



# AGS

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Editor: Scott F. Kramer

## AMERICAN GERIATRICS SOCIETY NEWSLETTER

### Geriatric and Chronic Care Management Act Would Reshape Reimbursement

*Legislation Pays Heed to Chronic Illness*

Taking up where the 2003 Geriatric Care Act (S. 387/H.R. 102) left off, the bipartisan Geriatric and Chronic Care Management Act (S. 2593) was introduced into Congress in late June, with strong support from the AGS. Its recommendations mirror several of those included in the AGS/Association for Directors of Geriatric Academic Programs (ADGAP) report *Geriatric Medicine: A Clinical Imperative for an Aging Population*.

The legislation, if enacted, would provide targeted help to physicians who care for the 20% of Medicare beneficiaries whose health is impacted by five or more chronic conditions, a patient base that consumes two-thirds of total Medicare spending. Blanche Lincoln (D-AR) and Harry Reid (D-NV) were joined by nine other cosponsors, while Rep. Gene Green (D-TX) introduced a companion bill (H.R. 4689) in the House.

Lawmakers are acting on the growing dissatisfaction among those who care for older adults with Medicare's fee-for-service policies, which fail to adequately factor into reimbursement the costs associated with two major services vital to managing overlapping conditions: geriatric assessments and care coordination services.

Under the bill, providers would conduct billable geriatric assessments of a beneficiary's medical condition, functional and cognitive capacity, primary caregiver needs and environmental and psychosocial needs.

Physicians and certain health professionals would be able to seek compensation for care management services. (See *GCCMA*, p. 11)

### AGS COMMITTEE SPOTLIGHT

#### Health Care Systems

The Health Care Systems (HCS) Committee was established by the American Geriatrics Society Board of Directors in 1999 to help determine the effects of health care delivery systems on the health, independence and quality of life of older people. It promotes, undertakes and present research that expands knowledge of health care delivery, provides advice on issues and public policy that affect delivery, quality and payment issues, and analyzes the effects of health care systems on the health and well being of older adults. (See *HCSC*, p. 8)

VOLUNTEER  
FOR A  
COMMITTEE!  
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#### Ethnogeriatrics

According to Chair Gwen Yeo, PhD, the Ethnogeriatrics Committee had its genesis in the actions of a small group of AGS members seeking recognition of the unique cultural issues involved in caring for rapidly growing numbers of older adults from diverse ethnic backgrounds. "It is gratifying to those pioneers to observe the growth in that recognition that has occurred over the last decade as AGS leadership has responded to the issues we have raised."

Formerly the Ethnogeriatric Task Force, the Ethnogeriatrics Committee's first goal was to include more sessions in the annual meeting that recognized the diversity of older patients as well as the need for knowledge and skills in cross-cultural encounters. (See *Ethnogeriatrics*, p. 8)

***This is a new, ongoing series that will give AGS committees the opportunity to discuss activities and spotlight accomplishments. If you would like to submit material, please contact Scott Kramer at [skramer@americangeriatrics.org](mailto:skramer@americangeriatrics.org).***

#### Student Researchers Benefit from Foundation Efforts



Student Researcher Peggy Mannon Cawthon

In 2004, fifty-nine students attended the AGS Annual Meeting with the support of awards that they received from the AGS Foundation for Health in Aging Student Researcher Fund. Participation in the meeting presented an important opportunity for these students to learn first hand about exciting developments in geriatric research and education and meet committed health care professionals who are enjoying careers spent caring for older patients. (See *Student Researchers*, p. 11)

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# From the President

*"Preventive care compliments geriatrics, and the AGS has worked hard to have a geriatric assessment included in Medicare."*

Dear Members:

As you know, good preventive care includes the hallmarks of geriatric care: care assessment and care plan development and coordination. In a population where managing disease is so complex, thorough preventive care can identify looming health problems before they develop into chronic conditions. It can spur the process of long-term management of these conditions, lessening the burden on both quality of life of older adults and the health care system that manages their diseases.

Preventive care compliments geriatrics, and the AGS has worked hard to have a geriatric assessment included in Medicare. These care services often trigger immediate treatment based on traits that point to the risk of substantial morbidity and could negatively impact quality of life, for instance, people in danger of Type II diabetes. The potential for preventive care to stop an acute illness like breast cancer from becoming fatal is more commonly recognized, but mitigating the impact of chronic illness is still a fundamental, critical challenge of any geriatric care provider.

This is why we at the AGS are so pleased to see that the Centers for Medicare and Medicaid Services (CMS) recently proposed regulations to the Medicare Modernization Act (MMA) of 2003 that would strengthen preventive care for older adults through functional screening and other measures, prolonging and

enriching their lives and paring down lifetime costs to the health care system in the process.

A review of the individual's functional ability and level of safety, including essential factors such as hearing impairment, activities of daily living, falls risk and home safety, would be included, based on the use of an "appropriate screening instrument" as determined by the physician or other qualified provider, who would choose, at their discretion, any available standardized screening test recognized by the AGS and other medical organizations.

The regulations also include a one-time "Welcome to Medicare" preventive examination at age 65 for new enrollees. This exam would be a major step forward for Medicare, one that would go a long way toward countering some of the well-intended but often penny wise, pound foolish policies currently hampering its effectiveness in treating older adults. The exam will be rounded out with education, counseling and referral to other preventive services offered through the provider.

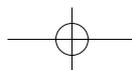
Along with standard preventive services such as mammography and diabetes screening, the new regulations would require providers to conduct a review of the individual's comprehensive medical and social history and potential risk factors for depression. Many geriatricians, of course, have long recognized the necessity of both of these factors and their impact on patients.



