in long-term care communities, such as Mt. Vernon, and are connected to the internet 24/7 in order to allow activity directors, residents, other staff, and family members to access the extensive library of music, games, videos, slideshows, puzzles and trivia questions for stimulating activities. The kiosks can be used individually or in small groups. Linked Senior is used in 50 centers in Virginia. Residents at Mt. Vernon with BPSD are directed to activities during times when BPSD is noted with the goal of reducing antipsychotic medications. At Mt. Vernon, Linked Senior has either eliminated or decreased the severity or length of such BPSD in residents.

**Senior Saddles**
Toano, VA

Dream Catchers at the Cori Sikich Therapeutic Riding Center

Dream Catchers at the Cori Sikich Therapeutic Riding Center is a non-profit, located in Toano and is accredited by the International Professional Association of Therapeutic Horsemanship. Students are assessed and an individualized lesson plan comprised of one-hour weekly sessions for ten weeks is created. Lessons involve learning horsemanship, grooming, tacking and mounted riding skills aimed at assisting students in gaining greater independence. Students at Dream Catchers live with a variety of disabilities including AD and dementia, autism spectrum disorder, seizure disorders, Down syndrome, and TBI or spinal cord injury, and others. The program gives older adults, including those with AD and dementia, opportunities to participate in both mounted and unmounted therapeutic horsemanship. Participants have experienced decreased anxiety, depression, irritability, agitation, aggression and sleep disturbances along with improvements in movement, balance and coordination. Senior Saddles is facilitated through a partnership between Riverside Health System Patriots Colony and the Williamsburg Landing.
Elder Equestrians
Henry, Franklin, Pittsylvania, and Patrick Counties, VA
Tackfully Teamed Riding Academy, Inc.
Tackfully Teamed has been serving individuals with disabilities of all ages for almost 11 years. The Elder Equestrians program can serve individuals from Henry, Franklin, Pittsylvania, and Patrick Counties. Last year, Tackfully Teamed and Kings Grant Retirement Community in Martinsville began discussing a collaborative opportunity and a local neurologist began referring individuals with AD to the program. Riders are given standardized testing to establish a baseline. The director reviews all testing materials with a consulting occupational therapist and together they establish individualized lesson plans. Tackfully Teamed currently has a sensory trail with eight stations, which can be done on the ground or while mounted on a horse, that work on ADL skills and encourage cognitive participation. The director created an AD and dementia specific worksheet to increase the carryover of ADL skills into participants’ daily lives with increased communication and participation with their caregivers. Staff report that adults with AD exhibit an immediate interaction with their environment while mounted and many participants and caregivers report remarkable improvements in quality of life.

Connections
Central and Western Virginia (serving 37 counties)
Alzheimer’s Association Central and Western Virginia Chapter (AACWVA) and Rappahannock Rapidan Community Services (RRCS)
Connections, which was evaluated with funding from ARDRAF in 2009 and ACL in 2010, provides caregivers with the tools and knowledge to set up individual “activity stations” based on leisure interests and current level of function of the individual with dementia. Caregivers are given an easy-to-use guide with instructions, a leisure interest survey to determine activity interests, and a cognitive function checklist in order to implement programming with their loved ones or clients. Trained home visitors offer eight weekly visits with structured partnering that allows the home visitor to teach caregivers about the program and how to implement it and continue it beyond the home visits. Created by Ellen Phipps, MSG, with the AACWVA, the Connections program has since been implemented by AACWVA and RRCS in the Charlottesville region, including Albemarle, Green, Madison, Orange, Culpeper, Fauquier, and Rappahannock Counties.

Dietrich Multisensory Room
Martinsville, VA
King’s Grant Retirement Community
Implemented in October 2012, the Dietrich Multisensory Room at King’s Grant Retirement Community in Martinsville, Virginia has continued to provide residents with AD and dementia one-on-one individualized opportunities for engagement. Trained by Linda Messenbauer, King’s Grant staff use the Dietrich Multisensory Room to engage residents in either calming or stimulating activities. Among other items, the room contains: water bubble columns, fiber optic lighting strands, a disco ball, a vibro-acoustic recliner, music, and a projector with many different abstract reels projected on the wall. Higher functioning residents, guided by staff, are able to manipulate the environment themselves, while those with lower functioning abilities are supported by trained staff during the session. Staff report positive experiences with residents.
**Daily Outings and Community Activities**

**Virginia Beach, VA**

**Out and About Day Services**

Out and About Day Services is a personalized day service for older adults that offers daily recreational outings and activities for individuals with dementia, specifically veterans. Small groups of active older adults who share similar interests are brought together through scheduled daily events that focus on keeping them stimulated and engaged in the community. Outings are tailored to the unique interests and experiences of veterans and can include visiting the Military Aviation Museum, the Naval Aviation Monument, the Warbirds Air Museum, and the Hampton Roads Naval Museum, among many others. Outings are generally three to four hours long and cost between $60 and $75. Clients have experienced improved sleep and a reduction in the use of antidepressants. Out and About also offers in-home observations and care coaching.

**Intergenerational Day Care**

**Harrisonburg, VA**

**Generations Crossing**

**VCU Health System Adult Day Services**

This day program is a care environment where participants and staff of different generations purposefully collaborate to support and nurture each other. This provides a natural environment in which to build relationships and renew social roles. The model is based on the utilization of participant strengths and interests in order to achieve their maximum level of functioning physically, emotionally, cognitively, and spiritually. In this environment, participants with dementia have demonstrated increased verbalization and attention span, transition to the environment more quickly and successfully, and experience purposeful engagement.

**Early Stage Engagement Social**

**Metro Richmond, VA**

**The Alzheimer’s Association Greater Richmond Chapter**

Across the Chapter area, the Alzheimer’s Association Greater Richmond Chapter holds quarterly Early Stage Engagement Socials with support from staff and trained volunteers who provide planning and implementation assistance. These socials provide opportunities for social engagement, which address social isolation, increase self-esteem and boost feelings of self-worth for both individuals with dementia and their caregivers. Socials have been held over the last five years in partnership with various organizations, such as the Virginia Museum of Fine Arts, The Visual Arts Center, Patterson Avenue Sports Park, Positive Vibe Café, Second Wind Glass Studio, and the Virginia Historical Society. Individuals with dementia and their caregivers help plan the events, which range from small luncheons to all day events.

