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◀ From left to right: Jefferson Ferry residents pose with Alexander Gee and Sebanti Bhowmik, Co-Presidents of the Stony Brook AGS Student Chapter.

## BACK TO THE FUTURE OF THE FIELD: FIVE QUESTIONS FOR A FUTURE GERIATRICS HEALTHCARE PROFESSIONAL

*Alexander Gee is a second-year medical student at Stony Brook University School of Medicine in New York. Co-President of the school's AGS Student Chapter, Gee represents the future of geriatrics not only as an emerging healthcare professional but also as someone taking leadership by the reins early in his career. AGS News put five questions to Gee to look at where he's been—and where he's going—on the road to a promising future in geriatrics.*

**Geriatrics seems to be all about stories—so what's yours? What led you to consider a career working with older adults?**

I obtained a degree in biochemistry from Georgetown University, where I also worked as an Emergency Medical Technician (EMT).

My training as an EMT helped me figure out how to work in a high-stakes environment. I learned that one of the most important aspects of emergency care is knowing how to work as a team and how to communicate effectively with others on the situation at hand, all while looking ahead to identify potential issues. In my EMT role at Georgetown, I enjoyed being in charge of stocking our standard supplies and equipment. It helped me build organizational skills and taught me how to think ahead when considering different types of emergencies or environments.

While working as an EMT, I started to develop an appreciation for how older adults could avoid emergency situations if they were better able to keep up with appointments and medications. My interest in geriatrics

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## NEW REPORT FROM PRESTIGIOUS NIA-FUNDED CONFERENCE LOOKS AT INTEGRATING FRAILTY RESEARCH INTO CARE AS WE AGE

Though it is one of the most frequently used health indicators as more and more of us age, frailty—the medical term for increased vulnerability to declines in health or a loss of independence—remains under-studied and under-utilized, so say researchers reporting on a prestigious conference hosted by the AGS and the National Institute on Aging (NIA), with support from the Alliance for Academic Internal Medicine and The John A. Hartford Foundation. Conference findings, published in the *Journal of the American Geriatrics Society*, are poised to advance not only a consensus definition for frailty but also our understanding of its biology,

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# AGS 360° WITH NANCY E. LUNDEBJERG, MPA

I vowed to keep these updates focused on AGS info you wouldn't hear elsewhere. That got me thinking about "inside scoops" I'd want if I were in your shoes.

Ironically, "shoes" are exactly where I started...

## Cleaning (as if someone else might have to)

A few weeks ago, a pile of shoes in my bedroom prompted an ambitious spring (OK: belated spring) cleaning of my house and the AGS offices. I even wrote a blog on the experience for the Health in Aging Foundation ([HealthinAging.org/blog](http://HealthinAging.org/blog)), mostly because it jogged memories of caregiving for my great aunt and mom.

Both eventually moved from home to assisted living facilities. Those moves—especially the cleaning *in preparation* for the moves—taught me a lot about the things we hold on to, what those things mean, and why it's important to clean as if someone else might have to (because, in both cases, someone else had to!).

But back to the original point of my letter, cleaning also reminded me that seeing someone else's home is probably the ultimate "inside scoop"—something that's particularly mysterious when you think about the "home" for a professional society like the AGS: Where do all those emails come from? What does it look like on the other end of that phone call about an AGS resource or meeting registration?

Those must have been questions we took to heart subconsciously this summer when we gave a group of fellows from the Icahn School of Medicine at Mount Sinai in New York the ultimate "inside scoop" with a tour of our offices.

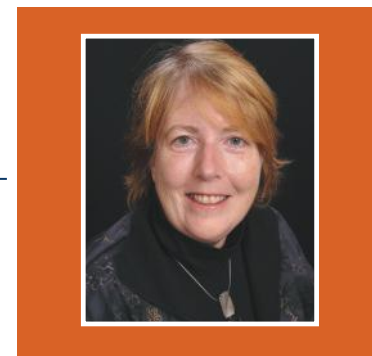
## From Cleaning to Learning to Sharing

Before I fuel jealousy among our fellows and program directors, let me just say how easy it was for these trainees to snag a VIP tour: All they had to do was ask (Well, their fellowship director, Helen Fernandez, MD, MPH, was technically the one who asked. If you've heard Helen's infectious laugh, you know we couldn't resist the request!). And the offer to host others always stands—especially since we found the experience eye-opening.

It was great welcoming some newly minted geriatricians to the AGS office. Helen spent much of the past semester discussing the clinical skills and advocacy we promote on their behalf, so this was an opportunity for them to see the hard-working staff behind those initiatives.

More important for us, however, was the opportunity to hear what had these fellows excited, what had them concerned, and what they saw in store for their own futures—and for the future of the field.

