

AGS NEWS

NEWSLETTER OF THE AMERICAN GERIATRICS SOCIETY

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May we all glide into 2023 like these Gadwall ducks enjoying a fall afternoon at the pool in Central Park. Our best for a happy and healthy New Year – *the AGS team*

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Photo by N. Lundebjerg.

GET READY TO HIT THE BEACH AT #AGS23 REGISTRATION OPENS ON DECEMBER 14!

Winter may be right around the corner but the AGS is already planning for the beach. We hope you'll join us at the 2023 Annual Scientific Meeting of the American Geriatrics Society (AGS) from May 4 – 6 (pre-conference day: Wednesday, May 3) in Long Beach, CA.

The AGS Annual Scientific Meeting is the leading educational event in geriatrics, providing the latest information on clinical care, research on aging, and innovative models of care delivery, delivering events and education for geriatrics professionals from all disciplines. Physicians, nurse practitioners, nurses, pharmacists, physician assistants, social workers, long-term care and managed care providers, health care administrators, and others will enjoy and benefit from sessions covering a wide range of topics. And as attendees experienced at AGS22, there is so much more to learn from meeting in person and taking advantage of the many social and networking events throughout the week.

"The Annual Scientific Meeting was back in person and better than ever last year, proving how important it is for the geriatrics healthcare community to come together to share ideas, discuss the latest research, and support future leaders in our profession," said Aanand D. Naik, MD, Program Chair. "There will be opportunities for attendees to engage in many ways, whether through attending a research presentation, plenary session, learning about our award winners, or listening to a keynote lecture. There is something for everyone at every stage of their career. I attended my first AGS national meeting when I was a Geriatrics fellow. I realized during this meeting that I made the right career choice and had found my professional home. It was such an inviting and exciting experience."

continued on next page

AGS POLICY UPDATES: ADVOCATING FOR EQUITY, THE HEALTHCARE WORKFORCE, AND AGING RESEARCH

The AGS believes in a just society where all people are full members of our communities and entitled to equal protection and treatment, and advocates for federal policies that will improve the health and well-being of all older adults. We look for opportunities to draw attention to discrimination—with a focus on the intersection of structural racism and ageism—across AGS statements, recommendations, and in comment letters as appropriate. Here is a recap of some recent highlights of AGS's policy work.

Special Statements

This year, AGS released the following statements addressing access to care across the lifespan and condemning policies that target any individual for their identity.

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AMERICAN GERIATRICS SOCIETY 2023 ANNUAL SCIENTIFIC MEETING

AGS23 ANNUAL
SCIENTIFIC
MEETING



MAY 4–6 ■ LONG BEACH, CA ■ #AGS23

#AGS23 continued from page 1

Sessions Preview

Sessions covering a scope of topics will run throughout the week, representing the wide range of subjects relevant to geriatrics. The following is a preview of the wider program:

■ Update on Vaccination Strategies for Older Adults: Matching the Approach to the Individual and the Care Setting

Moderator George A. Kuchel, MD will lead a discussion about vaccination against varied pathogens, representing one of the best-validated and most effective strategies for the prevention of disease, hospitalization, disability, and death in older adults. Nevertheless, even expert geriatrics healthcare providers often lack relevant knowledge, especially regarding vaccine use in older adults who are most vulnerable as a result of being frail, suffering from multiple chronic diseases, and/or residing in long-term care. Presenters will review the latest recommendations and guidelines pertaining to vaccination indications and schedules for older patients; describe published and emerging research evidence pointing to specific aging-related differences in immune responses and immune protections following immunization with varied vaccines; discuss the use of different vaccine formulations, addition of adjuvants, as well as geroscience-guided strategies for overcoming declines in immune responses with aging; and review literature demonstrating the utility of varied strategies designed to overcome barriers to implementation of FDA-approved vaccines.

Panelists:

- Introduction to the AGS/CMSS/CDC Vaccine Initiative:
Sharon A. Brangman, MD

- Staying Up to Date and Making Sense of CDC Vaccination Guidelines: Kenneth Schmader, MD
- Optimizing Vaccine Effectiveness in Frail Older Adults with Multiple Co-Morbidities: George A. Kuchel, MD
- Improving Vaccine Uptake in Long-Term Care Settings: Stefan Gravenstein, MD

■ Heart Failure with Preserved Ejection Fraction: New Insights into an Evolving Geriatric Syndrome

Michael W. Rich, MD will moderate presentations about heart failure with preserved ejection fraction (HFpEF), a disease predominantly of older adults and for which normative aging is considered a contributing factor to its development. It is also the most common form of heart failure in older adults, accounting for up to two-thirds of symptomatic heart failure in this age group. The management of HFpEF can be challenging in older adults due to co-existing complex multimorbidity, polypharmacy, and the socioeconomic burdens of aging. As a result, HFpEF is increasingly recognized as a geriatric syndrome and its management requires a multi-dimensional approach to care. Therefore, it is essential that clinicians caring for older adults have a clear understanding of the diagnosis and management of HFpEF in order to optimize the care of their patients in the clinic or the hospital setting. Presenters will share a review of the epidemiology, diagnosis, and pathophysiology of HFpEF; demonstrate how to recognize HFpEF as a geriatric syndrome requiring multi-dimensional care; discuss the state of the science for pharmacologic intervention for HFpEF, and available resources for non-pharmacologic interventions focusing on physical rehabilitation for HFpEF as a tool for optimizing quality of life; and acknowledge disparities and inequities in access to care for HFpEF and utilize strategies to resolve these issues.

Panelists:

- Heart Failure with Preserved Ejection Fraction: Epidemiology, Pathophysiology and Diagnosis: Michael W. Rich, MD
- Pharmacologic Management of Heart Failure with Preserved Ejection Fraction: Parag Goyal, MD, MSc
- Non-Pharmacologic Management of HFpEF: The Case for Physical Rehabilitation: Amy Pastva, PT, MA, PhD
- Disparities and Inequities in Access to Care and Outcomes for HFpEF: Khadijah Breathett, MD, MS

■ Geriatrics Literature Update: 2023 – Back by Popular Demand!