**Stand Tall, Don’t Fall**

**Prince William County, VA**

**Prince William Area Agency on Aging (PWAAA)**

Stand Tall, Don’t Fall is a community-level intervention program to prevent falls among persons 55 and older. The project design uses a certified fitness instructor from the George Mason University (GMU) Freedom Fitness and Aquatic Center to train local volunteer fitness instructors in specific techniques focused on strength and balance improvement proven to prevent falls among older adults. The exercise program is offered as a weekly class at the PWAAA Senior Centers located in Woodbridge and Manassas, VA. Stand Tall, Don’t Fall is being adapted for the PWAAA adult day center population, of which 92 percent have a dementia diagnosis. The program began with a grant from VDH.
Memories in the Making and More

The Alzheimer’s Association Greater Richmond Chapter

The goal of Memories in the Making and More offered by the Alzheimer’s Association Greater Richmond Chapter is to provide training for activity directors at residential communities, day centers and home care organizations. Offered two times per year the training teaches participants how to provide art programs for their residents or clients. Training sessions are approximately six to eight hours in length. Participants learn cost-effective techniques for implementing art programs involving music, poetry, dance, storytelling and the use of clay in addition to receiving a brief overview of dementia. Curriculum used during the training was developed by the Orange County Chapter in Irvine, CA and the Greater Richmond Chapter of the Alzheimer’s Association. Memories in the Making and More is a vital component of the professional training offered by the Chapter and has led to partnerships with music and art therapists.

Other Best Practices

Birmingham Green: Local Collaboration in Long-Term Care

Birmingham Green consists of a 45-bed District Home Assisted Living, a 5 star; 180-bed Health Care Center that is dually certified for Medicare and Medicaid, providing care to a large proportion of Medicaid recipients. The Willow Oaks Assisted Living is a 92 unit apartment building that is 100 percent Auxiliary Grant, one of few such entities offering these options within the Northern Virginia region. Gaps between the cost of care and the state-reimbursements are compensated by community funds from the local governments. Across the state, Birmingham Green is known for providing high-quality services in a person-centered model of care. Birmingham Green has established relationships with local hospitals, long-term care entities, and advocacy groups with a history of collaborating with partner localities. On the campus, about one in three residents are impacted by dementia related impairment. Each resident is evaluated and provided services in a person centered manner that is based on their personalized plan of care.

Telephone Reassurance Program

PWAAA and Action in Community Through Service (ACTS)

Senior Link or “Checking” is a free telephone reassurance program offered through a partnership between PWAAA and the ACTS Helpline. The program provides calls to homebound adults aged 60 and over. Through Senior Link trained volunteers provide regular contact, safety checks, and medication reminders that are scheduled at the recipient’s convenience. This greatly assists older adults who need memory triggers, such as those living with dementia, including AD.
FORMAL AND INFORMAL CAREGIVING:
EXPECTED PRACTICE COMPONENTS

Identify the caregiver–care recipient relationship and provide services that support it.

Given the debilitating nature of dementias, including AD, the assistance of a caregiver who is typically an immediate family member is necessary. Caregivers are essential partners when managing the health of individuals with dementia and are critical to the implementation of interventions not involving medications. Caregivers provide assistance with instrumental activities of IADLs and ADLs in addition to assistance with treatment and medication recommendations. Of particular note is the finding that within the African American and Hispanic communities, caregivers provide, on average, 30 hours of care per week, which is higher than the 20 hours or less associated with non-Hispanic white caregivers.

Caregiving is associated with elevated levels of emotional stress, depression, a weakened immune response, health detriments, loss of wages because of the inability to work, and depleted finances. Additionally, one study found that caregivers vulnerable to distress may be predisposed by genetic and environmental factors to experience stress, anxiety and depression. Unfortunately among community dwelling caregivers there are many unmet needs. In a recent study, 97 percent of caregivers had one or more unmet need. Caregiver needs can include referrals to resources, and education about dementia, general health care and mental health care. Research indicates that “higher unmet caregiver needs was significantly associated with nonwhite race, less education, and more symptoms of depression.”

In addition to providing opportunities to participate in support groups, respite care can also help caregivers. With respite care, caregivers get a temporary reprieve from their duties, which can be accomplished using adult day services, in-home care, or residential care, and is usually used for a specified number of hours each week. A study that examined caregivers in adult day services programs, including caregivers using the Walter Reed Adult Day Health Care Center in Arlington, Virginia, found that the use of adult day services can restore the stress hormones of caregivers to a more normal level and improve emotional well-being. Recognizing these needs, in July 2014, Access to Respite Care and Help (ARCH) published a fact sheet with recommendations for developing and implementing a successful respite care program.

Discuss driving, home safety and wandering.

Having discussions on driving can be difficult and the “right” decision is not always clear. A driving safety evaluation should be conducted semi-annually for individuals with dementia or more frequently if there is a change in their condition. During an evaluation, cognitive testing should be performed and the individual should be observed and examined to determine whether any sensory loss, pharmacological effects, signs of weakness or decreased range of motion are present, which could affect the individual’s ability to drive. Assessments should be informed by caregivers, family members, and friends, with referrals made to appropriate professionals. As possible, consider alternative transportation options and slowly incorporate them into the individual’s routine. If driving privileges are revoked or relinquished, it
is important to obtain an alternative form of identification and monitor the person for signs of social isolation.\textsuperscript{64}

Safety in the home is extremely important. Making accommodations in the home to ensure safety can reduce the risk of injury and improve quality of life. In one study, safety for the individual with dementia was identified as an important area of unmet need, specifically as it relates to the lack of falls risk management, wander risk management, and home safety evaluation. A comprehensive home environment assessment should be conducted to identify any risks, make modifications, and incorporate assistive technology.\textsuperscript{65}