- One thing I took to heart was how much these fellows valued the professional community they're joining. Many will be working in areas where they may be one of the only experts in older adult care. Not one of them balked at that challenge—in fact, every single one talked about the importance of expanding the field. That so many of them also are returning to (or staying in touch with) the mentors who got them interested in geriatrics couldn't have made me prouder!
- Many of the fellows also voiced concerns about public policy—concerns we've heard reiterated time and again by AGS members. Pursuing meaningful, bipartisan health reform



ranked high on their priorities; so too did the importance of opposing discrimination—discrimination against fellow professionals/trainees and discrimination against older adults and caregivers. It made me #AGSProud to hear these trainees rally behind our own renewed commitment to reject discrimination and to fight for state and federal policies that truly support and empower older adults and caregivers. It should make you #AGSProud, too: In our work individually and as a group, I think we've set an exceptional example for the field's newest practitioners where advocacy is concerned. And let me tell you, making policy engaging is no small feat!

Congratulations are in order—not only for Helen's fellows but also for the hundreds of new advanced practice nurses, geriatricians, pharmacists, physician assistants, social workers, and so many others who joined our ranks this summer. Even if we don't get to welcome you to our offices in person, we're as committed as ever to supporting what you value, what those values mean, and why they're so important to the field. ♦

Best,

A handwritten signature in black ink that reads "Nancy E. Lundebjerg".

**Nancy**  
Chief Executive Officer

*PS: What actually happened to the pile of shoes that started all this? Well, all pairs now have homes—there was even room to add new red sneakers!*



**Having an immersive experience in the daily life of older adults under Dr. Rhodes' care provided an accurate depiction of the context behind their care, and the particular barriers each person faced.**

developed further when I shadowed Paul Rhodes, MD, a D.C.-area geriatrician, on house calls. This was a truly eye-opening experience because I realized there was much to learn by seeing how patients lived in their own homes. Having an immersive experience in the daily life of older adults under Dr. Rhodes' care provided an accurate depiction of the context behind their care, and the particular barriers each person faced.

### **What makes your passion for geriatrics personal?**

Being an EMT was a great introduction to working in an interdisciplinary environment—one that includes paramedics, nurses, and law enforcement—and shadowing house calls offered me a new look at a promising career opportunity, one modeled by a skilled and attentive clinician. I came to Stony Brook ready to learn and absorb as much as possible to bridge these two experiences, because that's where I see the future of geriatrics and my own career. I've enjoyed working with Lisa Strano-Paul, MD, for example, who serves as the faculty advisor for our interprofessional AGS Student Chapter.

### **Where have you seen the classroom and the community you'll serve converge?**

Recently, our student chapter held an event at the Jefferson Ferry assisted living facility in Long Island, NY, where we hosted a health fair for older adults in the area. It was certainly a two-way learning experience, as we helped many of the residents find ways to work on their unique health concerns while also learning ourselves about the unique needs, preferences, and expectations of these diverse community members. The Stony Brook AGS Student Chapter has led this health fair for several years now, with more success each year. Looking to the future, I'm hoping our chapter can expand the reach and impact of the program to even more residential communities in our area, and especially to those who may not have access to health care or health resources.

### **What does the geriatrics community mean to you as an AGS member and future healthcare professional?**

As a fairly new member of the AGS, I'm looking forward to working with our community as I continue on my career path in geriatrics. My membership is a great way to find more mentoring and networking opportunities, such as the one I had shadowing a geriatrician, and it provides me access to a network of healthcare professionals outside of my institution and who all share the same concerns, goals, and passion. It's inspiring and humbling to see other stories of hard work and motivation from across geriatrics.

### **Beyond your career, what gets you out of bed every day? Any connections between your personal and professional passions?**

In my spare time, my favorite hobby is playing music. Growing up, I played the guitar and trumpet, and now I produce music as a way to de-stress. My favorite genres are R&B, hip-hop, and rap. Whenever I need to take a small break—which I've learned to value in my training as a future geriatrician!—I dive into music: You can't get overloaded if you keep a good rhythm! ♦

### **Students and Residents receive free e-membership with the AGS.**

To learn more, visit [AmericanGeriatrics.org/Membership](https://AmericanGeriatrics.org/Membership).

For details on how to start an AGS-affiliated student or resident chapter at your institution, email Lauren Kopchik, AGS Membership Communication Coordinator, at [lkopchik@americangeriatrics.org](mailto:lkopchik@americangeriatrics.org).