Speakers Kenneth Covinsky, MD, MPH, Eric Widera, MD, & Alexander Smith, MD, MS, MPH will lead one of the most entertaining and highly rated sessions at the annual meeting. The session will focus on the year's most important published papers and the implications of research findings and a discussion about the significance of findings and application to patient care. Topics that will be covered include how to identify areas in clinical medicine where new strong evidence has been uncovered that should affect geriatric practice, describe the results of a critical appraisal of this evidence, and discuss clinical advances in caring for older adults from a review of approximately 30 peer-reviewed journals from January-December, 2022.

Network, Network, Network

In addition to the educational and professional development opportunities at the Annual Meeting, one of the most valuable benefits of attending is the many chances to network in both a professional and social setting. The Presidential Poster Reception, Section Meetings, and Special Interest Groups meetings to discuss more than 30 topics in geriatrics are just a handful of the events available to attendees. There will also be receptions, a dance party, and informal gatherings to catch up with colleagues old and new.

“One of the most important things we can offer meeting attendees is the opportunity to network and build relationships now and in the future,” Dr. Naik said. “As we demonstrated at AGS22, the geriatrics profession is stronger when we come together to share ideas, make connections, and work together to realize positive, meaningful change.”

Follow #AGS23 for Updates!

Use the tags **#AGS23** and **#AGSProud** to spread the word about your meeting plans and connect with other attendees online. Look for updates from @AmerGeriatrics, @AGSJournal, @HealthinAging, and AGS CEO @NLundebjerg to remain in-the-know about all things #AGS23. Plus,

remember to follow meeting updates on MyAGSONline, the exclusive online forum for AGS members. Log in at MyAGSONline.AmericanGeriatrics.org and view the AGS Member Forum to learn about sessions that already have your colleagues talking. For people unable to attend the meeting in person, we will be offering AGS23 On-Demand, which includes access to 19 post-meeting session recordings on demand after the in-person meeting. Attendees who view those recorded sessions will be able to earn 19.5 CME/CE credits. ♦

➤ Visit Meeting.AmericanGeriatrics.org to register, view a program schedule, and check on other updates. Visit the site often for news about #AGS23!

AGS WELCOMES SIX NEW FELLOWS

In August 2022, the American Geriatrics Society honored six leading health professionals who joined the newest class of AGS Fellows – a select group of experts recognized for their deep commitment to the AGS and to advancing high-quality, person-centered care for us all as we age.

These colleagues have demonstrated commitment to the field, contributed to advances in care, and are active participants in AGS activities.

This year's fellows, from all regions across the country, reflect the dedication to geriatrics education, clinical care, and research indicative of our Society's commitment to quality care for us all as we age. They include:

- Michael Steinman, MD, AGSF
- Sandeep R. Pagali, MD, AGSF
- Mriganka Singh, MD, AGSF
- Philip A. Kithas, MD, PhD, AGSF
- Lynn M. Wilson, DO, AGSF
- Esteban Franco Garcia, MD, AGSF

Each year, a host of highly qualified AGS members earn fellowship status following a rigorous application process, which includes assessments covering a wide range of criteria from continuing education to public service and geriatrics scholarship. Applications are accepted twice yearly, with more information available at <https://www.americangeriatrics.org/membership/fellowship-ags>. ♦

AGS 360° WITH NANCY E. LUNDEBJERG, MPA



I'm always #AGSProud when I review the year-end staff reports for the November AGS Board meeting and this year was no different. For example, our policy team submitted 15 regulatory comments to a wide range of agencies in 2022. For me, it's not just about the volume of comments, but also about seeing the impact of our comments on the actions an agency then takes.

Our impact can be seen in the final 2023 Centers for Medicare and Medicaid Services (CMS) physician fee schedule (see AGS Policy Updates, pg. 1). Notably, CMS has adopted the revised CPT codes and RUC recommended values for additional E/M visit code families, including home and nursing facility visits, hospital visits, and emergency department visits. AGS was involved in revising these codes in collaboration with the American Medical Association (AMA) and other medical societies that utilize these services and urged CMS to finalize these updates. These changes allow time or medical decision-making to be used to select the E/M visit level. Another example is the recently released update of the Centers for Disease Control & Prevention (CDC) guideline for opioid prescribing. Our pain experts and members of our Clinical Practice and Models of Care Committee carefully reviewed the draft guideline and the final guideline reflects more attention to the needs of older adults, particularly those living with dementia, so that they are not living in pain.

In 2022, our AGS staff team also brought us back to an in-person meeting in Orlando and released the eleventh edition of the *Geriatrics Review Syllabus*. We rolled up our sleeves as we launched an effort to

increase adult vaccination, and began to develop a curriculum focused on inclusion of people with multiple chronic conditions in research, with funding from the Council of Medical Specialty Societies/CDC and the National Institute on Aging (NIA) respectively. Plus, we moved the AGS office and have begun to settle into a hybrid approach to work which has staff working both remotely and in the office. As we did throughout the pandemic, we've maintained flexibility for our team in recognition that we are all balancing work and life within the context of a contagious illness that has been mitigated by vaccines but is still very much with us.

The November Board meeting brought an opportunity to update our diversity, equity, and inclusion workplan and I'd like to highlight some of our efforts here. I was honored to work with two great teams of authors on two papers recently published in the *Journal of the American Geriatrics Society*. The first was "[Exploring the intersection of structural racism and ageism in healthcare.](#)" Our follow up plans for this paper are to create three educational modules (Structural Racism, Ageism, and how they intersect in health care). We are also planning a second paper focused on the legal environment and potential policy changes that would make a meaningful difference. The second paper was an editorial, "[Change is coming: Efforts to enhance diversity, equity, and inclusion within the Journal of the American Geriatrics Society.](#)" that is focused on efforts underway at JAGS. We are working on additional papers that will report on our approach to ensuring attention to diversity in research presented at our AGS Annual Scientific Meeting, a summary of our

priorities and actionable strategies suggested by AGS members and leaders during the listening sessions we held in 2021, and a paper series focused on diversity in research in specialties.

