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AGS News

American Geriatrics Society Newsletter

Geriatrics Fellowship Recruiting Series: Field-tested Strategies that Work

When Carrie Hoarty, MD, began her residency at the University of Nebraska Medical Center (UNMC) in Omaha, she wasn't sure what career path she'd ultimately pursue. "I was open to practicing any kind of medicine," she recalls. Now in her final year of residency, she's narrowed her choices to one: Next fall she starts a geriatrics fellowship at UNMC.

Dr. Hoarty's choice is an unusual one these days. Despite the rapidly growing number of older Americans—and the growing shortage of geriatricians in the US—about half of the nation's geriatric fellowship slots go unfilled. During the 2006–2007 academic year, just 54% of first-year fellowship positions in geriatrics were filled, compared with 99% of fellowship slots in dermatology and 98% in orthopedics.

According to a September *Journal of General Internal Medicine* study examining pay disparities among specialties, inadequate Medicare reimbursement is a leading disincentive to pursuing a continued on **page 7**

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To Packed House, Henderson Award-Winner Linda Fried, MD, Delivers State-of-Art Lecture on Frailty

Oscar Einzig Photography

Linda Fried, MD was named the American Geriatrics Society's 2008 Henderson State-of-the-Art Awardee at the Annual Scientific Meeting in Washington, DC

Growing evidence suggests that frailty is a distinct clinical syndrome resulting from diminished function across multiple physiologic systems that heightens vulnerability to stressors and, ultimately, risks of morbidity and mortality, Linda Fried, MD, told the crowd of healthcare professionals who gathered for AGS' annual Henderson State-of-the-Art Lecture in May. The lecture was among the highlights of the Society's 2008 Annual Scientific Meeting.

The Dean of Columbia University's Mailman School of Public Health and one of the world's leading experts on frailty, Dr. Fried is the Society's 2008 Henderson State-of-the-Art Award recipient. Named for the late Dr. Edward Henderson, who was instrumental in establishing the field of geriatrics, the award recognizes an individual whose research helps healthcare providers better understand and respond to problems inherent in caring for older people.

Frailty appears to be a definable clinical syndrome, associated with increased risks of falls, delayed recovery from illness, disability, hospitalization, and mortality, and is prevalent among older adults, particularly those older than 75.

"Frailty has been considered the core, even the raison d'etre, of geriatric medicine," Dr. Fried noted during her lecture.

Several different approaches have been developed to characterize frailty. But a growing body of research suggests that frailty is a distinct physiologic state of diminished function across multiple physiologic systems, she explained. A range of studies have linked frailty to systems dysfunctions, as manifested by diminished heart rate variability and immune function, low testosterone and IGF-1 levels, and elevated cortisol, insulin and glucose levels, among other things. Older adults with signs

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From the President

As I sat down to write this column, Congress had just overridden a Presidential veto of legislation rescinding the 10.6% Medicare physician fee cut that was to take effect July 1. Congress had earlier voted in favor of the legislation, which stabilizes payments for the rest of 2008, and offers a 1.1% increase in 2009. But President Bush—who had vowed to veto the measure because it offsets the cost of deferring the cut by trimming payments to private Medicare Advantage plans—made good on that promise, necessitating the Congressional override.

The override was good news for physicians who treat Medicare beneficiaries and for older Americans. In an American Medical Association (AMA) survey, 60% of participating physicians had reported that the cut would make caring for beneficiaries so financially untenable that they would be forced to stop accepting new Medicare patients. AGS applauds the Senate and Congress for their override, and the many Society members and other advocates for quality elder healthcare who joined its advocacy campaigns on behalf of the measure.

The newly approved fee fix, however, is only a stop-gap solution. We'll face yet another cut next year—unless Congress takes steps to overhaul or replace the highly controversial Sustainable Growth Rate (SGR) formula that has mandated the fee cuts year after year. But even that, alone, won't be enough. As I argued in my previous column, what the US needs is nothing short of sweeping, system-wide healthcare reform. With Medicare expenditures continuing to rise, and the country teetering on the edge of the coming Age Boom, projections are that Medicare will be bankrupt by 2018. That's a mere decade away. We're at a turning point. And we—each and every one of us—need to play active roles in efforts to reform the healthcare system, making it both more effective and more cost-effective.

AGS has played and continues to play an active part in efforts toward meaningful health system reforms. It has long advocated for fundamental changes in the way the Centers for Medicare and Medicaid Services (CMS) determines payment rates for physicians. In a recent letter to CMS regarding the fee schedule, it once again urged the agency to address flaws in the SGR methodology. The formula mandates cuts in physician pay when increases in Medicare outlays for these services exceed growth in Gross Domestic Product, but, inexplicably, includes rising expenditures for medications in the calculation of outlays. In its letter, AGS argues that CMS has the administrative discretion to remove drug outlays from the calculus of the SGR, and should do so immediately.

As a September study in *The Journal of General Internal Medicine* makes perfectly clear, current Medicare payment policies contribute to vast income disparities between geriatricians and higher compensated specialists—and, as a result, to the growing and near-critical shortfall of geriatricians in the US. "Ironically, Medicare's priority population, the elderly, is vastly underserved in part because of Medicare's own payment policies," conclude the authors, who advise government officials to "narrow inter-specialty income differentials by aligning billing codes and fee schedules with the amount of time physicians actually spend providing and coordinating care."

The Geriatric Assessment and Care Coordination (GACCC) Act, now before Congress, would take a step in this direction by authorizing Medicare coverage of geriatric assessment and care coordination for beneficiaries with multiple chronic conditions. The AGS—which has long argued that provider reimbursement should take into account differences in the complexity of patients' healthcare needs—and other elder healthcare advocates continue to urge legislators to support the Act. The Society is also working with other organizations to advance the related concept of the patient-centered "medical home."