We are pleased that the proposed benefit includes these pieces and are hopeful, through our efforts, that the final rule containing the benefit will maintain this important language. The AGS and its representatives in Washington have worked hard to ensure that the benefit will include preventive components of geriatric assessment, long a critical attribute of geriatric care. As always, I urge AGS members to continue to track developments on the policy front at the AGS Web site, *MyAGS*, and this newsletter, and to remain active and involved with issues critical to our practices.

Sincerely,

Meghan Gerety, MD



# The Patient Education *Forum*

## Arthritis Pain

By Keela A. Herr, PhD, RN, Professor, The University of Iowa, College of Nursing, Iowa City, IA  
& Bill McCarberg, MD, Director Pain Services, Kaiser Permanente, San Diego, California

Over 80% of older adults experience osteoarthritis (OA), the most common type of arthritis. Rheumatoid arthritis (RA) is the second most common type. Both cause pain and can make it difficult for older people to take care of themselves.

### Q: What is the difference between OA and RA?

**A:** OA is a degenerative disease caused by continued wearing down of the structure and/or tissue of mostly weight-bearing joints (cartilage and connective tissues). Pain is usually located in the knees, hips, feet, ankles, joints of the hands and neck and lower spine and may not affect joint pairs. RA is caused by inflammation that generally *does* affect joint pairs. RA may also affect internal organs such as the heart, lungs and eyes. Both can result in physical decline and disability. OA causes stiffness on rising and discomfort while using the affected joints. RA is usually felt as pain, swelling, warmth and tenderness in various joints, with discomfort and fatigue that may last throughout the day.

### Q: Can my arthritis be cured?

**A:** A treatment plan that includes drug and non-drug treatments (such as occupational therapy, physical therapy, psychological treatments, and education) can improve pain, function and overall quality of life, but there is no cure.

### Q: Do I just have to learn to live with my arthritis pain?

**A:** Although many people believe that arthritis pain is a result of aging and must be tolerated, living with the pain is not good for you. Untreated pain can have serious effects such as poor healing, weakness, breathing complications, depression, anger, as well as making overall quality of life worse. There are many treatment choices that can and should be explored to help relieve pain and its impact.

### Q: What can I do to help my arthritis?

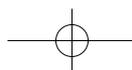
**A:** Learn as much as possible about your disease, its treatment and ways to adjust your life to it. The older person who takes charge of arthritis (in a self-management program) can lower pain and improve their function and overall quality of life. Many different strategies that improve health are often included in self-management programs and focus on nutrition, exercise, physical therapies, coping skills, use of canes and walkers, pacing activity, scheduling activity and stress management. When your self-management program, including over-the counter medication, is not relieving the pain, visit your primary care provider.

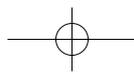


The AGS Foundation for Health in Aging

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**Q: Is there a difference in treatment between OA and RA?**

**A:** Yes, treatments can differ depending on the type of arthritis. Pain medicines and medicines to fight inflammation are most often used for OA, and are also useful in patients with RA. However, patients with RA are also treated with drugs that change the immune system.

**Q: Are the nutrition therapies advertised in magazines, television and on the internet useful to manage arthritis pain?**

**A:** Many have not been proven effective. You should be cautious about these. There is no specific diet that has been shown to improve symptoms, though some approaches, such as glucosamine sulfate, have been shown to help. Keeping a normal body weight and following a balanced diet with the right amount of protein, fat, vitamins and minerals is very important. Caffeine, nicotine and alcohol can interfere with sleep and also can impact your overall health and management of your disease.

**Q: It seems that exercise would only make joints that already have arthritis worse and cause pain. Should I limit my activity?**

**A:** Although it may not seem that way, exercise is an important part of an arthritis treatment program. Motion and lubricating fluid in the joint improve with mild to moderate exercise. Low activity can add to the pain and stiffness as well as loss of function. A carefully balanced program of activity is important.

**Q: Are joint injections a good treatment option for my joint pain?**

**A:** Injection of steroids into joints with arthritis should be considered in patients with OA or RA who have worse or severe inflammation in one or a few joints. Injection of hyaluronic acid supplements into the knee may be an option for people whose OA pain is not getting better with other pain medications. These injections replace or supplement the body's natural lubrication in the joint.

**Q: My doctor has tried numerous drug and non-drug treatments to control my arthritis pain, but I still have severe pain that prevents me from doing any of the activities that are important to me. Are there any other options?**

**A:** Strong pain medicines such as morphine, tramadol, oxycodone and hydrocodone might be used if other drug and nondrug treatments have not provided enough pain relief and your overall quality of life is made worse by the pain. Some find that using stronger pain medicine is needed to treat flares of pain that only last a day or a week to supplement other medicines. Surgical options, including joint replacement, are other alternatives to consider when drug and nondrug treatments are ineffective at maintaining function and quality of life. Consult your health care provider to discuss your options.

**Reference:** American Pain Society. (2002). *Guideline for the Management of Pain in Osteoarthritis, Rheumatoid Arthritis, and Juvenile Onset Arthritis. Clinical Practice Guideline No. 2.* Glenview, IL: American Pain Society.

**Additional Resources:** The Foundation for Health in Aging - *Eldercare at Home*, Chapter 11 "Pain" [www.healthinaging.org/eldercare/chap11.html](http://www.healthinaging.org/eldercare/chap11.html)

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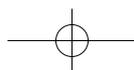
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## CMS SCHOLAR REFLECTS ON TENURE, ENCOURAGES PARTICIPATION

In June, AGS Member Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD completed a one-year term as a CMS Health Policy Scholar. He is currently serving as the Founding Executive Director of the Health Policy Institute at the University of the Sciences in Philadelphia. We spoke to him recently about his experiences at CMS and his activities in the months since, and his answers were both candid and revealing.