There is also work going on "under the hood" here at AGS as we embed attention to equity across our programs and products. To date, we have updated all of the Cultural Navigator chapters focused on ethnicity, and we expect to complete the updates to the chapters focused on religion by December 2023 (Cultural Navigator is included in our free iGeriatrics app found on geriatricscareonline.org). In addition to our review of the 11th edition of the *Geriatrics Review Syllabus (GRS)* by an ethnogeriatrics advisor, we also reviewed the self-assessment questions through an equity lens before publication. The 7th edition of the *Geriatrics Nursing Review Syllabus* (which is based on the *GRS*) also reflects attention to equity as do the *GRS & GNRS Teaching Slides* and 2022 edition of *Geriatrics At Your Fingertips (GAYF)*. As new products are being developed or existing products updated, we continue to pay close attention to equity in our editorial process. Finally, the Diversity in Research Subcommittee of the AGS Research Committee and the AGS Annual Meeting Program Committee continue to gather information on how we are ensuring that attention is paid to diversity in research at the AGS Annual Meeting.

AGS Census Update

In November, we reported to the

Board on where we stood in our efforts to better understand the diversity of our membership as well as the diversity of our current Board and Committee members. Tables 1, 2, and 3 report our findings, as of October 30, 2022, on gender, Hispanic, Latinx, or Spanish origin, and race & ethnicity. Please note that our respondent numbers differ from table to table because of the changes we made to our census questions in 2021. We are grateful for the data you—our members—provide because this informs our approach to Board and Committee nominations and appointments. With the goal of being fully transparent to our members about alignment between our leadership and our members, we will be updating this report annually and sharing it via our website. We encourage all members to become engaged with the Society by joining special interest groups and sections, participating in abstract review, and being on the lookout for other opportunities to get to know us. Most of our Board and Committee members started on their society leadership journey by taking these initial steps, which also helped them to grow their national network of colleagues and potential collaborators.

As always, I am grateful to our AGS members for the work that you do, the ways in which you support each other and our Society, and your dedication to the older adults that are in your care. On behalf of the AGS staff team, we wish each of you the very best for a happy, healthy, and peaceful 2023. You inspire us. ✦



| Table 1: Gender | | |
|----------------------|---------------------------|---------------------------------|
| Response | AGS Members (Dues-Paying) | AGS Board and Committee Leaders |
| Female | 2,563 (59%) | 116 (67%) |
| Male | 1,727 (40%) | 56 (33%) |
| Non-Binary | 3 (<1%) | 0 (0%) |
| Prefer not to answer | 17(<1%) | 0 (0%) |
| Respondents: | 4,310 | 172 |

| Table 2: Hispanic, Latinx, or Spanish Origin | | |
|---|---------------------------|---------------------------------|
| Response | AGS Members (Dues-Paying) | AGS Board and Committee Leaders |
| No , not of Hispanic, Latinx or Spanish origin | 1,389 (89%) | 132 (96%) |
| Yes , another Latin or Spanish origin | 73 (5%) | 3 (2%) |
| Yes , Mexican, Mexican Am, or Chicano | 27 (2%) | 0 |
| Yes , Puerto Rican | 25 (2%) | 0 |
| Yes , Cuban | 6 (<1%) | 0 |
| Prefer Not to Answer | 39 (3%) | 3 (2%) |
| Respondents: | 1,559 | 138 |

| Table 3: Race & Ethnicity | | |
|--|---------------------------|---------------------------------|
| Response | AGS Members (Dues-Paying) | AGS Board and Committee Leaders |
| White—For example, German, Irish, English, Italian, Polish, French | 916 (63%) | 77 (58%) |
| Asian—For example, Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese | 303 (21%) | 32 (24%) |
| Some other race, ethnicity, or origin | 39 (3%) | 4 (3%) |
| Hispanic, Latino or Spanish Origin—For example, Mexican or Mexican American, Puerto Rican, Cuban, Salvadoran, Dominican, Colombian | 95 (6%) | 3 (2%) |
| Black or African American—For example, Jamaican, Haitian, Nigerian, Ethiopian, Somalian | 88 (6%) | 9 (7%) |
| I prefer not to answer | 38 (3%) | 4 (3%) |
| Middle Eastern or North African—For example, Lebanese, Iranian, Egyptian, Syrian, Moroccan, Algerian | 37 (3%) | 6 (5%) |
| American Indian or Alaska Native—For example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community | 10 (1%) | 0 (0%) |
| Native Hawaiian or Other Pacific Islander—For example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese | 3 (<1%) | 0 (0%) |
| Respondents: | 1,464 | 132 |

*Respondents could choose more than one response.

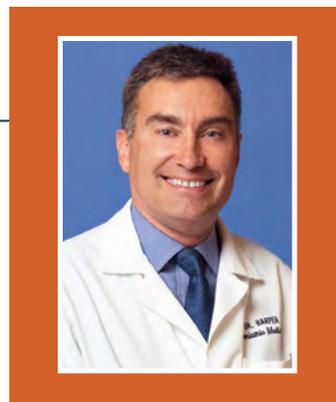
FROM OUR PRESIDENT

MICHAEL HARPER, MD, AGSF

I am writing this after attending our first in-person Board meeting since November of 2019. It felt good to be back together with colleagues in the new AGS office space on Fulton Street. Our new space is smaller, reflecting that the AGS has gone hybrid. Going hybrid allows us to continue offering a flexible approach to work for our wonderful AGS staff. This is in addition to reducing our overall operational costs, which alleviates pressure on our budget. As always, I was amazed by our staff's ability to seemingly effortlessly add moving the office to what is already a very full plate of programs, projects, and products.

At the Board meeting, staff and the Board finally had time to reflect together on the data that we and other societies have been gathering on the future of face-to-face meetings. One of the things that I think we all learned during COVID-19 is that virtual meetings can be very effective and in a lot of ways they are less of a drain on us as individuals than the days when we traveled – particularly when traveling across time zones as I often do. From our 2021 virtual meeting, we learned that many attendees appreciated that they could attend more sessions and from our 2022 hybrid meeting we saw that a number of our members chose the virtual offering. We also have been hearing from our own members and from other societies that there is pressure on academic travel budgets and that early career health professionals and those in training appreciated the flexibility that a virtual meeting offers. We realized that AGS is in a unique position to pilot an alternating schedule of virtual and hybrid (face-to-face with an on-demand option) annual meetings from 2023 to 2026, given that we do not have hotel contracts for 2024 and 2026 (see Table 1). We believe that

this pilot will offer us an opportunity to collect more data on member preferences and also to potentially serve a broader audience during the years that we are fully virtual. And when we do gather in-person after meeting virtually, we now have a greater appreciation for just how special that time



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can be. One more important benefit is that going virtual every other year is one way that AGS can reduce its carbon footprint, given the impact on the environment of a four-day face-to-face meeting. You'll be hearing more over the coming year about how we plan to support more frequent virtual networking among our members as we undertake this pilot. Stay tuned.