The Institute of Medicine's (IOM's) watershed report, "Retooling for an Aging America: Building the Healthcare Workforce," makes key recommendations for preparing the nation for the imminent Age Boom, including many that AGS has been promoting in recent years. Among other things, the report calls for loan forgiveness for those pursuing careers in geriatrics healthcare professions, and for expanded training for those caring for older patients—initiatives for which the Society has long advocated. AGS has been working with the John A. Hartford Foundation, the Atlantic Philanthropies, and the Meridian Institute to establish a broad alliance to move the IOM recommendations forward. Organizations that have been participating in initial planning sessions for the alliance include AARP, the American College of Physicians (ACP), and the American Academy of Family Practice.

In keeping with the strategic plan that the Society's Board adopted in May 2006, AGS has also been working to bring together

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Small Medical School in State With Large Elderly Population Tapped for Innovative Geriatrics Education Program

Marshall University's Joan C. Edwards School of Medicine, in Huntington, West Virginia, is a small medical college with limited resources, but a strong commitment to meeting the healthcare needs of a state with a large number of older residents.

So when Shirley Neitch, professor of medicine and chief of the school's sections of geriatrics and general internal medicine, heard about the Chief Resident Immersion Training in the Care of Older Adults (CRIT) demonstration project, she rushed to apply.

"I knew immediately upon reading the description that CRIT would be of enormous potential value to us," says Dr. Neitch.

The innovative demonstration project—which launched last year with five medical schools participating—trains chief residents to diagnose and treat health problems common among older adults, and to better prepare the medical students and residents who they supervise to do the same. The program also aims to encourage positive attitudes toward caring for the aging, foster leadership and teaching skills, and improve collaboration among the specialties and subspecialties involved in elder care.

This past June, the Association of Directors of Geriatrics Academic Programs (ADGAP)—which administers the project—announced the names of four new medical schools selected to participate in the second round of CRIT. The four are the Medical College of Wisconsin, and the medical schools at Yale, the University of Cincinnati—and Marshall.

"We were thrilled!" Dr. Neitch says.

Training healthcare professionals to meet the unique healthcare needs of older adults is a growing priority nationwide—and a particular challenge in West Virginia. The Mountain State is one of the nation's "oldest." It ranks close to the top for both median age and percentage of population over 65. Unfortunately, older adults in West Virginia also rank near the bottom on a number of key measures of health.

West Virginia is considered a rural state—with more than half of its population living in what the Census Bureau classifies as rural areas. And Marshall's medical school, founded in 1977, has, from the start, been committed not only to recruiting students from rural parts of West Virginia, but also to placing graduates in clinical practice in the region. The majority of the roughly 50 medical students Marshall graduates each year pursue careers in primary care. Given the high percentage of older West Virginians, Dr. Neitch and her colleagues had long recognized the pressing need to ensure that all of their trainees know how to care for older adults—who are likely to make up a sizeable share of their patients.

Marshall has several significant geriatrics training resources, including its Hanshaw Geriatric Center. An ambulatory care facility, the center offers geriatric evaluations and primary care for older patients. Marshall is

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Get Ready For 2009 in Chicago April 29–May 3

Call for Abstracts for AGS' 2009 Annual Meeting

To submit an abstract for AGS' 2009 Annual Scientific Meeting—slated for April 29–May 2 in Chicago—use AGS' online abstract submission site at www.americangeriatrics.org. Paper submissions will not be accepted.

The site will open September 22. The submission deadline is December 2.

Recognize a Colleague for Work in Geriatrics Education, Research and Training; Nominate Someone for a 2009 Award

On September 22, 2008, AGS will begin accepting YOUR nominations for its 2009 Annual Awards Program. Recognize a colleague for her/his outstanding work in geriatrics education, research and clinical practice. Awards are presented during the 2009 annual meeting, which is slated for April 29 to May 2.

AGS is seeking nominations for the following national awards:

- Clinician of the Year Award
- Clinical Student Research Award
- Dennis W. Jahnigen Memorial Award
- Edward J. Henderson Student Award
- New Investigator Awards*
- Scientist-in-Training Research Award
- Student Research Award*
- Outstanding Scientific Achievement for Clinical Investigation Award

The deadline for nominations is December 2. For further information about the awards, nominee qualifications, and the nominations process, visit the AGS Web site at www.americangeriatrics.org on or after September 22, or contact Dennise McAlpin at (212) 308-1414 (phone); (212) 832-8646 (fax) or dmcalpin@americangeriatrics.org.

*Applications for these awards must be submitted with an abstract for AGS' 2009 Annual Scientific Meeting. Use AGS' online abstract submission site at www.americangeriatrics.org, starting September 22. The abstract submission deadline is also December 2.

SAVE THE DATE!

AGS FOUNDATION FOR HEALTH IN AGING LIFETIME OF CARING GALA TO BENEFIT FOUNDATION

WHAT: The AGS Foundation for Health in Aging's Ninth Annual Lifetime of Caring Gala. The Gala supports the FHA's vital work—advocating for older adults and their special healthcare needs; supporting elder health research; and providing public education programs for older people and their caregivers

WHEN: January 28, 2009

WHO: The FHA's 2008 *Lifetime of Caring Award* will be presented to **Robert Butler, MD**, President and CEO of the International Longevity Center, who has dedicated his life and work to the health of the aging. Dr. Butler is the founding director of the National Institute on Aging of the National Institutes of Health, as well as the nation's first department of geriatrics, at Mount Sinai School in New York City. He was the principal investigator of one of the first interdisciplinary, comprehensive, longitudinal studies of healthy, community-living older adults, a landmark study finding that many things attributed to old age are in fact a function of disease and socioeconomic and other factors. He was awarded the Pulitzer Prize for his landmark *Why Survive? Aging in America*, has co-authored several other books on aging and health, and more than 300 medical and scientific articles. The *Lifetime of Caring Award* recognizes significant contributions to the care and well-being of older adults, and individuals whose life and work are testimony to the potential for extraordinary creativity, accomplishment and validity throughout life.