# FROM OUR PRESIDENT

## DEBRA SALIBA, MD, MPH, AGSF

*“Unless someone like you cares a whole awful lot, nothing is going to get better. It’s not.”*

—Dr. Seuss, *The Lorax*

When I spoke in May to our #AGS17 attendees about “navigating change in uncertain times,” few of us anticipated the truly extraordinary uncertainty that would persist over the summer as Congress tried to enact healthcare legislation.

If you followed the summer’s health reform debates, you were treated to no less than four proposals (as well as multiple revisions to those proposals) for repealing and replacing the Affordable Care Act (ACA). The drama of seeing these plans rise and fall was gripping, and undoubtedly the options being debated will have changed again by the time you read this.

At the AGS, knowing what was at stake, we’ve worked to set aside the partisan drama of health reform. We’ve focused instead on action—action grounded in compassion for older adults, their families, and their caregivers. This North Star drives our commitment to high-quality, person-centered care.

Most of the proposed ACA repeal bills called for drastic cuts to Medicaid, our nation’s largest public payer for long-term care services and supports. These cuts would have wrought serious damage to our health system, ultimately affecting large numbers of older adults, their families, and their caregivers. Specifically, these cuts would have increased out-of-pocket costs, reduced health and long-term care coverage, and diminished health benefits for millions of Americans, many of them older adults.

We’ve agreed that the ACA *can* be improved—but we’ve known that improvement can’t happen if we

sacrifice high-quality, person-centered, and affordable health coverage. Standing up for that—objectively and respectfully—is at the heart of who we are.

AGS staff, experts, consultants, and most especially individual members worked to make this commitment clear to policymakers amid all this uncertainty. We have approached this action with the collaborative spirit essential to achieving our goals. Through our Health in Aging Advocacy Center, for example, members connected with nearly half of U.S. Senators during the debate. By August, our national healthcare conversation shifted toward bipartisan collaboration and away from a focus on partisan victories. This positive development may indicate that citizens and policymakers heard the calm, committed tenor of our insights and those of other engaged health professionals and groups. We have demonstrated that our work in public policy isn’t just about standing *against* policies we know would harm older adults; it’s about standing *for* the priorities we see as critical to their well-being.

It’s going to take committed, continued action to achieve these priorities. We’ll get there. There are many ways we each can support that progress no matter where we find the debate. I’d like to highlight just one by way of recognizing our journals for the important work they do.

*Annals of Long-Term Care, Geriatric Nursing, and the Journal of Gerontological Nursing* recently joined the *Journal of the American Geriatrics Society* in adopting “older adult” as the preferred term for those who benefit from our expertise. In public policy, clinical practice, and research, changes like this speak to an important truth: *Language*



*matters*, and we shouldn’t leave it to chance.

To make that point even more practical, I’d like to share a few suggestions from the AGS’s work with the Leaders of Aging Organizations (LAO) and the FrameWorks Institute. The LAO-FrameWorks collaboration is helping build an evidence base for identifying language that will help us accelerate better care. Beyond embracing preferred terms like “older adult,” we have employed in our advocacy effective framing strategies that:

- Define aging through an emphasis on the opportunities and challenges we all experience across our life span.
- Highlight how social contexts and social policy influence aging. This involves recognizing that social policies and the organization of communities influence our ability to age as we prefer.
- Elevate awareness that ageism exists and that it can be addressed through sound support structures and systems.

With my presidency already passing the half-way point, I’m eager to see not only how our language continues to evolve but also how our words and actions start to crystallize some certainty in uncertain times. If the immediate past is any indication, we’re more than prepared to navigate that challenge; we’re poised to lead the way.

@DebraSalibaMD

assessment, and role in improving care across several specialties, from cardiology and geriatrics to behavioral and social sciences.

Convened in 2015 for recipients of the NIA's Grants for Early Medical/Surgical Specialists Transition into Aging Research (GEMSSTAR) program, the NIA "U13" conference brought together more than 75 scholars, researchers, leaders in the fields of aging and frailty, and NIA representatives to present and further stimulate research on frailty, particularly across the array of disciplines involved in the high-quality, person-centered care we all will need as we age.

According to the GEMSSTAR conference proceedings, managing frailty is increasingly important in medical specialties to improve quality of life, guide healthcare decision-making, and prevent deteriorating health or the risk for decline, wherever possible. Yet challenges to integrating frailty management into clinical care include not only uncertainty about what to measure but also when, who, and how to do so—particularly in the context of care addressing other specific health concerns.

Heart failure remains a considerable challenge for us all, for example—accounting for 1 million hospitalizations and more than \$39 billion in healthcare spending per year—yet the role that frailty plays for people living with heart failure “has been overlooked as a reason for the high-rate of hospital readmission,” conference attendees noted. Similar experiences have been reported for everything from end-stage renal disease to treatment for human immunodeficiency virus (HIV)—reinforcing the importance of understanding frailty's impact on health more clearly.