The end of the year is always a time when my family takes stock of our charitable contributions and the end of 2022 is no different. We support a number of great organizations through our giving but our own AGS Health in Aging Foundation is always top of my list as we plan for our end of year donations and look ahead to the New Year. There are three reasons for that.

First, the Health in Aging Foundation supports potential future leaders in geriatrics through its programs. I know that my donation brings trainees to our AGS Annual Meeting, supports New Investigators who are at the cutting edge of geriatrics research, and honors trailblazing leaders through our named awards (Hurria, Silverstein, and Yoshikawa). In addition to health professions students and residents, I am particularly pleased that, since 2016, our foundation has been bringing incoming geriatrics fellows to the AGS Annual Meeting – an opportunity they might not otherwise have as they finish their residencies and transition into new roles. In 2022, as incoming President,

Table 1. 2023 – 2026 AGS Annual Meeting Dates

| Year | Location | Dates |
|------|----------------|-------------------------------------|
| 2023 | Long Beach, CA | May 4-6 (Preconference Day, May 3) |
| 2024 | Virtual | May 9-11 (Preconference Day, May 8) |
| 2025 | Chicago, IL | May 8-10 (Preconference Day, May 7) |
| 2026 | Virtual | May 7-9 (Preconference Day, May 6) |

I had the honor of meeting some of our trainees and awardees. They are truly an amazing group of individuals and I believe our future is bright given the clear talent of our students, fellows, and early career professionals.

My second reason is our comprehensive (and free) online resource for older adults and those who care for them, HealthinAging.org.

To say that I am #AGSProud of this work would be an understatement. HealthinAging.org is another great example of where AGS has leveraged its own investment in professional education and clinical tools to bring the knowledge of geriatrics health professionals to the public via the Health in Aging Foundation. Speaking as Co-Editor in Chief of the eleventh edition of the *Geriatrics Review Syllabus (GRS11)*, it is incredibly cool to see all of the work that we did being leveraged to provide a free resource for the public. One thing I am particularly excited about this year is that the team is tackling readability with the goal of making our materials more accessible to everyone. This effort to make our public education resources more accessible is one aspect of the ways that AGS is working to embed attention to diversity, equity, and inclusion into all that we do (see AGS 360° on page 4 from our AGS CEO Nancy Lundebjerg for a fuller update on our efforts).

My third reason is that AGS leverages the work that we do as a professional society to support the work of the AGS Health in Aging Foundation. In addition to translating a member resource like the *GRS11* for the public, AGS provides the staff support that is the engine that drives the Foundation forward. Roughly translated, this means that 90% of the charitable contribution I make to the AGS Health in Aging Foundation is going to support programs that align with my priorities to support the next generation of geriatrics health professionals and to bring our knowledge and expertise to the public.

When AGS launched the Health in Aging Foundation in 1999, I was an early-career geriatrician and a relatively new member of AGS. To be honest, I wasn't paying attention to the Society's decision to establish a foundation, and could not have known how the importance of that decision reverberates now. These days, in the wake of COVID-19, there is a pressing need for societies like AGS to be trusted sources of health information for the public, and I am so grateful that we are positioned to do just that via HealthinAging.org. A tip of my hat to the current members of the AGS Health in Aging Foundation Board and our AGS staff team for the work that they do on behalf of all of us as we age. I am a proud supporter of the AGS Health in Aging Foundation due to their careful stewardship. If you aren't already a donor, I encourage you to visit <https://account.americangeriatrics.org/> donate to learn more about the ways in which you can support this important work.

In 2017, we celebrated the AGS's 75th anniversary and one of the themes of that celebration was how we are stronger together. The [performance](#) of our commissioned AGS theme song commemorating our 75th anniversary remains a fun moment in our history that is worth a listen. At the end of 2022, our 80th year, I remain grateful to our members for your passionate dedication to caring for all of us as we age and for the ways in which you have supported each other through the pandemic. Your resilience is amazing and you have all made us stronger together throughout these past several years.

As we round the corner to 2023, I hope each of you is able to take time to reflect on how important you are to the people around you and to think about the potential of 2023 for achieving your personal goals. I am looking forward to a happy, healthy, and hopeful new year for all of us. ♦



CMSS



SSAAI

SPECIALTY SOCIETIES ADVANCING
ADULT IMMUNIZATION

AGS is one of seven societies participating in an effort to increase adult immunization rates that is being led by the Council of Medical Specialty Societies (CMSS) with funding from the Centers for Disease Control and Prevention (CDC). To date, we have created and launched a new "[Essential Vaccinations for Older Adults](#)" section on HealthinAging.org devoted specifically to older adult immunizations. Over the next several months we will be updating and expanding our portfolio of public education materials on adult vaccinations so that these parallel the new professional resources that we are creating. Even as we embark upon this work, we recognize that our members are focused on ensuring that the older adults that they care for have been vaccinated against pneumonia and flu and are up-to-date on their COVID-19 shots. We encourage members to download iGeriatrics, which has the most up-to-date recommendations from Advisory Committee on Immunization Practices (ACIP), and also to be on the lookout for information on our new and enhanced resources in our Week in Review email.

AGS Calls on Congress and the President to Pass Legislation Protecting People's Access to Health Care Across the Lifespan

We released a [statement](#) condemning the Supreme Court decision in *Dobbs v. Jackson Women's Health Clinic* and calling on Congress and the administration to protect people's access to health care and right of self-determination across the lifespan.

AGS Opposes Policies that Discriminate Against LGBTQ+ Individuals

We released a [statement](#) opposing policies that discriminate against persons who are LGBTQ+. The statement also opposes legislation, orders, or policies that implicitly or explicitly single out or target groups or individuals and directly stigmatize and isolate already vulnerable populations.

