

GET INVOLVED

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Committee Applications Due January 8, 2024
Board Nominations Due October 2, 2023

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REENA KARANI, MD, MHPE, FACP, AGSF ELECTED AS FIRST WOMAN OF COLOR AND FIRST GERIATRICIAN TO SERVE AS NBME CHAIR

We are #AGSProud of Reena Karani, MD, MHPE, FACP, AGSF, who was recently elected Chair of the National Board of Medical Examiners (NBME). Dr. Karani is the first woman of color to serve as chair in the organization's 108-year history. "This election reflects Reena's dedication to ensuring that medical education is preparing students to care for all of us as we age," commented AGS Board Chair, G. Michael Harper, MD, AGSF. "Throughout her career, Reena has exemplified the best of medical education. Her commitment to equity is unparalleled and we are fortunate that Reena, who is also the first geriatrician to serve as NBME Chair, has contributed her time and talent to the AGS including in her most recent role as a member of the AGS Board of Directors."

Dr. Karani is the Director of the Institute for Medical Education and a Professor of Medical Education, Geriatrics and Palliative Medicine, and Medicine at the Icahn School of Medicine at Mount Sinai in New York City. She has served in a variety of educational leadership roles throughout her career, including as Co-Director of the Integrated Medicine-Geriatrics Clerkship and as Senior Associate Dean for Undergraduate Medical Education and Curricular Affairs at Icahn Mount Sinai. During her career, she has mentored hundreds of trainees and faculty members who have gone on to continue careers in geriatrics, lead geriatrics programs, and change health care across the United States.

AGS News caught up with Dr. Karani recently for a short conversation about her recent appointment and her commitment to improving the care of older adults through improving medical education.



AGS WORKS TO IMPROVE VACCINATION RATES

The American Geriatrics Society (AGS) is working to improve vaccination rates among older adults on two fronts. First, AGS policy leaders and staff are developing commentary on the Centers for Medicare and Medicaid Services (CMS) proposed 2024 Physician Fee Schedule. We were pleased to see that CMS is proposing to retain the additional payment for administering the COVID-19 vaccine in the home and to extend that additional payment to the following vaccines included in the Part B preventive vaccine benefit: pneumococcal, influenza, and hepatitis B. As a part of its rationale for this proposal, CMS noted that it had reviewed Medicare data and found that the extra payment correlated with an increase in vaccination for both Medicare and Medicare-Medicaid beneficiaries.

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This is the second version of AGS 360 that I've written for the Q3 newsletter. Our fabulous AGS staff had asked me to write about lecanemab from a care partner perspective and, as with most writing that draws on my own experiences, that has turned into a lengthier and more involved piece than I had anticipated. So here I am penning a different piece as I work through some of the rough patches in my first draft for potential submission to a journal.

A long time ago, I penned a letter to the editor of *The New York Times* (NYT) that commented on an article that they had published reporting how the mortality rate for women with high body mass index (BMI) exceeded that for women with lower BMI. Alas the letter was not published – for some reason, the NYT liked my comments about sports more than my comments on their health reporting. For those of you who are wondering, I used to seize every opportunity to write a letter to the NYT (see [Waking from a Dream](#) and [Emotions on the Court](#)). As I recall, my general comment was that the *Times* had simplified the results of the study so much that the reader was left with the impression that women with high BMI had a much higher chance of dying young than women with lower BMI.

Which brings me to a list of questions about lecanemab that AGS members might field from care partners like me and the older loved ones we care for.

1. What does that widely reported and much advertised 27% slower decline in cognition mean in real terms? And by real terms, I mean how many months would my loved one—or for that matter me—gain from going on a drug with a high risk of an adverse event. I asked

AGS leaders this question given we were working on our lecanemab professional education piece. As it turns out, the widely reported positive benefit—a 27% slowing of decline in cognition—was originally highlighted in a [press release](#) about the results of the Clarify AD trial that Eisai presented at the November 2022 Clinical Trials on Alzheimer's Disease (CTAD) conference, in San Francisco, California and virtually. In their *New England Journal of Medicine* (NEJM) paper ([DOI:10.1056/NEJMoa2212948](#)), van Dyck and colleagues described this result as follows: “*The adjusted least-squares mean change from baseline at 18 months was 1.21 with lecanemab and 1.66 with placebo (difference, -0.45; 95% confidence interval [CI], -0.67 to -0.23; P<0.001).*” Basically, this translates to a 27% difference from 1.66 points which was the decline in the CDR-SB score in the placebo group. Andrews and colleagues ([DOI:10.1016/j.trci.2019.06.005](#)) have defined minimally clinically important differences (MCID) when considering efficacy, for mild cognitive impairment (MCI) and mild Alzheimer's disease (AD), as being a difference of 0.98 and 1.63 points for CDR-SB, respectively). Therefore, the between-group difference of 0.45 does not meet the MCID.