“Many conditions associated with frailty increase as we age, but it's also incredibly important to remember that we all age differently,” said Arti Hurria, MD, a trained geriatrician and oncologist who serves as Director of Cancer and Aging Research at City of Hope in Duarte, CA. Dr. Hurria is also the Principal Investigator on the U13 conference grant. “Integrating frailty screening into our work as clinicians—identifying individuals at risk, altering treatment when needed, and developing new preventive strategies—represents a clear path toward the high-quality, person-centered care

we all need as we age. That's what this meeting of our GEMSSTAR colleagues is all about.”

The NIA's GEMSSTAR program awards support to early-career physicians trained in medical and surgical sub-specialties for research on the role of geriatrics within their specialties. The AGS serves as a central coordinating body for applicants in particular specialties (anesthesiology, emergency medicine, general surgery, gynecology, orthopaedic surgery, physical medicine and rehabilitation, urology, and vascular surgery) interested in applying for the Dennis W. Jahnigen Career Development Award, which provides funding for a Professional Development Plan to complement an "R03" research project (the grant mechanism administered by the National Institutes of Health to support small research projects carried out in a short period of time).

*For more information on the Geriatrics-for-Specialists Initiative and the GEMSSTAR program, visit [AmericanGeriatrics.org](http://AmericanGeriatrics.org). ♦*

## POLICY PRIORITIES FOR US ALL AS WE AGE

Renewed calls for collaboration in the wake of this summer's health reform debate have opened a door for bipartisan solutions to strengthen our nation's healthcare system.

We believe that's possible by working together on federal and state policies that:

- Expand older adults' healthcare options to include in-home services and other care that enable us to live independently as long as possible.
- Help older adults and caregivers better understand their healthcare needs and make the most of Medicare and other benefits.
- Provide caregivers with adequate resources and support.
- Ensure that value-based purchasing and other quality initiatives take into account the unique healthcare needs of all older people.
- Strengthen primary and preventive care and care coordination.
- Address the acute and growing nationwide shortage of all geriatrics healthcare professionals, and ensure that other healthcare providers have training that prepares them to meet the unique healthcare needs of older people.
- Step-up research concerning healthy aging; the prevention, diagnosis and treatment of age-related health problems; and the cost-effectiveness of various approaches to care.
- Ensure that older adults are adequately represented in research trials.

▶ Visit [AmericanGeriatrics.org/WhereWeStand](http://AmericanGeriatrics.org/WhereWeStand) to learn more and make your voice heard.

# A RECIPE FOR HEALTHY AGING FROM THE HEART OF THE MEDITERRANEAN

By Elizabeth Eckstrom, MD, MPH

On a recent trip, I attended a conference in Ostuni, Italy (at the heel of the boot), on aging and the Mediterranean Diet (MD). Our own Richard Besdine, MD, FACP, AGSF, was a leader of the conference, and I was lucky enough to join him for three amazing days learning about an important approach to nutrition—right in the heart of where it found its roots!

Like many of you, I'm no stranger to the MD or its benefits. I know it reduces heart disease, cancer, dementia, and cerebrovascular disease. I have handed out MD recipes to patients, and I've recommended MD cookbooks for years. I have been following the MD myself (straying mostly to add milk to my morning coffee), and I've convinced "meat and potatoes" friends to adopt it, too. But I learned fascinating things about the MD that I think all AGS members might find valuable in our work to improve health and independence for older adults.

For starters, the MD is not about specific foods but rather about embracing the eating patterns of Mediterranean countries. It is a philosophy of life that also includes exercise (walking every day) and dining with friends or family in a relaxed and convivial atmosphere. The most typical MD hails from Crete in Greece or Naples in southern Italy, featuring lots of olive oil and mostly vegetarian options (with modest amounts of lean chicken and occasional red meat). And, lest I forget: Wine in moderation (no more than 1-2 glasses per day) also is an important part of the MD!

One reason the MD has been seen as a powerful tool in health care is that it may be linked to hormesis (the concept that life exists in harsh environments, and that organisms have developed complex mechanisms to cope with environmental stressors). Eating more vegetables and fruits than the usual dietary patterns has been shown to improve multiple health outcomes. Just 200 grams of fruit/vegetables a day, in fact, decreases heart disease, cancer, and all-cause mortality. Cruciferous vegetables (like cauliflower, cabbage, Brussels sprouts, etc.), greens, and berries are best, and often help people lose weight. Importantly, randomized trials of the MD have shown cardiovascular mortality benefits even in the absence of weight loss, and a "pro-vegetarian" diet (one that includes almost no animal fats but is not completely vegetarian) also helps to reduce other adverse outcomes.