The FHA's *Impact Award* will be presented to **Evercare** for its role as a leader in geriatric healthcare and for its significant contributions to improving the health of older persons and enhancing their quality of life. Among other things, Evercare's pioneering Care Model provides highly individualized care for nursing home residents and community-dwelling older adults who have special needs due to chronic illness or disability. Evercare's advocacy efforts on behalf of preventive care and a culture of care that values older persons are an inspiration. Evercare Chairman **John Mach, MD**, will accept the award *Impact Award*, which recognizes organizations that have helped empower older adults and caregivers and support successful aging.

WHERE: The Plaza, Fifth Avenue and Central Park South, New York City

HOW: For further information, including information on purchasing tickets or tables at the FHA's Ninth Annual Lifetime of Caring Gala, please contact Li-Chia Ong at the FHA by email at long@americangeriatrics.org or by telephone at (212) 308-1414.

New Feature: Clinical Practice Corner

A new periodic feature for the AGS Newsletter, the AGS Clinical Corner highlights AGS Clinical tools that are available to our members for free. AGS members can download a pdf of these tools at www.americangeriatrics.org/myags.

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DEMENTIA

A POCKET GUIDE to DEMENTIA TREATMENT

From THE AMERICAN GERIATRICS SOCIETY

An estimated 5.2 million Americans have Alzheimer's Disease in 2008. The prevalence of Alzheimer's Disease and other dementias will continue to increase with the rapid growth of our older population. Managing these complex conditions can be a challenge for busy healthcare professionals. The American Geriatrics Society (AGS) is pleased to make this convenient pocket card on the Diagnosis and Treatment of Dementia available to healthcare providers and trainees who care for older adults.

The information in this card is based on two acclaimed AGS publications. *Geriatrics At Your Fingertips®* is a convenient, pocket-sized guide to the evaluation and management of diseases and disorders that most commonly affect older people. *The Geriatrics Review Syllabus: A Core Curriculum in Geriatric Medicine* is a comprehensive text for those who wish to expand and update their knowledge in the field.

The AGS is a nationwide, non-profit association of healthcare professionals dedicated to improving the health, independence and quality of life for all older people. The AGS has a diverse, multidisciplinary membership of healthcare professionals, researchers, educators, administrators and students. For more information on the AGS, its publications and membership benefits, please go to www.americangeriatrics.org or call 800-247-4779.

This pocket card is made available by an unrestricted education grant from Forest Laboratories.

Table 2. Guidelines for Pharmacologic Treatment of Agitation

Symptom	Medication and Usual Dosing
Agitation in context of nonacute psychosis	Risperidone[1] (*Risperdal*) 0.25–1.5 mg/d
	Olanzapine[1] (*Zyprexa, Zyis*) 2.5–10 mg/d
	Quetiapine[1] (*Seroquel*) 25–400 mg/d
	Aripiprazole[1] (*Abilify*) 5–10 mg/d
Agitation in context of acute psychosis (IM, IV needed)	Haloperidol[1] (*Haldol*) 0.5–2 mg/d[2]
Agitation in context of depression	SSRI, eg, citalopram (*Celexa*) 10–30 mg/d
Anxiety, mild to moderate irritability	Trazodone (*Desyrel*) 50–100 mg/d[3]
	Buspirone (*BuSpar*) 30–60 mg/d[4]
Alternative treatment for significant agitation or aggression	Divalproex sodium (*Depakote, Epival*) 500–1500 mg/d[5]
	Carbamazepine (*Tegretol*) 300–600 mg/d[6]
	Olanzapine (*Zyprexa IntraMuscular*) 2.5–5 mg IM[1]

[1] Greater mortality and cerebrovascular events than placebo; use with particular caution in patients with cerebrovascular disease or hypovolemia.
[2] Higher dosages may be needed in emergency situations; use for only short periods of time.
[3] Small divided daytime dosage and larger bedtime dosage; watch for sedation and orthostasis.
[4] Can be given q 12 h; allow 2–4 wk for adequate trial.
[5] Can monitor serum levels; usually well tolerated; check complete blood count (CBC), platelets for agranulocytosis, thrombocytopenia risk.
[6] Monitor serum levels; periodic CBCs, platelet counts secondary to agranulocytosis risk. Beware of drug-drug interactions.

FDA Advisory Information on Atypical Antipsychotics

In 17 randomized, controlled trials in which 5106 older adults with dementia-related behavioral disorders were enrolled, the risk of death in the drug-treated patients was 1.6–1.7 compared with that of the placebo group. Treatments consisted of *Zyprexa* (olanzapine), *Abilify* (aripiprazole), *Risperdal* (risperidone), or *Seroquel* (quetiapine). These trials averaged about 10 weeks. The rate of death was about 4.5% in drug-treated patients and about 2.6% in the placebo group. Most of the deaths appeared to be either cardiovascular (eg, heart failure, sudden death) or infectious (eg, pneumonia) in nature.

CAREGIVER ISSUES AND RESOURCES

Maintaining the health and well-being of caregivers is essential for effective treatment of dementia patients. Over 50% of caregivers develop depression. Physical illness, isolation, anxiety, and burnout are common. Intensive education and support of caregivers may delay institutionalization of patients with dementia. Adult day care for patients and respite services for caregivers may help.