Wandering is a common behavior among individuals with dementia and can compromise safety. Over 60 percent of individuals with dementia will wander and if not found within 24 hours, can be subjected to injury or death.\textsuperscript{61} Proactive interventions can be implemented to limit or prevent wandering. However, should wandering occur, first responders are an integral component for safely returning individuals with dementia to their homes. The Alzheimer’s Association also offers programs such as MedicAlert + Safe Return and Comfort Zone to assist in locating and recovering individuals with dementia who have wandered.\textsuperscript{64,66}

**Regularly assess the individual for BPSD.**

BPSD are observed in varying degrees in all forms of dementia and can evolve depending upon the stage of the disease. BPSD can include decreased inhibition, apathy, social inappropriateness, and wandering and in some instances, hallucinations and delusions can arise. Agitation, for instance, can occur during all stages of dementia and is marked often by irritability, vocal disruptions, excessive psychomotor activity and emotional distress.\textsuperscript{23} Another such BPSD, depression, is frequently noted as a symptom accompanying FTD, mild cognitive impairment (MCI) and early stage AD.\textsuperscript{23} An assessment of depression is important since 50 percent of individuals with dementia experience depressive symptoms.\textsuperscript{22} BPSD can cause sleep problems, poor nutrition, pain and other medical issues and lead to caregiver distress.\textsuperscript{23}

It is important to understand that BPSD can be caused by an underlying medical issue, such as pain, or be the result of an unfulfilled need.\textsuperscript{22} BPSD are neither good nor bad and should be viewed as a result of the disease or triggers related to overstimulation, fear, pain, or complex caregiver communications. BPSD can be a danger to the individual with dementia, accelerate disease progression, and result in nursing facility placement or psychiatric admission. A yearly screening using an assessment is recommended.\textsuperscript{23} Assessment of behaviors should involve an interview with the individual and their caregiver to discuss challenges and concerns.\textsuperscript{22}

**Train caregivers on dementia care needs and in identifying and managing BPSD.**

Major goals of caregiving include protecting individuals with dementia from injury, maintaining their independence, highlighting the abilities they still have, providing them with opportunities for engagement and supporting their sense of self-esteem and dignity.\textsuperscript{67} Since communication becomes difficult as dementia progresses, individuals with dementia may substitute actions for words.\textsuperscript{68} Caregivers, both formal and informal, should be provided frequent, consistent and repeated opportunities to receive training on a variety of topics that can
improve health outcomes and quality of care as well as communication with individuals with dementia. Such training should highlight the importance of avoiding physical restraints and focus on the topics of aggression, bathing, communication, eating and nutrition, incontinence, repetitive speech, sundowning, and wandering, among many others. For instance, in 2012, CMS developed the *CMS Hand in Hand: A Training Series for Nursing Homes Toolkit*, which teaches nurse aides how to implement person-centered dementia care and prevent abuse, which is available at [http://www.cms-handinhandtoolkit.info/index.aspx](http://www.cms-handinhandtoolkit.info/index.aspx).

Triggers for BPSD can often be identified and resolved. Caregivers should “ACT”:
- **Ask** questions such as “What happens just beforehand?” and “When does it happen?”
- **Collect** information from others to determine if they have observed anything important.
- **Treat** the BPSD using expected and best practices until a solution is found.67

**FORMAL AND INFORMAL CAREGIVING: BEST PRACTICE EXAMPLES IN VIRGINIA**

**Evidence-Based Best Practices**

**Project Lifesaver**
Project Lifesaver International
Project Lifesaver International, a 501(C)3 non-profit organization, provides search and rescue and recovery services to families to ensure the safety and protection of their loved ones. Project Lifesaver has established key relationships with advocacy organizations as well as groups in the AD and dementia, autism, and Down syndrome communities, and has connected with the national associations of police and sheriffs throughout the U.S. In Virginia, there are 163 public safety agencies that have implemented Project Lifesaver with over 1,000 successful rescues over the last 15 years.69 Most who wander are found within a few miles from home with search times reduced from hours and days to minutes. Recovery times for Project Lifesaver clients average 30 minutes; 95 percent less time than standard operations. The program has a 100 percent success rate with no serious harm or injuries during searches.

**Rosalynn Carter Institute: Resources for Enhancing Alzheimer’s Caregiver Health (RCI-REACH)**
Rappahannock Area Agency on Aging, Inc. (RAAA)
The goals of RCI-REACH, an evidence-based replicable program, are to reduce caregiver burden and depression and provide caregivers with better coping tools and behavioral management skills for their loved ones living with dementia. REACH provides in-home, tailored, caregiver support intervention with 10 to 12 individual sessions; up to 9 face-to-face and 3 telephone sessions with primary caregivers. In 2014, RAAA obtained permission and an individual license from RCI to conduct the RCI-REACH program in its service area. The RAAA Care Transitions Coach received RCI-REACH Interventionist recertification in April 2014 with support from the Partners in Aging Network. RAAA receives referrals from hospital and community contacts.
Driver Evaluation Clinic (DEC)  
Williamsburg, VA
Riverside Center for Excellence in Aging and Lifelong Health (CEALH)

The DEC at CEALH offers one of the most comprehensive driver rehabilitation clinics in Hampton Roads. Led by a Certified Driver Rehabilitation Specialist and a DMV-Licensed Commercial Driving Instructor, the clinic offers both driving assessments and re-training in order to help adults make good decisions about their driving abilities. This service helps to ease transportation challenges among older adults and helps reduce the dangers of having medically compromised drivers on the road. Nearly half of the older adults who are referred, by their physician, the DMV, or a judge, for a driving evaluation are referred because of cognitive impairment. Evaluation is done with either a road test or with use of DEC’s simulator. This program is not covered by insurance and costs $350 per evaluation. DARS is a routine partner in this program, helping to sustain it with funds through GrandDriver that allow for scholarships for those who cannot afford the full evaluation fee. DEC has been in operation since 2007 and serves the eastern part of Virginia with offices in both Williamsburg and Hampton. The DEC also routinely sees patients from around the state and from out of state, when other family live nearby.