2023 Medicare Physician Fee Schedule

In September, the AGS submitted extensive [comments](#) in response to the Centers for Medicare and Medicaid Services (CMS) Calendar Year (CY) 2023 proposed rule updating the Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP). On November 1, CMS released the final rule, which will take effect on January 1, 2023. AGS was still reviewing the rule as this update was finalized but of note, CMS has adopted the revised CPT codes and RUC recommended values for additional E/M visit code families, including home and nursing facility visits, hospital visits, and emergency department visits. AGS was involved in revising some of these codes in collaboration with the American Medical Association (AMA) and other medical societies that utilize these services and urged CMS to finalize these updates. These changes allow time or medical decision-making to be used to select the E/M visit level. CMS also finalized its proposal to extend telehealth coverage for the codes that were only going to be on the telehealth list through the end of the Public Health Emergency (PHE) for an additional five months. Our comments address additional areas of interest, including CMS's request for feedback on ways to identify potentially underutilized services which defined by CMS as supporting beneficiaries in promoting health and well-being. AGS highlighted the Annual Wellness Visit (AWV), complex/chronic care management, cognitive assessment and care, and immunizations and vaccinations, as high value services that more Medicare beneficiaries should be receiving. The AGS commented in detail on immunization administration and the importance of vaccine counseling to address patients' questions and concerns and to help overcome any hesitancy regarding vaccines and appropriate preventive care. We also highlighted the importance of maintaining payment for audio-only services after the end of the PHE. Also of note, the AGS continues to advocate individually

and in coalition urging Congress to act before the end of the year to address the impending Medicare payment reductions set to take effect on January 1st due to the Medicare Physician Fee Schedule adjustments, Medicare sequester, and Statutory PAYGO Act.

Work Related to the Approval of Aducanumab

Since the Food and Drug Administration (FDA) approval of aducanumab in June 2021, the AGS has been engaged in numerous activities including [professional](#) and [public education](#) work that have been in parallel to our regulatory policy comments that are outlined below.

Comments and Final Decision Around Coverage of Monoclonal Antibodies for Treatment of Alzheimer's Disease

In April 2022, CMS announced their decision around coverage for monoclonal antibodies directed against amyloid for the treatment of Alzheimer disease (AD). The decision finalized a two-part National Coverage Determination (NCD) that addresses coverage of aducanumab and any future FDA-approved monoclonal antibodies directed against amyloid for the treatment of AD. The AGS believes this is the right decision for the reasons we conveyed in our [February 2022 letter](#) on the NCD to CMS which indicated support for randomized trials and study populations that reflect the diversity of Medicare beneficiaries who are living with AD. The AGS also solicited an [editorial from Vincent Mor and Maria Glymour](#) for JAGS focused on trial design for the required CMS trials, which we highlighted in our comments. While aducanumab is the only treatment in the class with approval from the FDA at this time, AGS continues to monitor additional drugs in this class that are moving through the pipeline. In July 2022, Eisai and Biogen's Biologics License Application (BLA) for lecanemab was [accepted by the FDA](#) under the accelerated approval pathway. FDA's final decision is expected by January 6, 2023.

Comments on CMS Reconsideration of Beta Amyloid PET Scans

We submitted comments, both [individual](#) and in a [joint letter](#), to CMS on their reconsideration of the NCD on positron emission tomography (PET) beta amyloid imaging in dementia and neurodegenerative disease (NCD 220.6.20). This NCD limits coverage of beta amyloid PET scans to CMS-approved clinical trials that meet the requirements for Coverage under Evidence Development (CED) and limits the number of beta amyloid PET scans covered per patient to one per lifetime. The AGS believes that this NCD inappropriately limits coverage of beta amyloid PET for Medicare beneficiaries, including beneficiaries who may be candidates for monoclonal antibodies directed against amyloid for the treatment of Alzheimer disease (AD). As

we have recommended to CMS in the past, we continue to believe that NCD 220.6.20 should be retired in its entirety, which would mean that beta amyloid PET would be covered at the discretion of Part A/B Medicare Administrative Contractors (MACs) just like every other PET scan.

Recommendations to ICER on Beta-Amyloid Antibodies for Early Alzheimer Disease

We submitted [comments](#) to the Institute for Clinical and Economic Review (ICER) on its [draft scoping document](#) outlining the plan to assess donanemab and lecanemab for the treatment of early Alzheimer disease. We also supported a reassessment of aducanumab to update ICER's evidence review should new clinical evidence emerge. We provided several recommendations following ICER's framework—Populations, Interventions, Comparators, Outcomes, Timing, and Settings (PICOTS)—including to assess the reported level of diversity, equity, and inclusion. Given the racial and ethnic disparities in the prevalence of AD and other dementias among subpopulations and increasing diversity of older adults, it is critical to ensure granularity in the sociodemographic factors (i.e., age and race/ethnicity).

We also continue various regulatory and advocacy work around our key priorities that will improve the health, independence, and quality of life of all older adults.

Comments in Response to OTC Hearing Aids Proposed Rule

We submitted a [comment letter](#) in response to the FDA [proposed rule](#) establishing over-the-counter (OTC) hearing aids. We expressed support for the proposed changes to reduce barriers for the millions of Americans adversely affected by hearing loss and increase access to appropriate treatment. Our recommendations focused on the requirements for package labeling that provide information to persons planning to buy or use the OTC hearing aids. We encouraged greater visibility and readability for all the information provided by the FDA as well as using language that would reduce concerns around stigmatization associated with hearing loss and/or the visibility of hearing aids.

Recommendations to ASPR on the 2023-2026 National Health Security Strategy

We submitted [comments](#) to the Office of the Assistant Secretary for Preparedness and Response (ASPR), within the U.S. Department of Health and Human Services (HHS), to help inform the development of the 2023-2026 National Health Security Strategy. We shared our recommendations related to public health and medical preparedness, response, and recovery challenges as well as promising practices and actions to take to mitigate the challenges,

addressing concerns for older adults. We believe it is critical that we are prepared to identify and respond to the care needs for the whole of our population in an inclusive and equitable manner in the event of a national health security threat.