- Alzheimer's Association (www.alz.org) offers support and education; chapters are located in major cities throughout US.
- Family Caregiver Alliance (www.caregiver.org) offers support, education, and information for caregivers.

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REFERENCES

Barton C, Small GW, Yaffe K. Dementia. In: Pompei P, Murphy JB, eds. *Geriatrics Review Syllabus: A Core Curriculum in Geriatric Medicine.* 6th ed. New York: American Geriatrics Society; 2006:221–230.

Lantz MS, Lyketsos CG. Behavioral problems in dementia. In: Pompei P, Murphy JB, eds. *Geriatrics Review Syllabus: A Core Curriculum in Geriatric Medicine.* 6th ed. New York: American Geriatrics Society; 2006:231–238.

For more information on the American Geriatrics Society publications *Geriatrics At Your Fingertips* and the *Geriatrics Review Syllabus*, please visit www.geriatricsatyourfingertips.org

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TREATMENT

Primary goals are to improve quality of life and maximize functional performance by enhancing cognition and addressing mood and behavior.

General Treatment Principles

- Identify and treat comorbid physical illnesses (eg, hypertension).
- Promote brain health by exercise, balanced diet, stress reduction.
- Avoid anticholinergic medications, eg, benztropine, diphenhydramine, hydroxyzine, oxybutynin, tricyclic antidepressants, clozapine, thioridazine.
- Limit use of as-needed psychotropic medications.
- Institute stroke prophylaxis for vascular and mixed dementias.
- Maximize activities of daily living (ADLs) and exercise (eg, walking).
- Establish and maintain relationship with patient and family.
- Assess and monitor cognition, mood, and behavior.
- Monitor physical environment for safety (eg, stairs).
- Advise patient and family about driving, sources of support, financial and legal issues, and advance directives, including establishing surrogate decision maker.

Nonpharmacologic Approaches

Advise caregiver(s) to:

- Use scheduled toileting and prompted toileting for incontinence.
- Offer graded assistance (as little help as possible to perform ADLs), role modeling, cueing, and positive reinforcement to increase independence.
- Avoid adversarial debates; try to redirect conversation instead.
- Use services of caregiver support groups (*see last panel*).

Pharmacologic Treatment of Cognitive Dysfunction

Patients with mild or moderate Alzheimer's disease (AD) should receive a cognitive enhancer (**Table 1**). Because the effects of treatment cannot be fairly evaluated until the patient has been on a cognitive enhancer for some time, caregivers should commit to a trial treatment period of at least 3 months before the medication is started. In controlled trials, modest symptomatic benefit for cognition, mood, behavioral symptoms, and daily function was seen in patients with AD treated for 1 year with cholinesterase inhibitors versus placebo; open trials demonstrated benefit for 3 yr. Only 10%–25% of patients taking cholinesterase inhibitors show clinical improvement, but 80% have less rapid decline. Initial studies have shown benefits of these medications for patients with dementia associated with Parkinson's disease, Lewy body dementia, and vascular dementia. These drugs may attenuate noncognitive symptoms and delay nursing-home placement. Memantine (*Namenda*) demonstrated modest efficacy compared with placebo in moderate to severe AD as monotherapy and when combined with donepezil (*Aricept*).

Table 1. Cognitive Enhancers

Donepezil (*Aricept*)[1]	Start at 5 mg/d, increase to 10 mg/d after 1 mo
Galantamine (*Razadyne*)[1, 2]	Start at 4 mg q 12 h, increase to 8 mg q 12 h after 4 wk; recommended dosage 8 or 12 mg q 12 h
Extended release (*Razadyne ER*)	Start at 1 capsule daily, preferably with food; titrate as above
Rivastigmine (*Exelon*)[1]	Start at 1.5 mg q 12 h and gradually titrate up to minimally effective dosage of 3 mg q 12 h; continue up to 6 mg q 12 h as tolerated; for patch, start at 4.6 mg/d, may be increased after ≥4 wk to 9.5 mg/d (recommended effective dosage): retitrate if medication is stopped
Memantine (*Namenda* [NMDA antagonist])[3]	Start at 5 mg/d, increase by 5 mg at weekly intervals to max of 10 mg q 12 h; reduce dosage if kidney function impaired

[1] Cholinesterase inhibitors. FDA labeling for AD is as follows: donepezil—mild, moderate, severe; galantamine—mild, moderate; rivastigmine—mild, moderate. Continue if patient improves or stabilizes; stopping medication can lead to rapid decline. Adverse events increase with higher dosage. Possible adverse events include nausea, vomiting, diarrhea, dyspepsia, anorexia, weight loss, leg cramps, bradycardia, insomnia, and agitation.
[2] Increased mortality found in controlled studies of mild cognitive impairment.
[3] Approved by FDA for moderate to severe AD. Possible adverse events include dizziness, headache, somnolence. NMDA = N-methyl-d-aspartate.

Evaluation of Response to Any Cognitive Enhancer

- Elicit caregiver observations of patient's cognitive function and behavior (alertness, initiative) and follow functional status (ADLs and instrumental ADLs).
- Follow cognitive status (eg, improved or stabilized) by caregiver's report or serial ratings of cognition (eg, Mini-Cog).

Treatment of Agitation

- First, identify and examine context of behavior (is it harmful to patient or others?), environmental triggers (eg, overstimulation, unfamiliar surroundings, frustrating interactions).
- Are delusions or hallucinations interfering with function?
- Exclude underlying physical discomfort (eg, illnesses or medications).
- Consider nonpharmacologic strategies.
- Select pharmacologic agent on the basis of symptoms (**Table 2**).
  - Cognitive enhancers may slow deterioration, and agitation may worsen if they are discontinued.
  - Low dosages of antipsychotic medications have a limited role but may be necessary at times. Note: this use is "off label"; use in AD patients has a BLACK BOX warning because the risk of death was higher with drug treatment than with placebo in clinical trials. Risk–benefit must be discussed with both patients and caregivers before starting treatment. In the CATIE-AD trial (*NEJM* 2006;355:1525–1538), modest treatment with atypical antipsychotics showed no significant benefit (p=0.22). Olanzapine, risperidone, and quetiapine had marginally higher response rates (32%, 29%, and 26%, respectively) than placebo (21%). Response was mitigated by greater extrapyramidal symptoms, sedation, and confusion in the treated groups.