**AGS: What did you find rewarding about being a CMS Scholar?**

**RS:** Most rewarding was working on a daily basis with the Health Policy Group during the development of the regulations for the Medicare Modernization Act (MMA). This unique perspective gave me tremendous insight into the workings of CMS as well as the specific details and thought behind the MMA regulations.

**AGS: Why should other AGS members consider the Scholars program and how do they submit themselves for consideration?**

**RS:** Any AGS member interested in affecting health policy or just gaining a clearer understanding into how health policy is made would gain a great deal from the AGS-CMS Health Policy Scholars position. Applications are accepted through AGS; however, this is based on available [CMS and institutional] funding for the program so there is no regular timeline.

**AGS: What should they expect if they are chosen?**

**RS:** A tremendous adventure into the innermost workings of CMS. One thing they need to be aware is that this is a completely self-directed program. The benefit of this is that it allows individuals to move into activities that best fit their interests.

**AGS: What would you rate as your biggest success in the program?**

**RS:** Actively participating in several key activities regarding MMA where I was able to push forward the principles of AGS. For example, I participated in the formulary design for the discount card and was a reviewer for the long term care discount card application. One of the most interesting positions was serving on the regulatory writing team, where I was responsible for pharmacy access issues.

**AGS: Was there anything about working at CMS that surprised you?**

**RS:** Yes, I was surprised by how much influence a small group of individuals had—from within CMS and externally. Developing a channel of communication with key CMS staffers is critical to assuring that stakeholders' voices are heard.

**AGS: What are your thoughts on the Medicare Modernization Act?**

**RS:** It was the best we could hope for at the time. Given the environment that existed and the result of previous attempts, it is clear that if something wasn't done now it would be many more years before adding a drug benefit or other changes to Medicare would have been attempted. With that said I believe a great deal of work needs to be done to see that Medicare is truly modernized. For example, the specialized Medicare Advantage Plans and Chronic Care Improvement Programs are excellent steps in the direction of an interdisciplinary team approach to care and away from the fragmented care model that we currently practice under. From a clinician's standpoint, work needs to be done to fill in the donut hole and make the benefit much more patient friendly.

**AGS: What led you to your new position and what do you hope to accomplish there?**

**RS:** I was led to my new position at the University of the Sciences in Philadelphia, formally known as the Philadelphia College of Pharmacy—the oldest school of pharmacy in the US—by a desire to continue the work I started at CMS. The Health Policy Institute will focus on pharmaceutical-related issues, especially regarding MMA matters. This will be accomplished through implementing systems based on an understanding of the relevant policy as well as affecting policy through supportive services to public policy leaders and targeted research.

**CALL FOR ABSTRACTS—ONLINE ONLY—NO HARD COPY SUBMISSIONS**  
**AGS Annual Scientific Meeting, May 11-15, 2005, Walt Disney World Swan and Dolphin Hotel,  
Orlando, FL**

The AGS invites you to submit an abstract for presentation as a paper or poster at the 2005 Annual Scientific Meeting. Go to [www.americangeriatrics.org](http://www.americangeriatrics.org) and click on the Annual Meeting link to submit abstracts in the following categories:

**Biology of Aging • Body Composition • Case Studies • Clinical Trials • Dental Medicine • Economics  
Emergency Medicine • Epidemiology • Ethics • Geriatric Education • Geriatric Syndromes  
Health Services Research • Models of Geriatric Care • Neurological and Behavioral Sciences  
Organ Specific and Systemic Disorders • Policy • Preventive Medicine • Quality of Life Rehabilitation  
Surgery in Older Patients**

For more information, contact Dennise McAlpin at (212) 308-1414 or [dmcAlpin@americangeriatrics.org](mailto:dmcAlpin@americangeriatrics.org).

## AGS 2005 NATIONAL AWARDS PROGRAM

The Awards Subcommittee of the 2005 AGS Annual Meeting Program Committee is seeking nominations for several national awards. These awards recognize individuals whose outstanding work in geriatrics education, research and clinical practice contributes to the delivery of high quality health care for older people. Candidates may be nominated for more than one award, but will be selected for only one. All awardees will be presented with a plaque during the Awards Ceremony held at the 2005 AGS Annual Meeting, May 11-15 in Orlando, FL. The Annual Meeting registration fee is waived for all awardees. **The NOMINATION DEADLINE for all awards is DECEMBER 1, 2004. Please visit [www.americangeriatrics.org](http://www.americangeriatrics.org) or contact Linda Saunders at [lisaunders@americangeriatrics.org](mailto:lisaunders@americangeriatrics.org) or (212) 308-1414 for more information on the awards nomination criteria and history.**

### AWARD CRITERIA/NOMINATIONS PROCESS

#### Dennis W. Jahnigen Memorial Award

This award is given annually to an AGS member who has provided leadership to train students in geriatrics and has contributed significantly to the progress of geriatrics education in health professions schools. Teaching expertise as well as educational program development is valued in the selection process. Nominations must consist of a letter of nomination, at least one additional letter of support from colleagues, and the nominee's curriculum vitae. The nomination letters should specifically address how the individual's accomplishments relate to the purpose of the award. **Award:** Travel expenses to AGS Annual Scientific Meeting in Orlando.