More broadly, plant-based diets like the MD promote a highly diverse intestinal microbiota, in part because diet is the most important contributor to changes in gut



microbiota. This plasticity is important for adaptability: Gut microbiota can change in a matter of days to weeks! The gut microbiota of "super centenarians" (people between the ages of 105 and 110) have even been found to be more similar to younger people than to other older individuals.

Adding to these benefits, the MD also has been shown to:

- Reduce the risk of needing hypoglycemic medication in people newly diagnosed with diabetes.
- Reduce the risk of new-onset frailty by 70%.
- Reduce pain and increase quality of life for those with osteoarthritis.
- Increase psychological resilience. ♦

*If you aren't following the MD yet, try it—and encourage your patients to adopt it, too! Here is an MD-friendly recipe I made based on a salad I ate in Italy.*

## FARRO, TOMATO, AND ARUGULA SALAD

### Ingredients

- 1 cup farro (also called spelt)
- 1 cup cherry tomatoes, halved
- 2 cups baby arugula
- Good olive oil
- 2 cloves garlic, minced
- A pinch of dried red chili flakes
- 2 cups water

### Instructions

Toast the farro, garlic, and red chili flakes for 6-8 minutes (or until the farro turns light brown and the mixture is fragrant) on the stove top in a large frying pan with a generous amount of olive oil. Then, add 2 cups of water and simmer until all the water is absorbed (this could take 15-45 minutes, depending on your farro). Cool the ingredients completely, and then add the tomatoes, arugula, and some good sea salt. Serve and enjoy!



# NEW MEDICARE CARDS: WHAT YOU NEED TO KNOW

*In an effort to prevent fraud, fight identity theft, and promote high-quality care, the Centers for Medicare and Medicaid Services (CMS) unveiled new Medicare cards featuring a “Medicare Beneficiary Identifier” (or MBI) that replaces the need for a Social Security Number to be displayed. The new cards, which will start hitting mailboxes in April 2018, should be in the hands of all older adults by April 2019.*

*Here are CMS’s answers to four frequently asked questions that can keep you in-the-know on the transition to the MBI system.*

## **What’s happening? When? How does this change impact me?**

As part of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2016, CMS will roll-out the new MBIs to replace the Social Security Number-based Health Insurance Claim Number (HICN) on Medicare cards used for filing claims, determining Medicare eligibility, etc.

MBI-based Medicare cards will be launched in April 2018. Your systems will need to be able to accept the new MBI format from that point forward, but CMS will continue to support a “transition period” through December 31, 2019, allowing you to use either the traditional HICN or the new MBI in your work with Medicare beneficiaries. After the transition period ends on January 1, 2020, you’ll need to use MBIs on almost all claims (Visit CMS.gov for a list of limited exceptions).

## **What’s the design for the MBIs?**

MBIs will feature a combination of 11 numbers and uppercase letters. Each MBI will be unique and randomly generated, maximizing security and ease-of-use.

## **What do the new Medicare cards mean for people with Medicare?**

The MBI won’t change Medicare benefits. People with Medicare may start using their new cards as soon as they get them.

For providers, CMS already has plans to test systems that will use the MBI, including enhanced integration testing (EIT) for new or high-risk systems. You can use the transition period as a “live test” to make adjustments as necessary while still submitting and processing claims with HICNs.

## **What can I do to learn more or stay on top of the change?**

Visit [CMS.gov/Medicare/New-Medicare-Card](https://www.cms.gov/Medicare/New-Medicare-Card) for the latest news and information. Start confirming patient addresses and information now so you can help the older adults and caregivers you serve adjust to their new Medicare cards. Be sure to test your own system changes and work with your billing office staff so you’re ready to use the new MBI format as soon as possible. ♦



**AGS18** ANNUAL SCIENTIFIC MEETING

**Mark Your Calendars  
for Magical Moments at #AGS18**

**May 3-5 (pre-conference day: May 2)**

**Walt Disney World Swan and Dolphin: Orlando, FL**

Be sure to bookmark [Meeting.AmericanGeriatrics.org](https://www.Meeting.AmericanGeriatrics.org) for everything you need on abstract submissions, awards nominations, meeting registration, and travel deals.