Fellowship Recruiting Series: Field-tested Strategies that Work

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career in geriatrics. In 2006, when the median salary for a dermatologist in private practice was $335,899, it was $161,888 for a geriatrician.

But geriatrics offers unique satisfactions and opportunities as well. And these are what faculty at UNMC and other medical schools are making a concerted effort to share with their residents. Among other things, they're stepping up mentoring efforts, encouraging residents to both develop and submit posters and papers for presentation at annual scientific meetings devoted to health in aging, and attend these meetings.

Among the first things Dr. Hoarty mentions when asked why she decided to buck the trend and become a geriatrician, are her experiences with her mentor and at the AGS' annual meeting.

"Jane Potter has been a mentor for me throughout medical school and that's been very important," she says, referring to Jane Potter, MD, professor and chief of the section of geriatrics and gerontology at the school, and a member of AGS' Recruitment Subcommittee. The encouragement and efforts of other geriatrics faculty, including Cheryl Hinners, MD, Edward Vandenberg, MD, and UNMC geriatric fellowship program director William Lyons, MD, also played a role. Among other things, Dr. Hoarty notes, Drs. Potter, Hinners and Vandenberg sent her to AGS' Annual Scientific Meeting in Seattle in 2007.

"And that was a phenomenal experience," she explains. "Everyone was so enthusiastic about geriatrics and I learned so much more about it. After that I met with Drs. Potter and Lyons and was ready to sign on the dotted line."

UNMC's geriatrics fellowship "fill rate" is above average for the nation—both of the two slots available will be filled this year. "We were also able to mentor and encourage a third resident who had to leave the area and will join a fellowship program in Texas," Dr. Potter adds.

Mentoring, Dr. Potter notes, is UNMC's most successful strategy, and it starts early. Geriatrics faculty in the medical school's internal and family medicine departments regularly review incoming residents' personal statements, looking for any mention of an interest in geriatrics or the aging. They then call those who've expressed even a passing interest, offer them the opportunities to work with a geriatrics mentor, to join the campus' geriatrics journals club, and attend the medical school's monthly research conferences, and the Nebraska Geriatric Education Center's annual geriatrics conference.

"Mentors provide regular contact," Dr. Potter explains. "They also offer assistance with the various projects residents have to complete." In clinic, for instance, a mentor might point out an older patient whose medical history would make a good case study. He or she might also advise a mentee on preparing and submitting a poster or paper about the case for inclusion in an upcoming conference. Mentors offer advice about fellowship opportunities and career counseling as well.

UNMC is currently expanding its recruitment efforts, working more closely with internal medicine and family medicine programs at schools like Creighton University, also in Omaha, where UNMC faculty provide geriatrics training. "One of our recent fellows came from Creighton because our faculty made contact early, when she was a resident, and mentored her," Dr. Potter adds. UNMC geriatrics faculty members are also planning to do more to encourage interested residents to attend AGS' annual meeting.

"The annual meeting is an extraordinary recruiting tool," Dr. Potter explains. "People go and experience the excitement in the field, learn about the great opportunities in geriatrics, meet others working in the field, and other residents considering it. This can cinch the decision to go into geriatrics."

Visit the web version of this story for UNMC top recruiting strategies as covered in this story. In the next edition of the newsletter, we will visit with Drs. Sandy Bellantonio and Maura Brennan at Baystate Medical Center to learn more about strategies they use to recruit residents into geriatrics fellowship. AGS has also implemented a number of national strategies to help with recruitment—these include free memberships for residents, support for resident chapters, a resident poster session at the AGS annual meeting, a resident special interest group and newsletter, and an annual mentoring program.

AGS Now Accepting Applications for Committee Membership

The AGS is now accepting applications for membership in nine of its committees.

These include the Clinical Practice and Models of Care, Education, Ethics, Ethnogeriatrics, Health Systems Innovation-Economics & Technology, Public Education, Public Policy, Quality and Performance Measurement, and Research committees.

Appointments will be made at the start of the new year and terms will begin during AGS' 2009 Annual Scientific Meeting, slated for April 29 to May 3 in Chicago. All terms run three years, finishing at the May 2012 meeting.

AGS members interested in committee membership should review information about these committees and their missions, at http://www.americangeriatrics.org/about/board_adv_comm.shtml#comm and information about committee member responsibilities, at http://www.americangeriatrics.org/membership/commresp.shtml.
Applicants should send Anne Marie Evriviades (aevriviades@americangeriatrics.org) the following by December 15:

- A completed online application form (found at www.americangeriatrics.org/get url)
- Two letters of support from current Board and/or committee members
- A 2-page biographical sketch or short CV

Henderson Award-Winner Linda Fried, MD, Delivers State-of-Art Lecture on Frailty

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Oscar Einzig Photography

Henderson Lecture attendees listen to Dr. Fried's frailty lecture.

of such dysregulation run an increased risk of frailty. Multi-system dysregulation, Dr. Fried said, may be associated with the diminished energy availability, complexity of function, and, finally, the ability to maintain homeostasis in the face of stressors such as illness and injury.

"Physiologic vulnerability may precede the onset of frailty," she added.