Recommendations to HHS on the Physical Activity Guidelines for Older Adults

We submitted [comments](#) to HHS to inform the Physical Activity Guidelines Midcourse Report on older adults. As part of our letter, we provided recommendations around ensuring diversity and inclusivity in the report to communicate that physical activity is for all people, including people with diverse racial and ethnic backgrounds as well as individuals who have disabilities, use assistive devices, or reside in skilled nursing and other long-term care facilities. Considering the health benefits of physical activity, and the small number of older adults who meet recommendations for aerobic and muscle-strengthening activities, it is crucial to identify best practices to encourage older people to be more physically active.

Comment Letter to HHS on Strengthening Primary Care

We submitted comments in response to an HHS Initiative to Strengthen Primary Care. We highlighted the need for effective teams, which requires team-based training, payment for team-based care, and communication technologies that link a primary medical care site with other medical settings of care and community-based services. For this to occur, we emphasized the need for effective payment models for training and primary care, which currently only exist in pilots or demonstrations with few exceptions.

Funding Requests for Key Workforce and Aging Research Programs in FY 2023

In written testimonies to appropriators, we stated support for increased funding in Fiscal Year (FY) 2023 for the geriatrics workforce training programs, the National Institute on Aging, and the Veterans Affairs Medical and Prosthetic Research Program, emphasizing the increasing need for training in geriatrics and gerontology and necessity of investing more in research on the nature of aging.

Comment Letter to CMS on Revising Nursing Home Staffing Requirements

We submitted [comments](#) in response to a CMS request for information (RFI) on revising nursing home staffing requirements. Among other items, we recommended strategies for recruiting and retaining staff including sign-on and retention bonuses, free on-the-job training, and oversight, making the environment less punitive and more

supportive of training, and increasing salaries to attract registered nurses (RN) and nurses with a Bachelor of Science in Nursing to these settings. We also commented on minimum staffing requirements including support for a 24-hour RN presence and noted that when staffing levels are set too low, nursing homes may be incentivized to “staff down” to the minimum.

Recommendations to CMS on Revisions to the Geriatrics Specialty Measure Set

We submitted [comments](#) to CMS on revising the existing Geriatrics Specialty Measure Set for the Quality Performance Category for Performance Year (PY) 2023 of the Merit-based Incentive Payment System (MIPS) Program to ensure that the proposed Geriatrics measure

set for PY 2023 best addresses the unique healthcare needs of the geriatric population and reflects the most relevant measures appropriate for the geriatrics specialty. We particularly appreciated CMS’s consideration of two measures that are focused on the social drivers of health and strongly supported the inclusion of these measures.

Support for the WISH Act

We sent a [letter](#) to Representative Suozzi (NY) supporting the Well-Being Insurance for Seniors to be at Home (WISH) Act ([H.R. 4289](#)), a bill to create federal catastrophic long-term care insurance for older adults. It is critically important that we start to develop solutions to ensure robust choice in long-term services and supports for older adults and alleviate burden on families. ♦

➤ Please visit the online version of this newsletter at <https://www.americangeriatrics.org/publications-tools/current-ags-newsletter> for links to the work referred to in this article.

Apply to be an Editorial Board Member for JAGS

Please consider applying to be on the Editorial Board of JAGS. Being an editorial board member is an opportunity to engage in the selection and guidance of cutting-edge research and scholarship for the leading clinical Geriatrics journal. The primary role of editorial board members is to provide at least 6 high quality timely reviews per year. Detailed expectations of editorial board members are below. We are seeking applicants with the following qualifications:

- Reviewed for JAGS at least 3 times in the last 12 months
- Reviews are of high quality
- Academic faculty at the Instructor, Assistant, Associate, or Professor level
- Member of the American Geriatrics Society

Though we will consider applicants with expertise in all areas of geriatrics and gerontology, we are particularly interested in candidates who will provide exemplary reviews in the following areas:

- General geriatrics, including clinical trials and implementation studies
- Cognitive impairment and dementia
- Social well-being and social determinants of health
- Depression and other mental health issues
- Abuse and self-neglect
- Frailty
- Applied and translational geroscience
- Health services research
- Prescribing in older adults

We strongly encourage and welcome applicants from backgrounds that are traditionally under-represented in medicine.

To apply, please send the following via email to JAGS Managing Editor, Chandler Carpenter, at jags@jeditorial.com:

- A paragraph on why you are qualified and your motivation for joining the JAGS editorial board
- Your NIH biosketch or CV

This call for applications will be open until December 31.

Detailed expectations of JAGS Editorial Board members:

- Review a minimum of 6 papers per year (or as many as requested up to that number). It is expected that no more than 25% of the first six requests will be refused.
- Complete most reviews within 2 weeks of accepting the assignment and ALL reviews within 4 weeks.
- Review some general geriatrics papers as well as those in area(s) of personal expertise
- Focus reviews on relevance to current or future clinical practice, research, or policy
- Provide advice to help authors of every paper, even if opinion is to reject
- Attend the annual JAGS editorial meeting at AGS
- Participate in mid-year JAGS editorial meetings by phone or webinar
- Assist in recruiting 2 or more early career stage reviewers per year
- Solicit submissions to the journal
- Provide advice on overall journal strategy and future content

GINA UPCHURCH INTRODUCES VICE PRESIDENT KAMALA HARRIS'S INFLATION REDUCTION ACT SPEECH

Since founding Senior PharmAssist in Durham, North Carolina in June 1994, Gina Upchurch, RPh, MPH, has been promoting healthier living for older adults by helping them access and manage the medications they need, especially those on limited incomes. Over the years, Senior PharmAssist has helped individuals obtain necessary medications by providing direct financial assistance through a prescription card program to older adults in Durham with limited means and by helping people maximize alternative sources of medication assistance, including drug company programs. Recognizing that many beneficiaries needed help reducing out-of-pocket expenses despite federal and state programs, Senior PharmAssist helps older adults to empower themselves and become wiser consumers and active participants in the maintenance of their own well-being.