#### New Investigator Awards

Eight awards, funded through an educational grant from Merck U.S. Human Health, are open to young investigators in medicine (including physicians and physician assistants), nursing, and pharmacy, Fellows-in-training as well as new and junior investigators who have held an academic appointment for no longer than five years. The awards are intended to recognize work in clinical geriatrics, including medicine, psychiatry, nursing and all other relevant disciplines. The work reported must not have been published or presented at other national meetings. Topics are invited in basic research, clinical investigation, clinical medicine, and public health, as well as research in the fundamental neurosciences. Awards will be chosen based on originality, scientific merit, relevance of the research as well as the applicant's demonstrated commitment to and accomplishments in aging research. Investigators without a demonstrated focus on aging research should not apply. By submitting an abstract, the investigator agrees that the committee can select it for presentation as a research paper or poster and agrees to make the presentation him/herself. Applications must include the candidate's curriculum vitae, the research abstract, and three letters of recommendation. **Award:** \$1500—these funds are intended, in part, to cover awardees' travel expenses to attend the AGS Annual Meeting.

#### Edward Henderson Student Award

This award is intended to honor a student who has demonstrated a commitment to the field of geriatrics through leadership in areas pertinent to geriatrics and initiation of new information or programs in geriatrics or scholarship in geriatrics through original research or reviews. The student must be nominated by one faculty member with at least two supporting letters of nomination from other faculty. The application packet must be compiled by the nominator and must include: 1) the nominating letter; 2) two accompanying letters of recommendation; 3) the student's curriculum vitae; 4) a statement (approx. 150 words) from the student nominee describing his/her work and interest in geriatrics; and, 5) supporting materials, such as copies of research papers, abstracts, or reports mentioned in support of the nominee. A syllabus of the program the student has participated in or will participate in may also be included. Only documented work will be reviewed or considered by the selection committee. **Award:** \$500 travel stipend to attend the Annual Meeting.

#### Student Research Award

A Student Research Award will be presented to the student who submitted the most outstanding student abstract for the 2005 AGS Annual Meeting. The abstract will be chosen based on originality, scientific merit and relevance of the research. The awardee will present his/her research at the Annual Meeting. Applicants must submit an abstract of research or research-in-progress electronically via the AGS website. The student's curriculum vitae and a letter from the student's advisor verifying his/her contribution to the work must be sent to the AGS office. **Award:** \$500 travel stipend to attend the Annual Meeting.

#### Clinician of the Year Award

This award was established to recognize the great contributions of practitioners to the delivery of quality health care to older people and the importance of the geriatrics clinician in our health care delivery system. We welcome the nomination of exemplary geriatrics clinicians whose primary focus is the delivery of patient care in the office, hospital, long-term care facility or community. Nominees may have part-time clinical appointments at universities, but the majority of their activities must be in the delivery of primary care. Those holding part-time, clinical appointments at academic institutions should derive no more than 10% of their income from their University activities. Nominees must be AGS members. We encourage AGS state affiliates to nominate their members who meet the criteria for this award. Awardees should be dedicated to: 1) maintaining a high level of professional competence through continuing medical education; 2) being available and accessible to patients; 3) communicating clearly and carefully with patients and their families; 4) being aware of the ethical and social issues inherent in the practice of medicine; and, 5) contributing to community health care efforts. Nominations should consist of a letter of nomination addressing how the individual's accomplishments relate to the purpose of the award, at least one additional letter of support from colleagues, and the nominee's curriculum vitae. If the candidate has a part-time clinical appointment within a University teaching hospital, the nomination letter should also include the percentage of the candidate's salary that is supported by the University. **Award:** \$2,000.

#### Outstanding Scientific Achievement for Clinical Investigation Award

This award honors a clinician who is actively involved in geriatric patient care, has accomplished meritorious clinical research and who is still at a developing, active stage of his/her research career and can point to particularly meritorious early accomplishment. It is not intended to recognize the most mature and experienced investigators in the field, or accomplishments in basic or animal research. The applicant's date of graduation from graduate school should be on or after June 1989 unless there are specific definable circumstances that delayed the applicant's career development. Individuals who are still in training are ineligible. The candidate should be a resident of the U.S. or Canada. The nomination should consist of a primary letter of nomination outlining the candidate's research contributions and participation in geriatric patient care, curriculum vitae, reprints of up to three publications illustrating his/her most important contributions and one or two supporting letters of recommendation. The nominee should continue to be actively engaged in the line of research for which the award is made. Nominations will be reviewed and the awardee selected by the Research Committee of the American Geriatrics Society. The awardee's name will be published in the *Journal of the American Geriatrics Society (JAGS)*. He/she will be invited to present a paper describing his/her most important research accomplishments at the AGS Annual Meeting and will be invited to submit a paper summarizing this work for publication in *JAGS*. The paper will be reviewed under the usual *JAGS* editorial policies. **Award:** Travel expenses to attend the AGS Annual Meeting.

# From the Capitol

AGS made significant progress in advancing its legislative and regulatory agendas during the past several months. On Capitol Hill, the Society endorsed legislation introduced by Senators Blanche Lincoln (D-AR) and Harry Reid (D-NV) that would authorize Medicare coverage of geriatric assessment and care management for eligible Medicare beneficiaries. Rep. Gene Green (D-TX) introduced a companion measure in the House of Representatives. Developed with assistance from AGS, S.2593/H.R. 4689 would realign the financial incentives within Medicare fee-for-service to better support quality chronic care by reimbursing services shown to be effective in managing chronic disease, such as medication management, coordination with other providers to avoid duplication of tests, patient and family caregiver education and referral to and coordination with community services.