Certain core characteristics—including sarcopenia, lessened strength and exercise tolerance, slowed motor speed, diminished physical activity, and inadequate nutrient intake and weight loss—are widely considered hallmarks or manifestations of frailty. Research suggests that, like other syndromes, frailty follows a fairly predictable progression. This typically begins with a decline in walking speed or strength, followed by other manifestations of frailty, including declines in activity and loss of energy. Weight loss is usually a late-stage characteristic, Dr. Fried noted.

A number of studies, including the Cardiovascular Health Study—for which she is principal investigator—have found that older adults with three or more of these core characteristics of frailty run increased risks of falls, worsening disability, hospitalization and death. Other findings also suggest that higher numbers of these criteria of frailty are associated with worse outcomes.

"It's likely that the early stage of frailty, where you have one, two, or possibly three manifestations, would be most responsive to intervention," Dr. Fried noted. In light of this, screening older adults who are older than 75 or at increased risk of frailty for these core characteristics of the syndrome—particularly strength, exercise tolerance, and adequate nutrient intake—may be warranted. For adults at risk or with early manifestations of frailty, interventions targeting sarcopenia and undernutrition would also be warranted.

"We know that in the frail elderly, resistance exercise is highly effective in increasing muscle mass and strength, and we see greater effect with both exercise and nutritional supplementation," she added. Research into other potential interventions, including possible pharmaceutical approaches, is needed. Studies investigating the underlying causes of the multisystem dysfunctions that appear to set the stage for frailty are already underway.

American Geriatrics Society's 2008 Virtual Annual Meeting—Featuring Key Presentations from Premier Conference on Aging Research—Is Available Online

The American Geriatrics Society's (AGS) Virtual 2008 Annual Scientific Meeting—featuring 63 of the most popular sessions from the Society's April 30–May 4 annual meeting in Washington, D.C.—is available online for one year. You can access these virtual sessions—web casts of the highly diverse sessions include synchronized slides and audio—and earn CME. For additional sessions that are not Web cast, handouts are available.

The 2008 annual meeting can be accessed at http://www.capitalreach.com/rt/ags9800/. Those who attended the AGS Annual Meeting can access the entire virtual annual meeting for free, while non-attendees can purchase access to either the entire virtual meeting or to individual sessions.

2008–2009 Edition of *Geriatrics At Your Fingertips* for Handheld Devices Available This Fall

The 2008–2009 edition of *Geriatrics At Your Fingertips (GAYF)* for Pocket PCs and Palms debuts this fall. This will be the third update of the popular *GAYF* for handheld devices available for download from www.geriatricsatyourfingertips.org. This is a "must have" electronic reference for all healthcare providers who care for older adults.

The new PDA contains all the comprehensive information found in the annually updated print edition, with over 100 tables largely focused on the latest drug information and clinical guidelines. New sections on pulmonary artery hypertension, adverse events of atypical antipsychotics, and treatment of intolerable vasomotor symptoms in older women round out the latest edition.

GAYF for PDAs offers many unique features, including calculating equations for over 20 commonly used formulas; assessment instruments such as the ADL and IADL scales and the Performance-Oriented Mobility Assessment, which calculate responses; a browsable Table Contents, detailed Index, and simple Search Function; algorithms for a variety of evaluation and management approaches; bookmark and notepad sections; a "jump to" feature for quick navigation to subsections; and a footnote navigation button.

A brief tutorial on using *GAYF* for PDAs in the clinical setting can be downloaded from the *GAYF* Web site. A webcast tutorial session is also available on the American Geriatrics Society's Virtual Annual Meeting Website (www.americangeriatrics.org) and helps those using the PDA of *GAYF* apply this valuable resource in teaching sessions and patient care. The tutorial session can be accessed free of charge.

GAYF for PDAs is free for AGS student members and licenses are available for medical schools. For others, the cost is $23.95 for AGS members and $30.95 for non-members. "It was hard to imagine improvements, but the AGS and software developer USBMIS have done their jobs," pdaMD.com noted in a review of the 2005 edition. "The interface is really clean and aesthetically pleasing. You can search the index alphabetically or search the comprehensive table of contents. There is also a useful Tools tab that includes Abbreviations, Assessment Instruments, and Calculating Equations. *Geriatrics At Your Fingertips*…contains a wealth of information that is useful beyond the geriatric patient. It deserves a good trial in order to get used to all of the information it contains."

More Research Needed to Guide Palliative Care for Older Adults, Says Recipient of AGS' Outstanding Scientific Achievement for Clinical Investigation Award

Many older adults who need palliative care to ease pain and other symptoms still suffer without it, and both Medicare coverage and the knowledge base for palliative care for the aging are too limited, according R. Sean Morrison, MD, the recipient of the American Geriatrics Society's 2008 Outstanding Scientific Achievement for Clinical Investigation Award. Palliative care for older patients was the subject of AGS' 2008 Outstanding Scientific Achievement Award Lecture, which Dr. Morrison delivered during the Society's Annual Scientific Meeting this May.

"We're poorly treating pain in older patients," said Dr. Morrison, the director of the National Palliative Care Research Center, vice-chair for research at the Brookdale Department of Geriatrics and Adult Development, director of research at the Hertzberg Palliative Care Institute, and Hermann Merkin Professor of Palliative Care at the Mount Sinai School of Medicine in New York City.

Research suggests that the prevalence of significant pain in community-dwelling older people may be as high as 25% to 65%, according to Dr. Morrison. And as many as 80% of nursing home residents experience significant pain.

Because Medicare only covers hospice care for the last six months of life, however, many older adults suffering pain and other symptoms go untreated. Palliative care should not be restricted to the end of life, rather, it should be provided regardless of prognosis and simultaneously with other necessary treatment, including life-sustaining treatment, Dr. Morrison argued.