Through advocacy initiatives, Senior PharmAssist has also worked with other organizations and elected officials at state and national levels to promote policy changes that will improve medication access and safety for older adults. These efforts have yielded tangible results, including the creation of statewide programs such as NCRx and CheckMeds NC, which wrapped around the inaugural Part D benefit in the late 2000's. Senior PharmAssist has demonstrated meaningful change at the local level that has influenced how the health needs of older adults throughout the state—and beyond—are addressed. Gina is also an active member of the AGS's Public Policy Committee. Most recently, she co-authored a paper published in the *Journal of the American Geriatrics Society (JAGS)* that provides a framework for understanding the intersection of structural racism and ageism in health care.

On September 1, 2022, Gina was invited to host an event involving North Carolina Governor Roy Cooper, Administrator of the Centers for Medicare and Medicaid Services (CMS) Chiquita Brooks-LaSure, and Vice President Kamala Harris, who delivered comments about the Biden administration's efforts to lower health-care costs for older adults through the Inflation Reduction Act, which had recently been signed into law.

Working directly with the White House is a huge opportunity. How did you get involved in hosting?

About a week before, some folks with the state AARP advocacy office contacted me and told me about the Vice President's potential visit to North Carolina to discuss the passage of the Inflation Reduction Act (IRA). I think they saw via social media how positive we were about it and knew us as advocates for Medicare beneficiaries. They asked if we could bring some older adults to meet with the Vice President, to which I responded, "Absolutely! How many do you want? And what's the topic?" Once we agreed, the Vice President's office got in touch with us and after talking to one person, they decided that they were going to come to see us in Durham because it'd be easier than everyone traveling to Raleigh.

There must have been a lot of work to prepare! What was going on behind the scenes in the time period leading up to it? Did you speak to Vice President Harris in advance?

After I talked to the Vice President's scheduling person, two of the main policy people got in touch with me to start talking about the Inflation Reduction Act: what we thought of it, what specific points that I felt should be made, and whether we had older adults who could speak with her



Gina Upchurch with Chiquita Brooks-LaSure

about it. We certainly knew people who would be affected but we weren't sure how many of them would be willing to share their personal stories in such a high-profile way. At first, our participants—like most people—didn't necessarily understand exactly how the law would impact them, so I explained what it will mean for them and their specific medication issues and costs. We quickly found five older adults who said they would be thrilled to speak to the Vice President about the law. We were told that I would be her host and she would have private meetings with the older adults and advocates and then she would make public comments to a much larger audience.

I worked with the policy staff to focus on four targeted Medicare Part D highlights in the Inflation Reduction Act. They included insulin prices being capped at \$35/month and shingles vaccines being covered with no copayment beginning in 2023. And in 2024, the eligibility for "full" extra help with Part D would be expanded to those who currently only qualify for "partial" extra help. And finally, the catastrophic level for Part D when individuals without extra help still pay 5% of the list price for medications will be eliminated in 2024 and that annual cap goes down to \$2,000 maximum out-of-pocket in 2025.

I was supposed to be on vacation when I heard they were coming to

Durham, so I ended up talking to the Vice President's folks a lot that week and was fortunate to have others at the County-owned building where we are located—the Durham Center for Senior Life—take the lead on preparing the building for these special visitors! I woke up at 4 am one morning thinking about the visit and decided—without being asked—to write the introduction for the Vice President. I sent my draft to her office later that morning and one person quickly replied, “This is fantastic, just make it a little shorter and you're good to go!” I was surprised that they didn't edit it and allowed it to be in my perspective on the IRA and what it means to Medicare beneficiaries. They also encouraged the nine older adults and advocates that she met with to be authentic; they didn't want scripted conversations. Vice President Harris wanted to know about the older adults she was going to meet with. She wanted to understand their voices, who they were, and what they had to say.

There were two smaller meetings behind the scenes before the big event. During one we introduced the staff members working for the Vice President and CMS to the five older Senior PharmAssist participants and four advocates whom we've worked with at the state and local levels.

On the day of the event, I spoke to the Vice President before I introduced her to our participants and advocates. She was super warm. She thanked me for hosting and said she looked forward to meeting people who were going to be affected by the legislation. I expressed our appreciation for the work the current administration is doing to make life better for Medicare beneficiaries. I also thanked her for her leadership as a woman and as a Black woman, which is inspirational to me and many other people in our country. I also had a chance to speak during the afternoon with Chiquita Brooks-LaSure about the details of the legislation and with Governor Cooper about possible Medicaid expansion in North Carolina.

What was most surprising about your experience?

One thing that surprised me about the experience was that the security was just amazing. Many people worked behind the scenes to ensure safety in the building. On the Sunday before our event (which was on Thursday), there were 30 Secret Service people here. Sunday early morning, they were scanning the building and checking everything. If you went anywhere near the building on the day of the event, they scanned for bombs in your car and had sniffer dogs working. I think it's a commentary about how careful our elected officials need to be and made me admire them for the daily risks they endure to get their work done.

On a positive note, I was very impressed with the policy staff who work with the Vice President. As we were talking about the legislation and the impact that will have, they clearly knew what they were talking about, and they listened to what our older participants and advocates had to say, including ideas for strengthening Medicare. That was reassuring! It was also great that they wanted to know the people, the individual stories, and how this new legislation affects them on a day-to-day basis.

What impact do you think the event will have in the longer term?

I think it was important to put a face with the policy. It is easy to focus on data and talk about how this new legislation should decrease hospital stays, for example, and this is critical for deciding how to make investments. In addition, I have found that some officials are inspired to work on legislation when they understand how real people will be supported in tangible ways by hearing their stories. Ideally, the stories are from the individuals most directly impacted and we did just that with the Vice President's visit. An 85-year-old woman shared that her medicines current cost \$1,585 with partial “extra help” and this has been a major

struggle for years, especially when her husband had been diagnosed with Parkinson disease. With the new law and shift in extra help eligibility, her medication cost will drop to \$284 in 2024.

Another example includes a community pharmacist who shared that he regularly sees older adults leave his pharmacy without prescriptions because they simply cannot afford it. And a Hispanic advocate told the Vice President that too many individuals she knows who are legal residents that are eligible for Medicare because they have paid into Social Security for years are often not aware that they are eligible. Hearing these true stories firsthand make them real.