# SWEET TWEET!

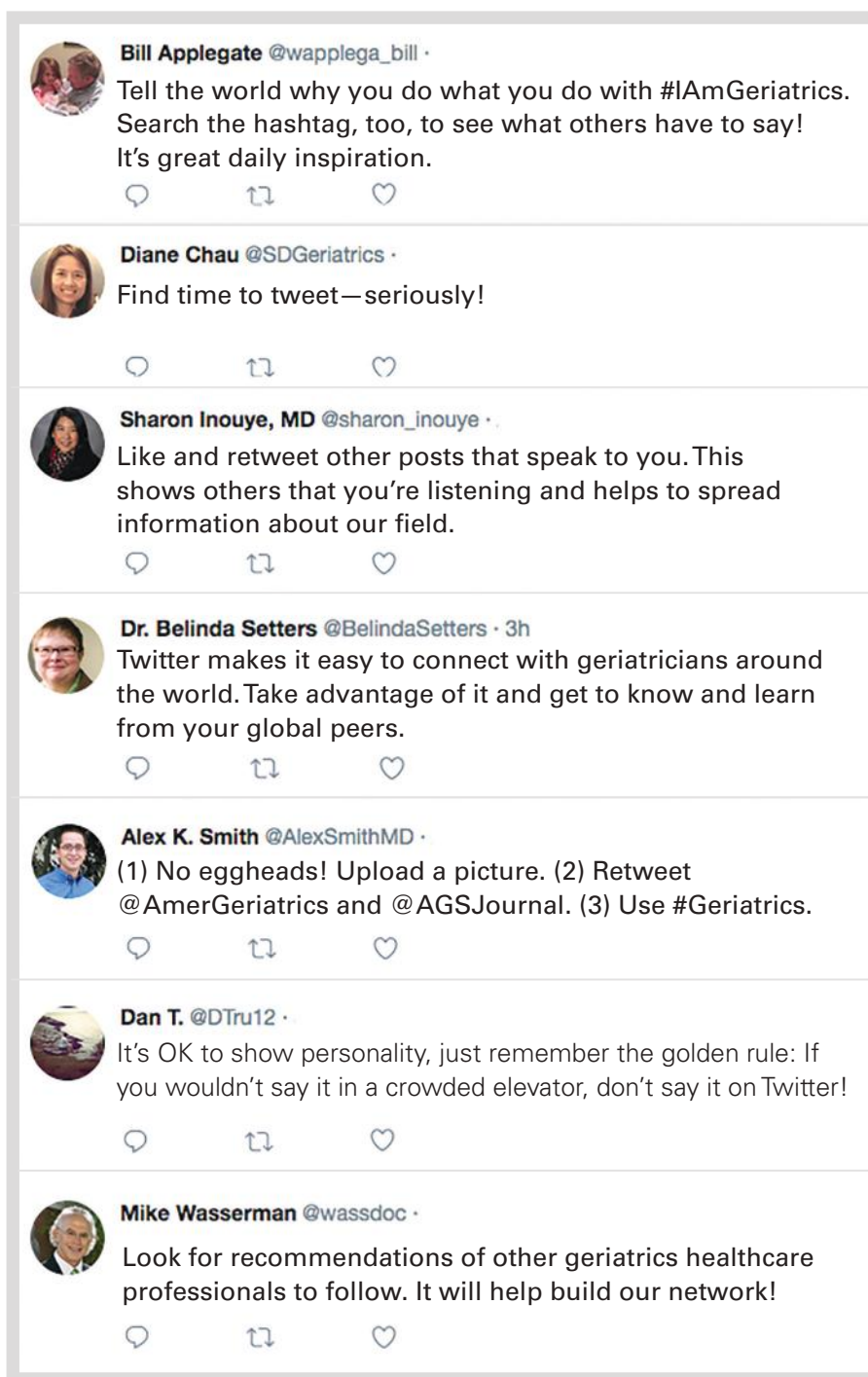
## QUICK TIPS FOR TWITTER...FROM PEOPLE WHO KNOW!

Social media is a game-changer for almost every profession—and geriatrics is certainly no exception! Platforms like Twitter are connecting us with older adults, caregivers, colleagues, and policy makers like never before...but that still doesn't make the digital domain any less intimidating.

Are you new to the Twittersphere and in need of advice? Do you have an account (#Yes!)—but still have a funny grey egg as your profile pic (#AlsoYes☹)? Get advice on what's #In and what's #Out from colleagues who are already part of the geriatrics Twitterati.

### Want even more advice?

Visit [AmericanGeriatrics.org](http://AmericanGeriatrics.org), or find friends to follow from the AGS at [http://bit.ly/AGS\\_F2F](http://bit.ly/AGS_F2F) (case sensitive)



**Bill Applegate @wapplega\_bill**  
Tell the world why you do what you do with #IAmGeriatrics. Search the hashtag, too, to see what others have to say! It's great daily inspiration.

**Diane Chau @SDGeriatrics**  
Find time to tweet—seriously!

**Sharon Inouye, MD @sharon\_inouye**  
Like and retweet other posts that speak to you. This shows others that you're listening and helps to spread information about our field.