## **Graduate Medical Education**

On the regulatory front, AGS scored impressive gains in enhancing residency training opportunities for geriatrics. CMS August 2 issued final regulations implementing a provision from the Medicare Modernization Act (Section 422 of Public Law 108-173) that redistributes unused residency training slots to teaching hospitals for purposes of calculating both direct and indirect graduate medical education payments. At AGS' urging, CMS retained Evaluation Criterion Two in the final rule, which provides special consideration for geriatrics and is one of several criteria that will be used in evaluating the applications for increases in hospitals' FTE resident caps. This criterion reads as follows:

*"The hospital will use the additional slots to establish a new geriatrics residency program, or to add residents to an existing geriatrics program. We believe that, of all the medical specialties, geriatrics is the one specialty that is devoted primarily to the care of Medicare beneficiaries. In addition, we note that encouraging residency training in geriatrics is consistent with Congressional intent as expressed, among other places, in section 712 of Pub. L. 108-173."*

In its comments on the draft rule, AGS also expressed concern over the impact on geriatrics of other provisions that proposed to require a nationwide fill rate of 95% where applicants plan to develop a new residency program. This requirement runs "counter to CMS' expressed goals in including Evaluation Criterion Two," the Society stated. In the final rule, CMS lowered the fill rate to 85 percent, again singling out geriatrics for preferential treatment:

*"... we are giving special consideration to geriatric programs to meet the "fill rate" criterion for demonstrating the likelihood of filling FTE resident slots under section 422. Geriatrics is not a separately approved training program; rather, it is a subspecialty of another specialty program. For example, there is a geriatrics subspecialty of family practice. In this final rule, for the purposes of meeting the 85 percent fill rate criterion, we will allow hospitals that are starting a new geriatrics program or expanding an existing geriatric program to use the fill rate associated with the overall specialty program (rather than the fill rate for the geriatric subspecialty) to meet this demonstrated likelihood criterion."*

## **Initial Preventive Physical Exam**

AGS praised CMS for including components of a geriatric assessment in proposed regulations implementing the new Welcome to Medicare Physical. Beginning in 2005, all newly enrolled Medicare beneficiaries will be covered for an initial physical exam, as mandated by the MMA. In addition to the typical components of a preventive exam, CMS proposes to include a review of the individual's comprehensive medical and social history, potential risk factors for depression, and ability and level of safety (at a minimum, a review of the following areas: hearing impairment, activities of daily living, falls risk and home safety), based on the use of an appropriate screening instrument, which the physician or other qualified provider could select from various available standardized screening tests. AGS is pleased that the proposed benefit incorporates these elements and has urged CMS to retain them in the final rule.

## **In Other News: AGS Supports Reagan Namesake Alzheimer's Legislation, Patient Safety**

AGS endorsed bipartisan legislation that would double federal spending for research on Alzheimer's disease. The Ronald Reagan Alzheimer's Breakthrough Act of 2004 (S.2533/H.R. 4595) "recognizes the important need to focus more attention on finding a cure for Alzheimer's disease while simultaneously educating the public about important prevention techniques," AGS said in a letter of support to Senate bill sponsors Barbara Mikulski (D-MD) and Christopher Bond (R-MO). The bill puts three existing Alzheimer's research programs at the NIA into statute: prevention research, cooperative clinical research, and caregiving research. It also would provide a \$3,000 annual tax credit for family caregivers of Alzheimer's patients and establish a tax deduction for premiums on long term care insurance. It seeks to increase access to respite care services through grants to states and nonprofit organizations.

In a July 16 letter initiated by the AMA, AGS, along with more than 90 groups representing providers paid under the physician fee schedule, asked CMS Administrator Mark McClellan to use his authority to remove physician-administered drugs from the sustainable growth rate calculation and include the full costs of new benefits and coverage decisions in the SGR target. If the formula is not corrected, reimbursements will be reduced by five percent a year for seven consecutive years beginning in 2006.

Finally, AGS supported passage of patient safety legislation by the U.S. Senate. Following a lengthy impasse, approved legislation aimed at improving the safety of the nation's health care system through the creation of a voluntary medical errors reporting system was approved on July 22. Approval of the measure, the Patient Safety and Quality Improvement Act (S. 720), was applauded by the medical community, including AGS, which had lobbied strongly for its consideration by the full Senate. Similar legislation (H.R. 663) was adopted by the House in March 2003.

## IN THE SPOTLIGHT: HCSC

(continued from p. 1)

According to Chair Steven L. Phillips, MD, CMD, the HCS committee has, in recent years, sought to develop educational programs, symposia and materials regarding systems of health care for health care professionals, scientists and public policy makers. In May 2004, the plenary session "Geriatrics Practice: The Art of Survival" was developed through the committee in collaboration with COSAR and the Practice Management Advisory group. In conjunction with Aurora Healthcare and the University of Wisconsin, the committee was involved in developing an online CME based on the information presented at the 2004 plenary session, available through the AGS website until June 2005. At the 2005 annual meeting in Orlando, FL the committee will be sponsoring educational programs in the areas of health care management, finances and the role of health information technology in improving the quality of geriatric care.

Dr. Phillips reports that the committee strives to serve as resource for the AGS on issues and matters of public policy as related to health care systems, working closely with AGS representatives in Washington, D.C. to provide input and testimony on Medicare reimbursement discussions and legislation.

Developing position statements on matters of health care delivery for the AGS, such as the 2003 position statement on Care Transitions and the position statement on Assisted Living approved by the AGS Board at this years annual meeting, is also a hallmark of the HCSC's work. Position statements on Disease Management and Electronic Prescribing are currently in various stages of development.

In the near future, the committee will work on issues of electronic prescribing, enhancing the role of health information technology to meet the needs of older patients and improving the quality of transitional care.