Telephone Support Program for Caregivers  
Metro Richmond, VA
A Grace Place Adult Care Center (AGP) and VCU Department of Gerontology

VCU Department of Gerontology in partnership with VCU Department of Occupational Therapy and AGP has implemented a caregiver telephone support program. VCU graduate students in Gerontology and Occupational Therapy are trained to initiate and provide telephone support to AGP caregivers. Through active and empathic listening, students (1) provide emotional support and (2) referrals to AGP for additional resources and services, when necessary. Analysis of the program has revealed that caregivers report that: they have positive experiences engaging with students; they enjoy being able to have someone to talk to about their caregiving difficulties; and it was helpful to verbalize their concerns to someone removed from the situation. Students report that they: develop meaningful relationships with caregivers; learn about caregiving struggles; and gain knowledge that benefits them both personally and professionally.

Evidence-Informed Best Practices

Responding to Alzheimer's Disease: Techniques for Law Enforcement and First Responders  
Statewide
International Association of Chiefs of Police (IACP) and Virginia Department of Criminal Justice Services (DCJS)

DCJS partners with IACP to offer IACP’s free, one-day training, “Responding to Alzheimer's Disease: Techniques for Law Enforcement and First Responders,” to Virginia law enforcement, first responders, and community police/crime prevention officers. Using the most current Alzheimer’s disease and dementia information available, this training features in-depth instruction to help law enforcement agencies enhance their capacity to handle calls involving people with Alzheimer’s disease and dementia. This course addresses the following topics: Understanding Alzheimer’s Disease; Responding Effectively; Search and Rescue; and Community Resources. IACP developed the training with grant funding from the Bureau of Justice Assistance, Office of Justice Programs and the U.S. Department of Justice.
Southside Geropsychiatric Services Training Initiative
City of Virginia Beach Department of Human Services

Since 2007, the Virginia Beach Department of Human Services MHSA Division has partnered with the Eastern Regional DSS Licensing Office and the Southeastern Virginia Chapter of the Alzheimer’s Association to provide trainings with the goals of: (1) increasing the knowledge and skills of staff and caregivers working with individuals with dementia in order to try to prevent some of the behavioral disturbances that may lead to involuntary psychiatric hospitalization; (2) improving the quality of life of individuals with dementia; (3) reducing the use of psychotropic medications when feasible; and (4) reducing frustration and possible injury of those providing care. The trainings were developed in collaboration with a team of professionals/community stakeholders with extensive geriatric mental health experience. The trainings are provided in Virginia Beach, but draw attendees from throughout Southeastern Virginia. Since inception, the initiative has provided training to over 7,600 people.

Caring For You, Caring For Me
Riverside Center for Excellence in Aging and Lifelong Health (CEALH)

The Caring for You, Caring for Me Education and Support Program, is the signature program of the Rosalynn Carter Institute for Caregiving. It is a ten-hour program for both families and professionals who are serving as caregivers for older individuals. The program is organized around five, two-hour weekly modules. In this unique program, family caregivers and professionals participate together to discuss coping mechanisms as well as local, state, and national resources; and to identify key issues and ways to work together to enhance quality of life for care recipients and caregivers. CEALH has received two Best Practices Awards, one from the Commonwealth Council on Aging and one from the Southern Gerontological Society for the program. Many partners support this program through funding, making referrals, or for providing respite so that caregivers can attend. Christine Jensen, program coordinator, is a Master Trainer with the Rosalynn Carter Institute (RCI) and the only master trainer certified in the program outside of RCI employees in the United States.

Offender Caregiver Programs
Virginia Department of Corrections (VADOC)

Deerfield Correctional Center and Haynesville Correctional Center

Two VADOC institutions utilize Offender Caregiver programs to provide specialized care for older offenders (age 50 and up). The larger program is at Deerfield Correctional Center (DFCC), which houses the highest concentration of older offenders in VADOC. The Assisted Living Unit (ALU) at DFCC is a living area dedicated to the care of older offenders who need assistance with ADLs as a result of medical conditions and/or neurocognitive disorders. Offenders from the General Population at DFCC have the opportunity to apply for positions as Caregivers in the ALU. The Caregivers assist ALU nursing staff with duties that include: lifting and transferring offenders; making beds and changing linens; and assisting offenders with storing property and keeping their living areas clean. Some Caregivers in the ALU are designated as Wheelchair Pushers and are responsible for transporting their assigned offenders to meals, recreation, church, school, commissary, and other necessary locations. The Caregiver program at Haynesville Correctional Center (HCC) is on a much smaller scale and enables older offenders with memory problems to be housed safely within the General Population while awaiting transfer to an ALU. The older offenders housed at HCC are mobile and able to care for themselves for the most part.
Caregivers do not provide hands-on care, but they do assist memory-disordered offenders with daily tasks that require orientation around the facility and keeping track of time. Duties include: assisting with adherence to medication schedule; accompanying offenders to and from meals, groups, or other appointments; ensuring that offenders shower at least every other day; and helping to keep track of personal belongings and state property. In both programs, the Caregivers also serve to provide an additional level of monitoring for offenders with BPSD.

**Caregiver Support Program**
Fairfax, VA

**Fairfax Area Agency on Aging (FAAA) and the Family Caregiver Consortium**

This program serves Fairfax City and County and Falls Church with three components:

- **Caregiver Consultation:** ElderLink, a partnership with FAAA, Inova Health System, and the Alzheimer’s Association National Capital Area Chapter, provides a free, one-hour consultation to family caregivers by phone or in the office. Often these consultations involve multiple family members participating by conference call. While not intended to take the place of a geriatric assessment, this consultation with a case manager provides time to discuss concerns, ask questions, learn options, and develop an action plan.