**Dr. Belinda Setters @BelindaSetters · 3h**  
Twitter makes it easy to connect with geriatricians around the world. Take advantage of it and get to know and learn from your global peers.

**Alex K. Smith @AlexSmithMD**  
(1) No eggheads! Upload a picture. (2) Retweet @AmerGeriatrics and @AGSJournal. (3) Use #Geriatrics.

**Dan T. @DTru12**  
It's OK to show personality, just remember the golden rule: If you wouldn't say it in a crowded elevator, don't say it on Twitter!

**Mike Wasserman @wassdoc**  
Look for recommendations of other geriatrics healthcare professionals to follow. It will help build our network!







**Nancy Lundebjerg**

## **@nlundebjerg's Quick Start Guide**

1. Understand your employer's #SocialMedia guidelines.
2. Read "How to Deal with Aging in 140 Characters" from @Age\_Matters.
3. Sign up for #Twitter at [www.twitter.com](http://www.twitter.com). Remember: Be yourself and don't forget to include "Opinions are my own" in your profile.
4. Follow, Follow, Follow: Check our @AmerGeriatrics follower list for #geriatrics friends.
5. While you're at it, be sure to follow @AmerGeriatrics, @AGSJournal, & @HealthinAging.
6. Acclimate yourself to Twitter by reading others' tweets, clicking thru on links, and continuing to follow people.
7. Don't be afraid to use hashtags (#geriatrics #IAmGeriatrics), emojis, and #Twitter shorthand (e.g., substitute "2" for "to").
8. Get active! Start slow: Like, reply, and retweet—and make it a daily habit! Tiny piece of advice: Always preview links before retweeting.
9. Start adding your own thoughts to retweets (use "quote tweet" AND start sending original tweets).
10. Be Twitter active: Keep following people and keep tweeting. Don't forget to tag people if you want them to see a tweet!

## **FAST FACTS ABOUT A FAST-GROWING FORUM**



Health professionals are using social media in new ways—which is changing how we think about, talk about, and act upon their work. For example, among researchers and scientists polled by *Nature*:

- **58%** said they think having a professional profile on any online network is "very important" to their scholarly work.
- **37%** said they visited Twitter daily—making it the most frequently visited social media site among those polled.
- **49%** reported engaging in scholarly discussions using Twitter.
- **37%** said they use Twitter to share research from their colleagues, but only **25%** said they use Twitter to post about their own work.
- It's probably not surprising, therefore, that **46%** of researchers and science professionals said they should probably do more to promote their work using online networks.

**Get ahead by stepping-up your social media game today!**

**Visit [Twitter.com/AmerGeriatrics](https://twitter.com/AmerGeriatrics) for more information.**

# WHY I'M AN AGS MEMBER

LISA M. WALKE, MD, MSHA, AGSF

My “Aha!” moment for becoming a geriatrics healthcare professional came during my internship at Montefiore Medical Center in New York. Before entering medical school I had worked in the breast oncology clinic at Memorial Sloan Kettering Cancer Center. I had entered medical school and internship with plans to become an oncologist. I was fortunate to have had a wonderful mentor, and at the end of my intern year we had a chat.

She told me she saw things in me that I didn't see in myself—that I was drawn to palliative care (then a rela-

are committed to approaching older adults and caregivers holistically. That extends to our own relationships with one another, too. We all seem to be kindred spirits and a success for one is a success for all—I'm definitely living proof of that.

Recently, I was extremely honored to receive the AGS's Outstanding Mid-Career Clinician Educator of the Year Award. It's a testament to the AGS that our members are so big-hearted: I was thrilled to receive so many congratulatory notes and accolades from my colleagues. Receiving the award was not only a wonderful profes-

sional tribute for me but also underscored the importance of the work we do together. It's



**When I work with trainees, I get to see things through their eyes; their perspectives are enlightening.**

tively new field), for example, and we started talking about geriatrics. I spent time in the geriatrics department, and I realized her encouragement was spot-on.

Geriatrics satisfies me in so many ways. I love the older adults I care for, in large part because I love hearing their stories. It's rewarding to help older adults regain function and the ability to interact with people.

I'm doubly fortunate in that my work at the Yale University School of Medicine in Connecticut also entails helping train future geriatrics healthcare professionals. My work teaching is every bit as gratifying as my clinical work, though for equally special yet unique reasons. When I work with trainees, I get to see things through their eyes; their perspectives are enlightening. Teaching really is a two-way street!

Another terrific aspect of geriatrics is the community it represents. I work with wonderful colleagues who

great that my institution is appreciated for supporting geriatrics education by virtue of my recognition, for example.