The trick for geriatricians who are discussing lecanemab with older adults and their care partners will be turning that really complicated set of concepts into the same sort of plain English that caused me to ask the question about the reported 27% decline in the first place. As a care partner and even a potential candidate for the therapy, I would want to know that there is a lot of uncertainty around whether lecanemab is going to have a meaningful impact on my disease trajectory and that there

is an ongoing debate about what the magnitude of the clinical meaningfulness is in the lecanemab trial. If I were pressed to sum this up into a sentence, as a layperson, I might say: “this drug clears brain amyloid and it does that well; experts disagree as to how well it might do in slowing your cognitive decline. Some experts posit that it might give you 5 more months than if you were to do nothing and others are not so sure. The data we have doesn't really tell us what those five months might look like for you because we do not know what the slower decline means in terms of your being able to still do the things that you love to do. I know there is a lot of uncertainty in what I am telling you but I think it is important for you to know that there is much we don't know before making a treatment decision.”

2. What are the risks of adverse events for this drug? As it turns out, those are significant and, when I think about the people I have cared for, we would be in uncharted territory because they quite likely would have been excluded from the trial. I would want to know what the risks are, if there are ways to mitigate those risks, and what I can do as a care partner to monitor for potential adverse events.

3. How much additional caregiving time should I be budgeting if we decide to try this treatment? The Clarity AD trial required that anyone participating in the research have a partner who had 8 hours of availability

weekly to support and spend time with their loved one. To me, it makes complete sense that if I were undergoing this treatment, I should have a care partner with similar availability given I would already have mild to moderate dementia. As a potential care partner, I'm lucky I have a job that I can do from anywhere and I do not have children. For others, being available may mean they are borrowing from another time bank to add additional time into their day-to-day caregiving for their loved one. Sadly, when we talk about access to new treatments, we all too often do not discuss what that means for the care partner – particularly those who are hourly wage workers, or those who can't work remotely (e.g., a clinician with a full patient load), or someone who is caring for young children.

4. Can you give me a range for the out-of-pocket costs we might incur as a family for this treatment? It's important that people considering lecanemab have an understanding of all the potential costs of this treatment. Arbanas and colleagues ([DOI:10.1001/jamainternmed.2023.1749](https://doi.org/10.1001/jamainternmed.2023.1749)) have estimated that the annual out-of-pocket cost for Medicare beneficiaries could be as high as \$6,636 annually based on Medicare paying 80% of all costs and beneficiaries being responsible for the remainder. They did not factor the cost of caregiving into this analysis and did not account for Medigap policies which could potentially cover the entirety of the costs. In a January 2023 [press release](#), Eisai projected that the average patient receiving lecanemab would be on the drug for 3.6 years.

5-7. What happens when lecanemab stops working and my loved one's cognitive decline picks up speed? What do I need to be thinking about in terms of their needs as their dementia progresses? They are on a fixed income with limited savings, how do I weigh the potential time gained with

a drug like lecanemab against the likelihood they will need long-term services and supports? Quite frankly, Alzheimer's disease and related dementias (ADRD) are just one of the many ways our bodies decline even as scientific advances allow us to live longer lives. As a clinician, you may not have the answers to all of these questions but should be prepared to steer older adults and their loved ones to resources that can support them in making decisions that take into account the long-term trajectory of ADRD. Our AGS Health in Aging Foundation resource, HealthinAging.org, provides top-level information and a roadmap to resources from other organizations. It's also important to have information on local resources available including how to get in touch with your [local area agency on aging](#).

8. What matters to me or to my loved one? As a potential future candidate for treatment and a care partner, this

is the most important question of all. If my or my older loved one's answer is that "lecanemab is the right treatment" for meeting my care goals, then we need to honor that decision. Hopefully, I would have access to geriatrics health professionals to help navigate all the decisions that are going to come in the wake of that **very** big decision. I have been a care partner with and without access to clinicians with expertise in caring for older people and having access to geriatrics expertise makes a world of difference to their care. Unfortunately, as we know, geriatrics health professionals can be hard to find.