- **Telephone Support:** A second component is the Telephone Support Group, which runs once a month in the evening and offers an opportunity to participate in a support group by phone for those caregivers who cannot leave their caregiving responsibilities. The support group is led by a geriatric social worker with the FAAA and often includes speakers on topics of interest to the group.

- **Caregiver Seminar Series:** The Caregiver Seminar series offers 10 to 12 workshops twice per year on topics of concern to caregivers. These workshops are offered in different neighborhoods as fall and spring semester classes and are conducted in partnership with the members of the Family Caregiver Consortium, which includes ElderLink partners, Insight Memory Care Center, and other professionals who can address requested topics.

**Respite Program**
Fairfax, VA

**Fairfax Area Agency on Aging (FAAA) and ElderLink**

The Fairfax County Respite Program, which serves caregivers in Fairfax County and the cities of Falls Church and Fairfax, has two components: (1) a respite program based on the clients’ income and functional abilities providing up to six hours of certified nursing assistant (CNA) delivered respite care per week, and (2) the volunteer respite program to provide temporary flexible respite hours to the family caregiver without regard to income. The volunteer respite program, which does not provide personal care, matches volunteers with caregivers based on schedule needs, recruits volunteers through the FAAA’s Volunteer Solutions, and trains them through ElderLink in partnership with the Insight Memory Care Center. Volunteers commit to six hours per month for one year. Both respite programs provide a care manager to oversee the program and provide care coordination to the family. Additionally, both programs utilize (1) a survey that is completed by a caregiver to identify their loved one’s hobbies and interests, and (2) a caregiver stress test developed by the American Medical Association to identify the level of stress the caregiver is experiencing and what additional interventions may be appropriate.
Other Best Practices

**Caregiver Advocate**

James City and York Counties, Cities of Hampton, Newport News, Poquoson and Williamsburg, VA

Peninsula Agency on Aging (PAA)

PAA designated a Caregiver Advocate position with specific duties to provide support, information, referral to services, and serve as the agency’s “go to” person for stressed caregivers. While all care coordination staff at PAA is trained on caregiving and dementia related issues, the designated Caregiver Advocate carries a smaller caseload consisting of clients with stressed family caregivers to provide more time for resource coordination, emotional support and intense case management. Additionally, the Caregiver Advocate facilitates a monthly caregiver support group; is an active member of the Virginia Caregiver Coalition; and partners with CEALH to maintain an updated list of area support groups.

**Institute for Innovations in Caregiving (IFIC)**

Statewide

SeniorNavigator’s new IFIC initiative aims to ultimately advance the physical and emotional health of caregivers with a special focus on the caregivers of people with AD or related dementias—mobilizing the business, technology community and other partners in this important effort. The IFIC’s ultimate goal is to improve caregivers’ self-care and their ability to manage emotional stressors and tough decisions while bolstering their access to the latest technologies and community resources. To date, the IFIC has (1) formed an Advisory Council consisting of leaders in Virginia in the service, scientific, educational/academia, and other disciplines involved in AD care and caregiving; (2) focused on planning a Virginia App Design Competition with interdisciplinary student teams from Virginia colleges and universities that will create state-of-the-art apps to assist caregivers in staying well; and (3) leveraged SeniorNavigator’s existing resources to create enhanced tools for Virginia caregivers.

**Partnerships to Deliver Family Caregiver Trainings**

Culpeper, Fauquier, Madison, Orange, and Rappahannock Counties, VA

Aging Together

Aging Together began implementing free training and support for family caregivers in 2008 in order to ensure that family caregivers in each of the five counties in the region (Culpeper, Fauquier, Madison, Orange, and Rappahannock) have access to hands on, easily accessible training. Aging Together, in partnership with local service providers, faith-based organizations, and aging and dementia experts, provides a menu of caregiver support topics for local county teams. The local county teams select topics based on community needs, and Aging Together staff then assist the local teams with training logistics and identifying experts who can teach within the topic areas. Aging Together partners volunteer their time and resources to develop and deliver the workshops, which include topics like legal issues, nutrition, falls and many more.
VI. BEST PRACTICES FROM OTHER STATES

This does not represent an exhaustive list. Programs and resources that are listed below were shared by members of the stakeholder workgroup for potential implementation in Virginia. Many of these programs have been developed and studied with federal grants.

ACT on Alzheimer’s: Communities in Minnesota have formed a statewide volunteer-driven collaboration to prepare for the impact of AD and dementia. The website provides a toolkit and resources to direct communities on how to become dementia friendly and how to help professionals identify and manage dementia. For more information, visit: http://actonalz.org/

Brain Health As You Age: You Can Make a Difference!: A collaboration between ACL, the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) has led to the creation of a brain health PowerPoint presentation that can be given in 60 minutes and that covers: aging and health; good health vs. normal aging in the brain; threats to brain health; and healthy aging. In addition, an educator guide, and supplementary handout are included. For more information, visit: http://www.acl.gov/Get_Help/BrainHealth/Index.aspx

Building Better Caregivers: The Department of Veterans Affairs (VA) and the National Council on Aging (NCOA) provide a workshop for caregivers of veterans affected by AD and dementia, post-traumatic stress disorder (PTSD), TBI and other medical conditions. Over six weeks caregivers participate in an interactive online workshop that was developed at Stanford University. Classes provide 20 to 25 family caregivers with skills to manage stress and emotions, eat healthy, and exercise. To learn more, visit: https://va.buildingbettercaregivers.org/

Dementia Care Ecosystem: A grant from the Centers for Medicare & Medicaid (CMS) has been awarded to UC San Francisco and the University of Nebraska Medical Center to develop a web-based dementia care model. Participants will be assigned a navigator who will monitor their care and communicate with family through an internet tool. The program will start in the fall of 2014 with 2,100 patients. To learn more, visit: http://www.ucsfhealth.org/news/index.html

“Excellence in Design: Optimal Living Space for People with Alzheimer’s Disease and Related Dementias”: This white paper offers recommendations for the design of care settings that provide person-centered care while accommodating the needs and wishes of individuals with cognitive impairment and their families. Examples of recommendations include hiding operational equipment from view to create a home-like environment and encouraging family visitation by providing private meeting rooms, a sleeper sofa in the den, and a private bathroom. For more information, visit: http://www.alzfdn.org/documents/ExcellenceinDesign_Report.pdf