I suppose that's part of why I've been an AGS member since 1999. Events like the AGS Annual Scientific Meetings have helped me celebrate my peers' successes while also affording me the opportunity to see what they and other leaders are doing. Membership in the AGS is one key way I've learned about innovation in our field so I can stay current with research.

Another key aspect of my membership is that it exposes me to the advocacy AGS leads on our behalf. With health policy in flux these days, we all need to be advocates for our field, and—thanks to AGS—I'm inspired to add that to my own list of important things to do.

When I'm not working, I have a couple of hobbies I enjoy. One is travelling. My bucket list includes trying to visit every independent Caribbean



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Section of Geriatrics

country. My other hobby might seem surprising: I hold a black belt in Taekwondo. It's a high-energy martial art that includes a lot of kicking and yelling—the louder the better. Though some may think of it as a fighting sport, the reality is that Taekwondo is all about courtesy, respect, integrity, self-control and perseverance. I find those very compatible attributes for my career in geriatrics education! ♦



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AGS News is published quarterly by the American Geriatrics Society. For more information or to become an AGS member, visit [AmericanGeriatrics.org](http://AmericanGeriatrics.org). Questions and comments about the newsletter should be directed to [info.amger@americangeriatrics.org](mailto:info.amger@americangeriatrics.org) or 212-308-1414.



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## Preventing and Addressing Elder Abuse

No matter how old we are, we are all entitled to be treated as full members of our communities. Yet elder abuse is a significant challenge to our nation's belief in justice for all. Elder abuse is widespread and impacts everyone in our society. It takes away from our public health, civic participation, and economic resources. The mistreatment of older people can take many forms, including physical, emotional, and sexual abuse, financial exploitation, and neglect. Though as many as 1 in 10 older people are abused each year, a majority of cases go unreported for many reasons, including a lack of social supports needed to make reporting easier.

### What We Can Do

We can reduce the risk of elder abuse by putting systems in place that can prevent abuse from the start. For example, we can create community supports and services for caregivers and older people that can reduce risk factors tied to elder abuse (such as social isolation). We can increase funding to provide training for people who work in aging-related care on the prevention and detection of elder abuse. We can identify ways to empower older people through senior centers and intergenerational programs that will reduce the harmful effects of ageism (biases against or stereotypes about aging that keep us from fully participating in our communities as we grow older).

In addition to building supports to keep our communities safe, it is also important that we recognize what abuse is and its warning signs. This makes it possible for us to report elder abuse and stop it in its tracks. We can all learn how to recognize, prevent, and report abuse.

## Signs of Mistreatment

### NEGLECT

- Lack of clean clothing or clothing inappropriate for the weather
- Lack of basic hygiene
- The home is cluttered, dirty, in need of repairs or the home has fire and other safety hazards
- The home does not have needed utilities such as electricity, working plumbing, heating/cooling





## FINANCIAL ABUSE/ EXPLOITATION

- Unusual patterns of spending or withdrawals from an older adult's account
- Frequent purchases of inappropriate items
- Bills going unpaid or utilities being turned off
- The presence of a new "best friend" who is accepting generous "gifts" from the older adult

## PHYSICAL ABUSE

- Bruises, especially on the head or torso, and those shaped like a hand, finger, or thumb
- Unexplained burns, cuts, sores, or other injuries
- Denying an older person enough food/water, needed medications, or assistive devices such as canes, walkers, hearing aids, and glasses
- Giving older adults unnecessary tranquilizers or sleeping pills, or confining or tying an older person to a bed or a wheelchair

## EMOTIONAL/ PSYCHOLOGICAL ABUSE

- Intimidation or yelling
- Making threats
- Humiliating or ridiculing someone
- Isolating an older adult from friends and keeping them from activities they enjoy for no good reason.

## SEXUAL ABUSE

- Unexplained anal or vaginal bleeding
- Torn or bloodied underwear
- Bruises around the breasts or genitals

If there is an unexplained genital infection, we should look to have a conversation with the older adult's healthcare provider. If we don't know the name of the healthcare provider, try to get more information about the infection from the older adult and contact the authorities.

No matter how old we are, we deserve to be treated justly and as full members of our communities. We can all ensure that remains a reality for us as we age by reporting these or other signs of abuse to an Adult Protective Services agency that can investigate potentially abusive situations. We are the solution. If we notice that someone in our community is in immediate danger, it is up to us to call 911 or local police as soon as possible for help.

For more information concerning elder abuse, contact the National Center on Elder Abuse (NCEA) at 1-855-500-3537, [ncea-info@aoa.hhs.gov](mailto:ncea-info@aoa.hhs.gov), or <https://ncea.acl.gov>.