"All members of the HCS Committee are committed to working with other AGS committees to improve the delivery of health care to those patients that we serve," according to Dr. Phillips. "The Health Care Systems Committee is a very active entity engaging in out-of-the-box thinking and is constantly looking for new members and ideas."

**For more information on these committees, please contact Julie Pestana at [jpestana@americangeriatrics.org](mailto:jpestana@americangeriatrics.org).**

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## AGS WELCOMES FEEDBACK

If you have any ideas, questions, concerns or comments about the content of the *AGS Newsletter*, please feel free to share them with Scott Kramer at [skramer@americangeriatrics.org](mailto:skramer@americangeriatrics.org).

## IN THE SPOTLIGHT: ETHNOGERIATRICS

(continued from p. 1)

As interest in ethnogeriatric issues increased and more members with relevant expertise joined the committee, its goals expanded to include development of ethnogeriatric resources for providers, development of curriculum resources for health care educators, support of the Eldercare Initiative in the Indian Health Service and input on ethnogeriatric issues in AGS publications.

With the committee's support and encouragement, a section of the *Journal of American Geriatrics Society (JAGS)* focusing on ethnogeriatrics and special populations was established, with committee members serving as reviewers and the section editor. A curricular framework for teaching ethnogeriatric content in medical schools, the collaboration between committee members and representatives of the University of California Academic Geriatric Resource Program, was also published in *JAGS*. In addition, the Committee facilitated the contribution of several hundred copies *Geriatrics at Your Fingertips* to providers across the U.S. in the Indian Health Service.

"The most ambitious accomplishment of the Ethnogeriatric Committee to date," according to Dr. Yeo, has been the development and production of *Doorway Thoughts: Cross-Cultural Health Care for Older Adults*. The small volume is designed to assist providers with pertinent information about elders from seven different populations before they "open the door" to see an older patient from an ethnic background with whom they are not familiar. With long hours of dedicated work by two editors and seven authors, all members of the committee, and assistance from AGS staff members and Board members who reviewed the text, the volume was released in time for the annual meeting in Las Vegas and sold hundreds of copies in its first two months in print, according to Yeo.

The Committee is now planning a second volume of *Doorway Thoughts* focusing on elders from eight additional ethnic populations. In addition, members of the committee are reviewing and contributing to the next edition of the *Geriatric Review Syllabus* as well as to guidelines and other materials being developed by AGS. Several efforts have been made to secure funding for two projects the Committee hopes to implement: development of a set of teaching slides and materials on ethnogeriatrics for faculty in health care training programs; and a Web-based researchable data base in ethnogeriatrics. "The dream still exists for implementing those projects, but they await enlightened donors," Yeo remarked.

She credits the "enthusiasm of the members and the tradition of collegial work emphasized by past Chairs" for imbuing their hard work with a sense of fun and the excitement of contributing to something important.

## MEMBERS IN THE NEWS

**Molly Carnes, MD** received the 2004 Athena Award at the Business Forum's 7th Annual Celebration of Excellence in March... The Paul Beeson Career Development Award from the National Institute on Aging was recently awarded to **William Dale, MD**... **Catherine Du Beau, MD** was recently named the 2004 Continence Care Champion of the American Geriatrics Society. The selection was made by the National Association For Continence, with sponsorship by Pfizer Global Pharmaceuticals, Inc., and was announced at the AGS Annual Scientific Meeting in May... At the new Ron Robinson Senior Care Center at San Mateo Medical Center in San Mateo, California, **Susan P. Ehrlich, MD, MPP** is serving as Medical Director... Oregon Health and Science University School of Nursing has awarded the 2004 Medsurg Nursing in Genetics Writer's Award to **Karen Greco, RN, ANP** for her article "Nursing in the Genomic Era: Nurturing Our Genetic Nature"... With the recent merger of the University of Michigan's Institute of Gerontology and the Medical School's Geriatrics Center, it was announced **Jeffrey B. Halter, MD** will serve as Director. The Institute of Gerontology will become the research arm of the Geriatrics Center... The University of Chicago's Section of Geriatrics announced the following geriatrician promotions: **Greg A. Sachs, MD** to Professor of Medicine; **Stacie Levine, MD** to Assistant Professor of Medicine; **Don Scott, MD** to Assistant Professor of Medicine; and **Joe Shega, MD** to Assistant Professor of Medicine... **Ricardo Salinas, MD** has been appointed Chief to the inaugural Centro Regional Para El Estudio Del Adulto Mayor in Monterrey, Mexico... WaveNY Care Network in New Canaan, CT, has appointed Dr. **Barney Spivack, MD, FACP, AGSF** to the position Director of Medical Services... Two years of additional funding have been awarded to **Lawrence J. Weiss, MD** and **Steven L. Phillips, MD** through the Task Force for a Healthy Nevada to further develop and implement a statewide Geriatric Resource Team.

## Call for Volunteers for AGS Committees

Members volunteering for committee service must submit a letter of interest indicating why you would like to volunteer to serve on a particular committee, as well as recommendations from two current Board and/or committee members. Please send supporting documents and your CV to the attention of Julie Pestana at [jpestana@americangeriatrics.org](mailto:jpestana@americangeriatrics.org) at the AGS office by November 1, 2004 for the 2005-2008 term of committee service.

Volunteer committee members are asked to serve a three-year term, beginning in May. Appointments will be made at the end of February. Newly appointed committee members are expected to attend the May 2005 committee meetings in Orlando, FL.

## DYER ELECTED COSAR CHAIR

Carmel Dyer, MD was recently elected the new Co-Chair of COSAR. A member of the Texas Geriatrics Society (TGS) for over six years and an AGS member for over a decade, Dr. Dyer has served on the TGS Board of Directors and as President of the TGS.