Geriatric Emergency Departments (EDs): Older patients can have complex clinical presentations and represent 43 percent of hospital admissions, including 48 percent admitted to intensive care units. Dementia and MCI are common in geriatric ED patients and often go undetected. Geriatric EDs are becoming increasingly more common and several dementia screening tools have been validated in ED settings. The 2013 Geriatric ED Guidelines from the American College of Emergency Physicians, the American Geriatrics Society, the Emergency Nurses Association, and the Society for Academic Emergency Medicine promote the evaluation
of adults presenting with signs of delirium and dementia. To learn more, visit: http://www.acep.org/geriEDguidelines/

Habilitation Therapy: The aim of “habilitation therapy” is not to restore people with a dementia such as AD to what they once were, but to maximize their functional independence and morale. Direct care workers receive training on the five domains of habilitation therapy: physical, social, communication, functional, and behavioral. The Alzheimer’s Association Central and Western Virginia Chapter aims to train direct care workers in the near future. For more information visit: http://www.sahp.vcu.edu/vcoa/newsletter/ageaction/agefall11.pdf

Making Sense of Memory Loss: Making Sense of Memory Loss is a training program for families and other caregivers of people in the early stages of AD. The Making Sense of Memory Loss program was developed by the Mather LifeWays Institute on Aging and the Greater Illinois Chapter of the Alzheimer’s Association. The five training modules are: 1) overview of memory loss and related symptoms; 2) communication strategies; 3) making decisions; 4) planning for the future; and 5) effective ways of caring and coping. For more information visit: http://www.matherlifewaysinstituteonaging.com/family-caregivers/making-sense-of-memory-loss/

Managing Difficult Behaviors: A Standardized Intervention to help Family Caregivers (STAR-C): STAR-C is a standardized intervention to aid family caregivers in identifying, reducing, and managing a loved one’s BPSD. The intervention is delivered over a six-month period. A consultant meets with the caregiver in the home once a week for eight weeks in order to develop the family caregiver's skills in identifying BPSD and determining strategies to address them. To learn more, visit: http://www.aoa.gov/AoA_Programs/HPW/Alz_Grants/star-c.aspx

New York University Caregiver Intervention (NYUCI): The NYUCI program provides caregivers with six individual and family counseling sessions over a four month period. In addition, weekly support groups and telephone counseling are offered. In studies, caregivers have experienced lower rates of depression and nursing facility placement was delayed for care recipients. The program has been implemented in Minnesota with potential costs savings if continued. For more information, visit: http://www/rosalynncarter.org/UserFiles/NYUCI(1).pdf

Reducing Disability in Alzheimer’s Disease (RDAD): The RDAD program provides exercise training for people with AD who live at home in order to improve their overall health. In addition, family caregivers learn about how to manage BPSD and to care for a loved one with memory impairment. The program aims to reduce BPSD and improve ADL performance. For more information, visit: http://www.aoa.gov/AoA_Programs/HPW/Alz_Grants/reducing.aspx

Savvy Caregiver: Savvy Caregiver offers training to prepare individuals and families for their roles as caregivers for a loved one with dementia. The program focuses on stress management and providing caregivers with the knowledge, skills and attitudes necessary to effectively assume a caregiving role. The curriculum is a 12-hour training program typically delivered in two-hour sessions over six-weeks and has a particular focus on rural caregivers. To learn more, visit: http://www/rosalynncarter.org/caregiver_intervention_database/dimentia/savvy_caregiver/

TimeSlips: TimeSlips is a free, web-based interactive software that enables people to experience creative storytelling wherever they live. It is appropriate for both informal and formal caregivers. With over 100 prompts on the site, visitors are invited to click on an image that leads them to a story page with open-ended questions. To learn more, visit: http://www.timeslips.org/
VII. RECOMMENDATIONS

Having outlined dementia care expected practice components and best practice examples in Virginia, this section provides recommendations for how to continue implementing expected practices while expanding and encouraging the development of evidence-informed and evidence-based best practices throughout the Commonwealth. The Virginia Department for Aging and Rehabilitative Services (DARS), the Dementia Services Coordinator (DSC) at DARS, and state and local partners should work to implement the following recommendations:

RECOMMENDATIONS FOR ASSESSMENT FOR DIAGNOSIS AND TREATMENT:

1. Continue to identify interdisciplinary memory assessment centers, share information about them with consumers, and provide professional development opportunities for center staff.

2. Promote Geriatric Emergency Departments in hospitals to assure safety and best outcomes for elder patients, to include the evaluation of adults presenting with delirium and dementia.

3. Partner with DARS Adult Protective Services Division, the Virginia League of Social Service Executives, Virginia’s Area Agencies on Aging (AAAs), the Department of Behavioral Health and Developmental Services (DBHDS), and the Community Services Boards (CSBs) to identify solutions and promote best practices for providing crisis stabilization for individuals with dementia who have behavioral and psychological symptoms of dementia (BPSD).

RECOMMENDATIONS FOR DEMENTIA CARE:

1. Advocate for and increase awareness of advance directives and end-of-life planning for all older adults, with particular emphasis on individuals with AD and dementia.

2. With the AAAs, integrate dementia capable training and practices into efforts focused on improving transitions across care settings for older adults.

RECOMMENDATIONS FOR FORMAL AND INFORMAL CAREGIVING:

1. Restore dedicated funding and implementation of training for first responders and law enforcement focused on communicating with individuals with dementia and responding to search and rescue efforts, with specific information about Project Lifesaver and other preventive wandering tools and locator devices.