Among other things, providing palliative care regardless of prognosis improves outcomes and saves money, he noted. A recent abstract, presented at the European Association of Palliative Care, examining the cost implications of providing palliative care regardless of prognosis at eight U.S. hospitals found that such care resulted in an average savings of $1,500 per admission.

"Palliative care demonstrates that lower cost and higher quality do indeed go hand in hand and is beneficial for all patients with serious and life threatening illness, " Dr. Morrison reported, estimating that, for the average 300-bed hospital, providing such care when needed would result in savings of $1.3 million annually.

Palliative care is becoming more widely available. Between 2000 and 2006, for example, the number of U.S. hospitals offering palliative care services rose from 600 to 1,300. But investment in palliative care research still lags.

"We need more research in palliative care," Dr. Morrison said, emphatically. "If someone has high blood pressure, we have

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From the President

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other health and aging organizations with common interests and priorities. These efforts came to fruition on June 16 when AGS convened a meeting of representatives from organizations representing health professionals in the field of aging to identify common ground. Organizations sending representatives to the meeting included the American Medical Directors Association, the National Association of Directors of Nursing Administration, and the Gerontological Society of America. Attendees identified common areas of interest related to the IOM report and are currently identifying shared goals and strategies for achieving these.

At a recent American Medical Association (AMA) House of Delegates (HOD) meeting, AGS also proposed a resolution calling on the AMA to join specialty societies in reviewing the IOM report and drafting suggestions for supporting and helping implement key recommendations in "Retooling for An Aging America." The HOD adopted the resolution, and AGS looks forward to continued work with these organizations. The IOM report, with the weight of the highly respected institutes behind it, offers us a golden opportunity to generate needed momentum for systemic healthcare reform in this country.

Reaching out further, the Society has also been working with the Obama and McCain campaigns, to ensure that the Presidential candidates are familiar with the complex issues surrounding elder healthcare and Medicare, and with recommendations from the IOM and other sources. This outreach is absolutely critical. There's a good chance the next president will be in office for eight years, which means most of the remaining years of Medicare solvency (unless we start implementing sweeping reforms now).

As the editors of the *New York Times* wrote in a July 17 editorial about the Congressional override of the Bush veto of the Medicare pay cut-rescinding legislation, "This week's victory shows that with the right political strategy—and a sensible argument—Medicare reform is not only essential, it's also possible."

I agree wholeheartedly. It is most certainly possible. But I would argue that grassroots advocacy is also necessary to reform—right up there with good political strategy and sensible argument. Members and friends of AGS who joined the Society's campaigns on behalf of the pay cut legislation, and members of the AMA, AARP and other organizations that launched similar efforts, played essential roles in mobilizing votes for the override. We needed and will continue to need that kind of grassroots involvement as we pursue healthcare reform. And we look forward to further work in coalition with these organizations and others who share our priorities—including you.

Why I'm an AGS Member

John B. Murphy, AGS President, Professor of medicine and family medicine at Brown University's Warren Alpert Medical School and Chief Physician Officer at Rhode Island Hospital

There are many reasons why I'm a member of the AGS. I joined the organization 24 years ago and in terms of what it's meant for my career, it's been a place where I've developed great relationships with wonderful colleagues.

Among other things, these relationships have helped me maintain my passion for caring for older people, particularly at times when that's been difficult. Our current healthcare system creates many challenges for our field; financing has and continues to be a problem. But the relationships I've developed with colleagues have helped me stay passionate about caring for older adults—despite the low points we've had to deal with as a specialty.

AGS has also been a place where I've found many helpful resources, including educational products like *Geriatrics at Your Fingertips* and the *Geriatrics Review Syllabus*. The *Journal of the American Geriatrics Society* is also a tremendous resource—it's grown with the specialty and reflects how much we've grown our evidence base for what we do."

I've also enjoyed working with colleagues on some of these products—I've either been an editor or a member of the editorial board for all but the first of the six editions of the *Geriatrics Review Syllabus.* And I've enjoyed being involved in leadership in the AGS. I've been a member of the Education and Professional Education Executive committees, have been on the Board of Directors since 2003, and was Treasurer prior to becoming President in May. In these leadership roles, I've also enjoyed working with the AGS staff, which is very professional and responsive.

These are just a few of the reasons I'm an AGS member.

Small Medical School in State With Large Elderly Population Tapped for Innovative Geriatrics Education Program

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also home to a driving assessment clinic for older people, provides geropsychology services, and trains students and residents in three local nursing homes where faculty members serve as medical directors. A family medicine faculty member spearheads the Seniors' Services program at one of Marshall's affiliated hospitals. And Marshall is involved with statewide initiatives such as Geriatrics Educators of the Medical Schools (GEMS) of West Virginia and the West Virginia Geriatrics Education Center, based at West Virginia University in Charleston. But the teaching staff at Marshall—which offers fellowships in cardiology, pulmonology and endocrinology but not geriatrics—is stretched.

"Our internal medicine and family and community medicine departments include a total of seven faculty members with geriatrics credentials and expertise, but neither department has been able to develop a true full-time geriatrics teaching program," explains Dr. Neitch, herself a certified geriatrician and one of the seven. "We estimate we have about two to two-and-a-quarter full-time equivalent faculty to teach geriatrics to our 120-plus resident trainees. Each department feels that it is barely fulfilling its own departmental needs for geriatrics care and teaching."

The CRIT program, Dr. Neitch says, is a breakthrough for Marshall. The school gets support from local and regional foundations. But it's too small and has too few administrative resources to meet the criteria for geriatrics programming grants from the National Institutes of Health or organizations such as The John A. Hartford Foundation or the Reynolds Foundation.