Through her work at the local level as the COSAR representative for Texas for the last two years, Dr. Dyer understands the importance of grassroots efforts and is a welcome addition to COSAR and the AGS Board of Directors.

## AGS Congratulates Fellows

The following members have been awarded fellowship status in the American Geriatrics Society:

**Kyle R. Allen, DO**  
**Adnan Arseven, MD**  
**Richard Gordon Bennett, MD**  
**William J. Burke, MD**  
**Edward A. Christy, MD, CMD**  
**Andrew Neal Dentino, MD**  
**Amy R. Ehrlich, MD**  
**G. Paul, Eleazer, MD, FACP**  
**Jeffrey E. Escher, MD**  
**Bruce A. Ferrell, MD**  
**Moira Fordyce, MB, ChB, MD, FRCP**  
**Ihab M. Hajjar, MD, MS**  
**Victor H. Hirth, MD, MHA, CMD, FACP**

**Donna J. Jacobi, MD, CMD**  
**Vicki T. Lampley-Dallas, MD, MPH**  
**Bruce A. Leff, MD**  
**Sharon A. Levine, MD**  
**Robert M. McCann, MD, FACP**  
**Laura Mosqueda, MD**  
**Elizabeth A. O'Keefe, MD**  
**Barney S. Spivack, MD, CMD, FACP**  
**Richard G. Stefanacci, DO, MGH, MBA, CMD**  
**Daniel Lee Swagerty, Jr., MD, MPH**  
**Margaret J. Wallhagen, PhD, RNCS**  
**Leslie Saltzstein Wooldridge, GNP**  
**Gwen Yeo, PhD**

Fellowship is awarded to members who have demonstrated sustained professional commitment to geriatric medicine, contributed to the progress of geriatric care and are active participants in Society activities. If you would like to know more about applying for AGS fellowship please contact the Membership Department at 212-308-1414

## UNIVERSITY OF PITTSBURGH

Ranked among the nation's top universities in both NIH funding and quality of care, the University of Pittsburgh seeks faculty for several positions in aging:

- **Researchers (especially in outcomes-based research)**
- **Director of Education**
- **Director of Home-Based Primary Care**
- **Geriatrics Section Chief at the adjacent Pittsburgh VA**
- **Clinician educators**

These faculty will join a Division designated as a National Center of Excellence in Geriatrics and comprising two dozen fellowship-trained geriatricians. Collaborative opportunities abound. The University currently has more than \$140 million in extramural support devoted to geriatric research, with major foci in aging epidemiology, stroke, heart disease, oncology, osteoporosis, mobility and falls, pain, sarcopenia, sleep disorders, caregiver stress, voiding dysfunction and incontinence, prostate cancer, rehabilitation, and palliative care.

In addition, the university has an integrated health system comprising all levels of care, from population-based to institutionalized. One of the country's largest such enterprises, it affords unique opportunities to develop and evaluate innovative new care models, one of which will actually be deployed by UPMC as a new Medicare HMO product.

The university also has multiple federally-funded Centers of Excellence. In addition to new NIH-funded Cancer and Aging and "Pepper" Centers, it has centers in Alzheimer's Disease (ADRC), Pneumonia (AHRQ-PORT), GRECC, GEC, Healthy Aging (CDC's only such center), Health Care Research, Late Life Mood Disorders, Chronic Disease, and several more at its School of Public Health (Health ABC, Cardiovascular Health Study, Study of Osteoporotic Fractures, etc). NIH-funded investigators also include experts in policy, health services, economics, ethics, law, nursing, and anthropology, as well as occupational and physical therapy. Many collaborative opportunities are also possible with RAND-Pittsburgh, as well as with adjacent Carnegie Mellon University in high tech medicine, informatics, artificial intelligence, and robotics. Pittsburgh is routinely included in lists of America's best and most affordable places to live.

The Director of Education will oversee an extensive portfolio that spans every level from undergraduate to CME, including innovative programs in which students and residents "major" in geriatrics. The fellowship is a 2-year academic program that includes masters programs in research, informatics, or education. Interest in further innovation is desirable.

The Home Care service is an integral component of our vertically-integrated continuum of care and it offers ample opportunity for growth as well as the possibility to develop innovations as part of UPMC's new geriatric care model.

**For further information, contact:**

**Neil M. Resnick, MD**  
**Professor and Chief, Division of Geriatric Medicine**  
**Director, University of Pittsburgh Institute on Aging**  
**3471 Fifth Avenue, Suite 500, Pittsburgh, PA 15213**

## Student Researchers *(Continued from p. 1)*

These young, talented students were grateful to the Foundation for Health in Aging for the providing them with an opportunity to present their research at a special student poster session. Several of this year's stipend recipients spoke with the *AGS Newsletter* staff about their experiences.

**Peggy Mannon Cawthon** is a candidate for a PhD in epidemiology at the University of California at Berkeley. She called the 2004 meeting "an exciting opportunity to present data from my dissertation and network with others who are interested in aging research." She very much enjoyed the student poster session, where she had the chance to meet other students and their advisors. "As an epidemiologist, I don't often have the chance to interact with medical students and physicians, and it was helpful to see this field from another angle. The travel stipend allowed me to attend every day of the conference. I look forward to attending AGS conferences in the future."



**Thomas A. Leeson** is attending the University of New England College of Osteopathic Medicine, where he is pursuing a Doctorate of Osteopathy. The Student Researcher Fund was instrumental in helping him attend the AGS Annual Meeting. "I was able to present my AFAR-supported research, for which I won the Presidential Poster Session award for surgery in elderly patients. Without the financial support of the fund, I would not have gained the experience of presenting my poster and receiving a great deal of constructive critique and support from AGS attendees, nor the opportunity to network with fellow students, and future colleagues."