2. Advocate for the collection of caregiver data through Virginia’s 2015 and 2016 Behavioral Risk Factor Surveillance System (BRFSS) to identify caregiver frequency and needs and to lay a foundation for coordinated efforts to respond to identified needs.
CROSS-CUTTING RECOMMENDATIONS: In addition to the specific theme recommendations listed on the prior page, the following recommendations span all three overarching themes and are essential to ensuring Virginia’s dementia capability:

1. Recommend that all expected and best practices consult and adhere to, as applicable, the guiding principles when developing, implementing, and replicating programs.

2. Advocate and recommend that expected practice components be standard for assessments, service delivery, and training and oversight of medical and health professionals and paraprofessionals engaged in caregiving.

3. Identify opportunities for continued use and expanded application of evidence-based programs in Virginia and advocate for their adoption in appropriate care settings.

4. With additional study and subsequent positive outcomes, identify opportunities for continued and expanded use of evidence-informed programs in Virginia, including the shift of quality evidence-informed programs into evidence-based programs. Such further study and advancement could be supported:
   a. With pilot grants that take practices from bench to bedside through Virginia’s Alzheimer’s and Related Disease Research Award Fund (ARDRAF), which is administered by the Virginia Center on Aging at VCU.
   b. In partnership with state agencies through federal grant opportunities, like the Alzheimer’s Disease Supportive Services Program (ADSSP) within the Administration for Community Living (ACL) and the U.S. Centers for Medicare and Medicaid Services (CMS) Innovation grants and pilot demonstrations.
   c. In collaboration with higher education institutions and private for-profit and non-profit organizations with experience in research and development.

5. Expand AlzPossible resources and its library of free, quality trainings and online materials available to address dementia care and research needs in Virginia, to include:
   a. Dementia and caregiving data for tracking trends in the Commonwealth.
   b. A comprehensive listing of available, evidence-based and evidence-informed trainings for professional caregivers.
   c. A clearinghouse of evidence-based and evidence-informed dementia care interventions and therapies not involving medication.

6. Integrate findings from this report into the Virginia Alzheimer’s Disease and Related Disorders Commission’s Dementia State Plan update, which is scheduled for release in October 2015.
VIII. REFERENCES


January 29, 2014

James A. Rothrock, Commissioner
Department for Aging and Rehabilitative Services
8004 Franklin Farms Drive
Henrico, VA 23229

Dear Commissioner Rothrock,

Del. Mark L. Keam has introduced House Bill 831 this year to request that the Department of Health convene a work group to study and make recommendations related to the provision of care for individuals with dementia residing in nursing homes and facilities in the Commonwealth. The bill was tabled in committee. However, based on discussions with stakeholders, it was agreed that, rather than pursue legislation, agency consideration could achieve the same goals.

As Chairman of the Health, Welfare and Institutions Committee, I respectfully request that you, as Commissioner of Aging and Rehabilitative Services, call for the Dementia Service Coordinator to consult with other relevant agency staff, providers of dementia services as well as dementia experts and advocates, in order to prepare a report that highlights dementia care “best practices” in the Commonwealth and ways to expand and encourage such practices across all level of care and settings.

I would further request that being apprised of any findings no later than October 1, 2014.

I thank you in advance for considering this request, and I will be happy to assist in any way.

Sincerely,

Robert D. “Bobby” Orrock, Sr.

cc: Delegate Mark L. Keam
    Delegate John M. O’Bannon, III
Appendix B:  
Stakeholder Workgroup Members

Alzheimer’s Association  
Carter Harrison

Institute of Law, Psychiatry Public Policy, University of Virginia  
Heather Zelle, J.D., Ph.D.

Memory and Aging Care Clinic, University of Virginia  
Carol Manning, Ph.D. ABPP-CN

Orange County Department of Social Services  
Robert Lingo

Senior Navigator  
Adrienne Johnson  
Richard Lindsay, M.D. (Institute for Innovations in Caregiving)

Virginia Adult Day Health Services Association  
Sue Nutter (Adult Care Center of Roanoke Valley)  
Michael DiGeronimo (Walter Reed Adult Day Health Care Center)

Virginia Alzheimer’s Disease and Related Disorders Commission  
Lynne Seward

Virginia Assisted Living Association  
Judy Hackler  
Jeffrey Gruber (Commonwealth Assisted Living)

Virginia Association for Home Care and Hospice  
Marcia Tetterton

Virginia Association for Hospices and Palliative Care  
Brenda Clarkson

Virginia Association of Area Agencies on Aging  
Courtney Tierney (Prince William Area Agency on Aging)

Virginia Association of Community Services Boards  
Mary Ann Bergeron  
Kathleen O’Connor (Virginia Beach Department of Human Services)  
Glenda Blake and Eileen Keane, Ph.D. (Arlington County Department of Human Services)

Virginia Association of Nonprofit Homes for the Aging  
Dana Parsons  
Mary Ann Crocker (Harbors Edge)

Virginia Center on Aging  
Ed Ansello, Ph.D.

Virginia Coalition for the Prevention of Elder Abuse  
Joyce Martin

Virginia Department of Behavioral Health and Developmental Services  
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Virginia Department of Health  
Lisa Wooten

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Missy Currier

Virginia Department of Veterans Services  
Sandra Ranicki

Virginia Health Care Association  
Keith Hare  
Beverley Soble

Virginia Hospital & Healthcare Association  
Susan Ward

Virginia Department for Aging and Rehabilitative Services  
James A. Rothrock, Commissioner  
Robert Brink, Deputy Commissioner  
Charlotte Arbogast, Dementia Services Coordinator*  
Devin Bowers, Research Assistant*  
Ali Faruk, Special Assistant to the Commissioner  
Patti Goodall, Brain Injury Services Unit Manager  
Bob Krollman, Assistive Technologist  
Joani Latimer, State Long-Term Care Ombudsman  
Amy Marschean, Senior Policy Analyst  
Paige McCleary, DARS/APS Program Consultant

* DARS Staff for this Report
### Appendix C:
#### List of Best Practice Organizations