Which brings me to older adult and care partner question number nine. This is the question I think every older adult (and their care partners) should be asking their clinicians regardless of discipline or specialty. **What is your expertise in caring for people like us as we age?** ✦

Nancy E. Rumbold

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The AGS/AGING Learning, Educating, and, Researching National Initiative in Geriatrics ("LEARNING") Collaborative is supported by an R25 grant from the National Institute on Aging (NIA) to the American Geriatrics Society (AGS) in partnership with the Health Care Systems Research Network (HCSRN)-Older Americans Independence Centers (OAICs) AGING (Advancing Geriatrics Infrastructure and Network Growth) Initiative. The Collaborative will aim to fill educational and training gaps in multiple chronic conditions (MCCs) research.

FROM OUR PRESIDENT

DONNA FICK, PHD, GCNS-BC, AGSF, GSAF, FAAN

Starting in January 2024, AGS is going paperless with the *Journal of the American Geriatrics Society (JAGS)*, and the *Journal of Gerontological Nursing (JGN)* went green starting with the August 2023 edition. This is the latest in a series of steps that the Society has taken over time to reduce our collective reliance on paper. Our annual meeting is almost completely paperless and all of our products are available in digital formats. We've come a long way since that first edition of *Geriatrics at Your Fingertips* was released on Palm Pilot (!) in 2009. AGS members who want to get ahead of the curve on converting their *JAGS* subscription to digital only can elect to go paperless now by logging into MyAGSOnline. If you aren't quite ready to go paperless come January 1st, you will be able to subscribe to *JAGS* with details on how to do so and the cost coming soon. I know this may seem like a big change for some. As an Editor, I have chosen the paperless route. I do still print out individual papers at times to read on the plane—but I look forward to my digital versions!

As AGS and ADGAP members may recall, we matched 177 fellows into 152 geriatric medicine fellowship programs on November 30, 2022. "Fellowship Match Day" is followed by the Supplemental Offer and Acceptance Program (SOAP) Post Match Recruitment", a period of time during which fellowship programs participating in the National Resident Program Match (NRMP) are still recruiting. I am pleased to report that our geriatrics fellowship programs recruited an additional 102 into geriatric medicine and that at least 279 fellows reported to duty on July 1, 2023 (per a survey that AGS/ADGAP fields that all programs participating in the NRMP match are

required to complete). Several geriatric medicine fellowship programs do not participate in the NRMP match and we are currently surveying them about their recruitment efforts.

For our new fellows, other trainee members, and early career professionals, I believe it truly is an exciting time to be embarking on a career caring for older adults. We have made so much progress in our understanding of aging since I first joined the AGS. You will be at the forefront of treating people as whole persons, engaging in team-based care, and being sure that the care someone receives is focused



One way new geriatrics fellows and early career professionals can engage with the Society immediately is to participate in our leadership curriculum this year.

on what matters to them. You will be working with older adults and their care partners on strategies to preserve function and help those in your care to remain independent in their homes as they age. What excites me most is the interest I see from other specialties and disciplines in both leading aging research programs and partnering with geriatrics health professionals to contribute to our geriatrics knowledge base. One way new geriatrics fellows and early career professionals can engage with the Society immediately is to participate in our leadership curriculum this year. This is a great way to



start to build a national network and to gain new leadership and life skills. Through my early membership in AGS, I have developed a national network of colleagues and collaborators. Perhaps more importantly, I have made many wonderful friends who are there for me in good times and in bad times.

I've been tracking the discussion of what would be appropriate geriatrics health professional benchmarks in MyAGSOnline and it is clear to me that our community knows just how valuable our work is and is searching for ways to prove it. To help others comprehend that value, as Mike Harper reported late last year, we have asked our geriatrician members to contribute to a benchmarking survey that we launched earlier this year in collaboration with Phairify. We are asking physicians to answer a series of questions about their clinical practice which will help them to benchmark their compensation against others and will help AGS to articulate the business case for geriatrics care. As Mike noted, we hope to launch a similar survey focused on our advanced practice nurse members in the future. In the meantime, one way we will be using the full data set is to support geriatrics academic programs in negotiating productivity agreements with their health systems. For our nursing members, I believe that the initial dataset will help us to provide a clearer picture of the value of the care that is provided by all of us who are focusing our careers on caring for all of us as we age.

As this issue of *AGS News* was being put to bed, our policy experts and staff team were hard at work developing our comments on the proposed 2024 Medicare Physician Fee Schedule and our professional education team was working with member experts to finalize professional and public education pieces focused on lecanemab, which was approved by the Food & Drug Administration on July 6, 2023. By the time this newsletter reaches your inbox, both of these

will be featured on our home page at www.americangeriatrics.org. These are invaluable tools for all of our members. As a nurse educator and clinician I use these with my students and in consulting with older adults. I hope you too will access these resources.