Since September, I have been in touch with the policy staff at CMS and in the Vice President's office. We're watchfully waiting and keep an eye on what unintended consequences may come from some of this. How regulations are rolled out really matters. While I had their attention, I quickly shared some ideas that we feel could improve a couple of things. I wouldn't have had that opportunity if I hadn't been involved in this event. ♦



AGS COMMUNICATIONS TEAM

Michelle Miller
Communications Manager

Brooke McPherson
Communications Coordinator

Elvy Ickowicz
Senior Vice President, Operations

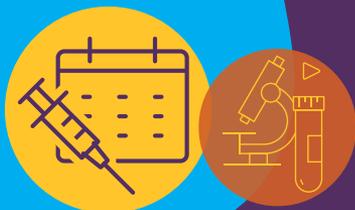
Nancy Lundeberg
CEO

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GET THE BASICS

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Essential Vaccines for Older Adults

Getting vaccines to protect you from illness is one of the most important things you can do to stay healthy. Vaccines are often injections, sometimes called “shots.”

Vaccines are very safe. Vaccines can have side effects, but for most people, it is more dangerous to risk getting sick. If you have concerns about vaccine side effects or safety, speak to your healthcare provider.

To get your vaccines, you can contact your healthcare provider. You can also ask your local health department for more information on where to get these vaccines. You also may be able to get vaccines at your local neighborhood pharmacy.

There is a government agency called the Centers for Disease Prevention and Control (CDC). The CDC recommends the following vaccines for most older adults.

- **COVID-19 Vaccine**
- **Influenza (Flu) Vaccine**
- **Pneumococcal (Pneumonia) Vaccine**
- **Shingles (Herpes Zoster) Vaccine**
- **Tetanus/Diphtheria Vaccine**



■ COVID-19 Vaccine

What it does: Protects against getting seriously ill from COVID-19.

Who needs it: Everyone older than 6 months should be up to date with the COVID-19 vaccine.

When to get it: All adults should be up to date on COVID-19 vaccines. You are up to date with your COVID-19 vaccine if you have had your primary series of COVID-19 shots and a bivalent (updated) booster.

The timing of the primary series and booster can be different based on your age, the type of vaccine you get, or if you are immunocompromised (have a weakened immune system). Your healthcare provider will let you know which doses you should get and when.

There are four vaccines used in the United States to prevent COVID-19. Pfizer, Moderna, and Novavax are the vaccines that the CDC recommends. The Johnson & Johnson vaccine is not recommended in most situations.

■ Influenza (Flu) Vaccine

What it does: Protects against serious illness from yearly flu viruses.

Who needs it: All older adults should get a flu vaccine. People with certain conditions should especially get a flu vaccine, since they are at higher risk for serious side effects from the flu. These groups of people include:

- People 65 years old or older
- Nursing home residents
- People with serious health conditions such as heart disease, diabetes, asthma, lung disease, or HIV.
- Caregivers for older adults. This helps them avoid spreading the flu. There are flu vaccines that are specifically for people 65 or older. The CDC recommends that people 65 or older receive any of the flu vaccines specifically for older adults.

You should not get the flu vaccine if you have had an allergic reaction to the flu vaccine in the past. You should also not get a flu vaccine if you have been diagnosed with Guillian-Barre Syndrome within 6 weeks after previously receiving the flu vaccine.

When to get it: New strains of the flu develop all the time. Because of this, you should get the flu vaccine every year. You should get your flu vaccine in the fall.

■ Pneumococcal (Pneumonia) Vaccine

What it does: Protects against serious illness caused by pneumococcal bacteria. Pneumococcal bacteria can cause pneumonia (a serious infection in the lungs) and infections of the blood and brain.

Who needs it: Anyone 65 years or older

When to get it: There are two kinds of pneumococcal vaccines available: Pneumococcal conjugate vaccines (PCV13, PCV15, or PCV20) and pneumococcal polysaccharide vaccine (PPSV23).

Ask your healthcare provider which vaccine is best for you.

■ Shingles (Herpes Zoster) Vaccine

What it does: Protects you from getting shingles. This vaccine is called Shingrix. It is very effective in reducing the risk of shingles for older adults. It also protects people from developing a side effect that causes chronic pain (called postherpetic neuralgia).

Who needs it: The CDC recommends that people 50 years and older get the Shingrix vaccine. You should get the shingles vaccine even if you have had shingles before. There also is an older shingles vaccine called Zostavax. You should get a Shingrix shot even if you have had a Zostavax shot previously.

You should not get a Shingrix vaccine if you have had an allergic reaction to any of its ingredients before. You should also not get the vaccine if you currently have shingles. Wait until your symptoms are gone before getting the shingles shot.

When to get it: Shingrix requires two doses. The second dose should be given between 2-6 months after the first dose. If it has been longer than 6 months since the first dose, it's okay to get the second dose at any time.



■ Tetanus/Diphtheria Vaccine

What it does: There are two types of vaccine that protect you from two potentially deadly bacterial infections. One type is called TD. TD protects you from the diseases tetanus and diphtheria. The second type is called Tdap. Tdap protects you from tetanus, diphtheria, and another disease named pertussis (also called “whooping cough”).

Who needs it: Everyone. You should get a one-time dose of the Tdap vaccine if you are 65 or older and have not had the Tdap vaccine previously. This will help protect you and your grandchildren from whooping cough.

When to get it: Once every 10 years.

The CDC also recommends other vaccines for older adults.

These include the measles, mumps, rubella (MMR) vaccine, and vaccines for varicella, hepatitis A and B, and meningococcal disease. You could have a higher risk of getting these diseases if you have certain health problems, occupations, or lifestyles. Ask your healthcare provider if you should get any of these additional vaccines.

For additional information, visit the CDC website at <https://www.cdc.gov/vaccines>.



40 FULTON STREET
SUITE 809
NEW YORK, NY 10038
212.308.1414 TEL

Info@healthinaging.org

The AGS Health in Aging Foundation is dedicated to improving the health, independence, and quality of life of all older people. We aim to empower older adults and caregivers to actively participate in their health care and decision-making.

DISCLAIMER: This information is not intended to diagnose health problems or to take the place of medical advice or care you receive from your physician or other healthcare provider. Always consult your healthcare provider about your medications, symptoms, and health problems. August 2022

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