<table>
<thead>
<tr>
<th>Organization</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Grace Place Adult Care Center</td>
<td>8030 Staples Mill Road, Richmond, VA 23228</td>
<td>(804) 261-0205</td>
</tr>
<tr>
<td>Aging Together</td>
<td>P. O. Box 367, Culpeper, VA 22701</td>
<td>(540) 829-6405</td>
</tr>
<tr>
<td>Alzheimer’s Association, Central and Western Virginia</td>
<td>1160 Pepsi Place, Suite 306, Charlottesville, VA 22901</td>
<td>(434) 973-6122</td>
</tr>
<tr>
<td>Alzheimer’s Association, Greater Richmond</td>
<td>4600 Cox Road, Suite 130, Glen Allen, VA 23060</td>
<td>(804) 967-2580</td>
</tr>
<tr>
<td>Arlington County Department of Human Services</td>
<td>2100 Washington Boulevard, Arlington, VA 22204</td>
<td>(703) 228-1700</td>
</tr>
<tr>
<td>Birmingham Green</td>
<td>8605 Centreville Road, Manassas, VA 20110</td>
<td>(703) 257-0935</td>
</tr>
<tr>
<td>Circle Center Adult Day Services</td>
<td>4900 West Marshall Street, Richmond, VA 23230</td>
<td>(804) 355-5717</td>
</tr>
<tr>
<td>Dream Catchers at the Cori Sikich Therapeutic Riding Center</td>
<td>10120 Fire Tower Road, Toano, VA 23168</td>
<td>(757) 566-1775</td>
</tr>
<tr>
<td>Fairfax Area Agency on Aging</td>
<td>12011 Government Center Parkway, Suite 708, Fairfax, VA 22035</td>
<td>(703) 324-5411</td>
</tr>
<tr>
<td>Generations Crossing</td>
<td>3765 Taylor Spring Lane, Harrisonburg, VA 22801</td>
<td>(540) 434-4901</td>
</tr>
<tr>
<td>Geriatric Mental Health Partnership</td>
<td>c/o Virginia Health Care Association, 2112 W. Laburnum Avenue, Suite 206, Richmond, VA 23227</td>
<td>(804) 353-9101</td>
</tr>
<tr>
<td>Goodwin House Alexandria</td>
<td>4800 Fillmore Avenue, Alexandria, VA 22311</td>
<td>(703) 578-1000</td>
</tr>
<tr>
<td>Insight Memory Care Center</td>
<td>2812 Old Lee Highway, Suite 210, Fairfax, VA 22031</td>
<td>(703) 204-4664</td>
</tr>
<tr>
<td>International Assoc. of Chiefs of Police</td>
<td>c/o VA Dept. of Criminal Justice Services, 1100 Bank Street, Richmond, VA 23219</td>
<td>(804) 786-4000</td>
</tr>
<tr>
<td>King’s Grant Retirement Community</td>
<td>350 Kings Way Road, Martinsville, VA 24112</td>
<td>(276) 634-1125</td>
</tr>
<tr>
<td>Mt. Vernon Nursing &amp; Rehab Center</td>
<td>8111 Tis Well Drive, Alexandria, VA 22306</td>
<td>(703) 468-0533</td>
</tr>
<tr>
<td>The Orchard</td>
<td>20 Delfae Drive, Warsaw, VA 22572</td>
<td>(804) 313-2500</td>
</tr>
<tr>
<td>Out and About Respite Services</td>
<td>Virginia Beach, VA 23455</td>
<td>(757) 577-2147</td>
</tr>
<tr>
<td>Peninsula Area Agency on Aging</td>
<td>739 Thimble Shoals Boulevard, Suite 1006, Newport News, VA 23606</td>
<td>(757) 873-0541</td>
</tr>
<tr>
<td>Prince William Area Agency on Aging</td>
<td>5 County Complex, Suite 240, Woodbridge, VA 22192</td>
<td>(703) 792-6400</td>
</tr>
<tr>
<td>Project Lifesaver International</td>
<td>815 Battlefield Boulevard South, Chesapeake, VA 23322</td>
<td>(757) 546-5502</td>
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<tr>
<td>Rappahannock Area Agency on Aging</td>
<td>460 Lendall Lane, Fredericksburg, VA 22405</td>
<td>(540) 371-3375</td>
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<tr>
<td>Riverside CEALH</td>
<td>3901 Treyburn Drive, Suite 100, Williamsburg, VA 23185</td>
<td>(757) 220-4751</td>
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<tr>
<td>Riverside Health System</td>
<td>1020 Old Denbigh Boulevard, Newport News, VA 23602</td>
<td>(757) 856-7030</td>
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<tr>
<td>SeniorNavigator</td>
<td>7501 Boulders View Drive, Suite 201, North Chesterfield, VA 23225</td>
<td>(804) 525-7728</td>
</tr>
<tr>
<td>Tackfully Teamed Riding Academy</td>
<td>7975 Henry Road, Henry, VA 24102</td>
<td>(276) 627-0024</td>
</tr>
<tr>
<td>UVA Institute of Law, Psychiatry, and Public Policy</td>
<td>1230 Cedars Court, Suite B, Charlottesville, VA 22903</td>
<td>(434) 924-5435</td>
</tr>
<tr>
<td>UVA Memory and Aging Care Clinic</td>
<td>500 Ray C. Hunt Drive, Charlottesville, VA 22903</td>
<td>(434) 982-0803</td>
</tr>
<tr>
<td>VCU Department of Gerontology</td>
<td>P. O. Box 980228, Richmond, VA 23298</td>
<td>(804) 828-1565</td>
</tr>
<tr>
<td>VCU Health System Adult Day Services</td>
<td>607 North 10th Street, Richmond, VA 23298</td>
<td>(804) 828-8027</td>
</tr>
<tr>
<td>Virginia Beach Department of Human Services</td>
<td>297 Independence Boulevard, Pembroke 6, Suite 302, Virginia Beach, VA 23462</td>
<td>(757) 385-4202</td>
</tr>
<tr>
<td>Virginia Department of Corrections</td>
<td>6900 Atmore Drive, Richmond, VA 2325</td>
<td>(804) 674-3119</td>
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