"There is no doubt in my mind that enabling our few available geriatricians to expand the institution-wide dissemination of geriatrics knowledge through CRIT will be of immeasurable value," she adds.

Boston University Medical Center (BUMC) pioneered the highly successful CRIT program in 2005 with funding from the Donald W. Reynolds Foundation. And the program showed impressive results right out of the gate. The 16 BUMC chief residents who participated in 2006, for example, saw their scores on a test of geriatrics knowledge jump more than 40% after they completed the two-and-a-half day intensive educational retreat that's at the heart of the program. They also showed significantly greater understanding of multifaceted geriatric health problems, expertise in assessing older patients, and related skills. In 2007, the John A. Hartford Foundation awarded a $2.095 million grant to ADGAP and Boston University to replicate the program via the nationwide demonstration project.

Medical schools at the universities of Colorado, Kansas, Nebraska, Rochester, and South Carolina were chosen to participate in the first phase of the CRIT demonstration project last year. Each participating institution receives a 30-month grant of $114,000 to conduct two intensive training retreats and follow-up training for their chief residents. Teams that include both a chief resident and a faculty member responsible for residency training in surgical and medical specialties attend the interactive 2 ½-day retreats. Most chief residents also develop and implement projects designed to foster geriatric education or improve a specific element of clinical care. Each retreat includes roughly 15 chief residents and their mentors.

The CRIT demonstration project review committee was looking for several things when it evaluated applications for the program this year. Among others, it considered a school's ability to sustain the program, demonstrated commitment in the accompanying letter from the dean of the school, whether a non-geriatrician would serve as principal investigator (PI) or co-PI, the strength of the school's geriatrics program, and the potential impact the grant would have.

"Marshall was like the little engine that could—it really scored very high in all of the parameters, except that, like many schools with limited resources, it didn't have a powerhouse geriatrics education program," says CRIT demonstration project director Sharon A. Levine, MD, Associate Professor of Medicine and Director of the Geriatrics and Geriatric-Oncology Fellowship Programs and Associate Dean of Academic Affairs at BUMC. "But their ability to have an impact, the buy-in from the residency directors and dean, their passionate description of how they'd institutionalize this program, and the changes they could make beyond their institution made us really willing to take a chance on this little engine that could. We all know that, because of workforce trends, there will never be enough geriatricians to take care of all the older folks, especially in rural places where there are very few geriatricians. We saw that, with Marshall, the impact could be very great."

So enthusiastic about CRIT are Dr. Neitch and colleagues at Marshall that they're already generating interest in the program among others in the Geriatrics Educators of the Medical Schools (GEMS) of West Virginia group.

"We're already seeing an interest in the CRIT program from others in GEMS—and we're a year away from even having our first retreat," Dr. Neitch said early this past summer. "We're exploring the possibility of one or more educators in that group attending our CRIT retreat and planning to make this a GEMS-sponsored and—nurtured program for the future."

More Research Needed to Guide Palliative Care for Older Adults

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more than 50 medications to choose among. If a patient has pain, we have fewer than 10."

When it comes to easing the pain and suffering of older adults, the knowledge gap is particularly problematic. "There's a lack of solid evidence to guide care regarding pain and symptoms in older patients," Dr. Morrison explained.

Palliative care research and clinical guidelines have focused primarily on younger adults, particularly those with cancer. But palliative care that is appropriate for younger people may not be for older adults, due to the differing nature and duration of chronic illness in late life, he noted. Older patients, who often have multiple health problems, may have a variety of different types and etiologies of pain. Further complicating matters, there are few validated pain and symptom assessment tools for older patients, and assessment is even more difficult among those with cognitive deficits. In addition, recommendations for age-adjusted dosing are lacking for most analgesics and many of these can cause side effects, such as delirium and renal failure, that are particularly problematic for or amplified in older people.

To address this, further public and private investment in research is imperative, Dr. Morrison added. Research concerning the prevalence of pain and other symptoms among, and the effects of palliative treatment on outcomes in, elderly patients is crucial. So are new palliative care research methodologies designed to take into account differences between younger and older adults. To advance this research agenda, additional geriatricians trained as palliative care investigators are needed as well.

Palliative care and geriatrics are two overlapping specialties, Dr. Morrison argued. "We as two specialties can do a better job of integrating care for older patients," he concluded. "Palliative care is an integral part of geriatric medicine."

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The American Geriatrics Society (AGS) Foundation for Health in Aging (FHA) Tip Sheets

To help seniors and their caregivers with a variety of health issues pertaining to older adults, the American Geriatrics Society (AGS) Foundation for Health in Aging (FHA) continues to release easy-to-understand tip sheets. FHA's tip sheets, on numerous seasonal and timely health topics, are posted on the Foundation's comprehensive public education Web site, available at http://www.healthinaging.org/public_education/latest_tip_sheets.php. These tip sheets, as well as other FHA public education resources found on the FHA website (www.healthinaging.org)and FHA's *Aging in the Know* website (http://www.healthinaging.org/agingintheknow/), are all available in printer friendly formats, ready to be printed and distributed to others at no cost.

The latest FHA Tips sheets include:

Caregiving:

- Guide to Advance Directives
- Tips for Avoiding Caregiver Burnout

Healthy Aging:

- Cognitive Vitality
- Overcoming Challenges to Healthy Aging

Holidays:

- Tips for Beating the Holiday Blues
- Top 10 Healthy New Years Resolutions for Older Adults

Safety:

- Emergency Preparedness Tips
- Falls Prevention Tips
- Hot Weather Safety Tips
- Safe Travel Tips
- Safety Tips for Seniors Considering Visits to Retail Medical Clinics
- Walking Tips
- Winter Safety Tips

Vaccinations and Medications:

- Avoiding Overmedication and Harmful Drug Reactions
- Vaccination Tips