**Jonathan Austrian** is pursuing his MD at Weill Cornell Medical College. "Participating in the AGS conference was a wonderful finale to the AFAR/Hartford/Samuels foundation research experience," he stated. "It was rewarding to share my findings with experts in my research area and feel like I am contributing, in a small way, to the geriatrics research community." Austrian said that the poster session discussions provided invaluable feedback that he integrated into his final research manuscript.

The AGS Foundation for Health in Aging Student Researcher Fund, established in 2003, provides students an opportunity to meet and learn from leaders in geriatrics and offers those same leaders a chance to share their enthusiasm for geriatrics with the next generation of care providers. The fund is supported by donations from AGS members, corporations, and foundations and proceeds from *An Evening with Friends*, an annual event that features the diverse talents of AGS leaders. This year, the Foundation is particularly grateful to the Donald W. Reynolds Foundation for its support of *An Evening with Friends*.

Look for information on the 2005 *Evening with Friends* in Orlando in the coming months. Also, if you would like to support our students now, please make a donation to the FHA Student Researcher Fund online at [www.healthinaging.org/donate](http://www.healthinaging.org/donate) or call Sara Reinthaler at (212) 308-1414.

### *GCCMA (continued from p.1)*

Under the bill, providers would conduct billable geriatric assessments of a beneficiary's medical condition, functional and cognitive capacity, primary caregiver needs and environmental and psychosocial needs. Physicians and certain health professionals would be able to seek compensation for care management services. These services include everything from development of a care plan to telephone consultations to patient and family caregiver education.

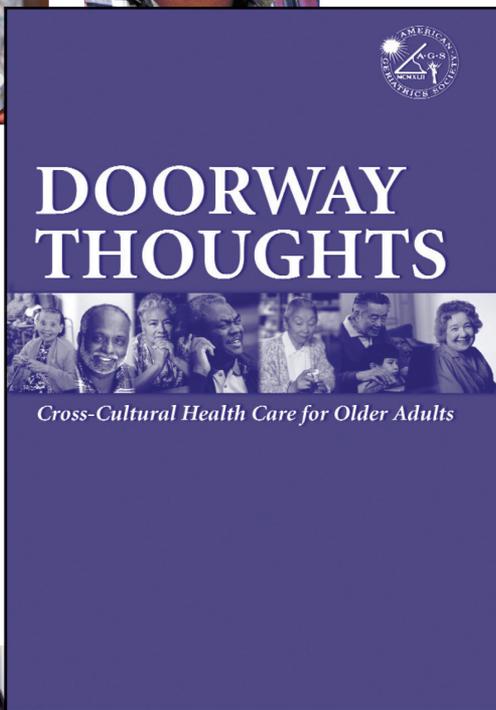
According to Connecticut Geriatrics Society COSAR representative and former COSAR co-chair Barney Spivack, MD, "When you think of how important these services are to our patients with multiple and overlapping chronic conditions, and how many of us and our colleagues perform these services at no cost to Medicare despite the burden they impose in time and resources, it is clear that this legislation is long overdue."

The bill also highlights problems with the vendor-based chronic care improvement program (CCIP) included the Medicare Prescription Drug, Improvement and Modernization Act last year. According to AGS President Meghan Gerety, MD, "One of the central tenets of disease management—patient self education and management—fails to take into account the critical needs of patients with dementia." Alzheimer's is recognized as a unique variable in the legislation.

## Board Nominations Sought for 2005-2008 Term

The AGS is accepting nominations **two open seats Board of Directors for the 2005-2008 term**. Members are asked to send letters of nomination to the AGS office by **November 1, 2004**. Nominees should have a demonstrated commitment to the field of geriatrics and to the Society through experience on AGS committees or related activities. A nominee's professional responsibilities should be considered in relation to the amount of time he or she will have available for active participation in Board and Society activities. Board terms are three years, with the possibility of re-election for a second three-year term. Members will be asked to serve on standing Society committees, are required to attend all regularly scheduled Board meetings and meetings of the committee(s) on which they serve and must review all agendas prior to the meetings. The Nominations Committee strives to have balanced representation from all geriatrics health care professions and from a variety of practice settings (e.g., community-based, long-term care, academia). Geographical distribution of Board members is also considered. The Society encourages nominations of women and minorities. In accordance with the revised bylaws, the Nomination Committee will select two candidates for each position on the Board. Candidates will be voted on by the entire AGS membership through a mail-in ballot, prior to the May 2005 Annual Meeting. **To submit a nomination or receive more information, contact Julie Pestana at [jpestana@americangeriatrics.org](mailto:jpestana@americangeriatrics.org).**

# Announcing...



**A new publication to help health care professionals better prepare to care for older adults**

*Doorway Thoughts: Cross-Cultural Health Care for Older Adults*

American Geriatrics Society  
Reva Adler, MD • Hosam Kamel, MB

© 2004 • 128 pages • Softcover  
ISBN: 0-7637-3338-5

*Doorway Thoughts: Cross-Cultural Health Care for Older Adults*

addresses the role of ethnicity in health decision-making in America. This book focuses on how clinicians caring for older adults can develop an understanding of different ethnic groups in order to effectively care for their patients. Chapters in this volume, which is the first in a series, address cross-cultural health care for older adults who are from one or more minority groups, including:

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- Asian Indian Americans
- Chinese Americans
- Hispanic Americans
- Japanese Americans
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