I very much appreciate the many AGS members who join our committees and subcommittees and lend their expertise to our work. If you are interested in becoming an AGS Committee member, [applications](#) are

open through January 8, 2024. If you are a nurse reading this, please feel free to reach out to AGSPresident@americangeriatrics.org with any questions about committees.

This has been a bit of a potpourri of a column as I wanted to touch on a number of areas that I thought would be of interest to our members. I am #AGSProud of the work that we do and grateful to the many members who contribute to that work. We are stronger because of your engagement. ♦

Vaccination Rates continued from page 1

If this proposed payment is included in the final rule, clinicians administering vaccines in the home would be able to bill for an additional payment of \$38.51 in 2024. It is important to note that this would be a flat fee and is not dependent on the number of vaccines administered; however, the administration of each unique vaccine would be paid separately. In the rule, CMS has also proposed changes to quality metrics and AGS' quality leaders, consultants, and team are reviewing that proposal as well.

All of this comes on the heels of the good news that the Inflation Reduction Act included provisions that eliminate out-of-pocket costs for people with Medicare drug coverage for vaccines that the Advisory Committee on Immunization Practices (ACIP) recommends for adults age 65+. Which leads us to the AGS Older Adult Vaccine Initiative. AGS is working with geriatrics teams at 6-7 health systems to test and assess quality improvement interventions in their health systems to increase vaccination rates. Initially, the teams will be focused on increasing overall vaccination rates for COVID-19, Flu, Pneumonia, and Zoster. Some proposed interventions to test include redesigns of work flow, clinician education, and education for older adults and their care partners. The results of these tests will allow for successful quality improvement interventions to be incorporated into various clinics and programs, and will serve as models for others seeking to improve vaccination rates at their institutions.

The AGS is one of seven specialty medical societies to be granted a subaward under a Council of Medical Specialty Societies (CMSS) contract with the CDC to increase adult vaccination rates (across all vaccines) in this country, called Specialty Societies Advancing Adult Immunization. CMSS is creating a collaborative community of clinicians and society staff, all of whom are committed to improving immunization rates.

The AGS launched its Older Adults Vaccine Initiative website (vaccines.agscocare.org) earlier this year. The website offers free resources for health professionals seeking to improve immunization rates in their practices in accordance with the Standards for Adult Immunization Practices (SAIP). Resources include a self-directed online educational curriculum, a podcast, clinical tools, patient education resources, and a mobile app that includes content focused on vaccine education and training. ♦

Want to get involved?

We are looking for AGS Vaccine Ambassadors who are interested in working to improve vaccination rates among older adults in their own community or at their institution. Ambassadors will have access to the full suite of tools available on the AGS Vaccine Initiative website, as well as support and guidance to help them promote the importance of vaccines in older adults. Ambassadors will also have access to a Real Time Learning Network (RTLN), a virtual online community exclusively for all Health System Partners and Vaccine Ambassadors to connect, network, and strategize on ways to improve immunization practices. Members of the RTLN can post questions and comments, and can share resources, experiences, and learnings as they work towards the same goal.

Join the AGS team and help increase immunization rates for vaccine-preventable diseases in older adults by [signing up](#) to be a Vaccine Ambassador.

Get more information at vaccines.agscocare.org.

Why is it important for health professions schools to address diversity, equity, inclusion, and access in teaching, learning, and assessment?

Historically, medical education has been fundamentally flawed because it has taught race as a biologic category based on innate differences that produce health outcomes. The reality is that race is a social category that reflects the impact of unequal social experiences on health. Centuries of structural racism and bias have contributed to racial and ethnic disparities in health, outcomes, and opportunity. As a result, we have a critical imperative to right these wrongs across the continuum of training in health professions education.

Why is your work with the NBME so important?

Medicine has had a long history of racism and bias, beginning with who is allowed to join the profession and ranging from what is taught and assessed and how clinical care is delivered to the policies, practices and procedures of our systems. NBME's mission is to protect the health of the public through state-of-the-art assessment and, as such, we have a critically important role to play in ensuring that these assessments are evidence-based, patient-centered, and bias-free.

What are you most proud of when thinking about your work with the NBME to date?

It's been wonderful collaborating with the many leaders and staff who contribute to NBME's work. I've served as a member of several test material development committees and on the NBME's Board of Directors. Faculty of medicine from across the nation volunteer their time and expertise to develop NBME assessments. The joy of working with and learning from these colleagues has been so meaningful to me and I am very proud of the supportive and nurturing environment the organization and its staff have

fostered for us all to come together and center the health of the public.

What do you hope to focus on in your new role as Board Chair?

I see this role as an opportunity to lead NBME as we strengthen our commitment in two key areas: mitigating bias and continuing to advance the assessment of the critical competencies necessary for health care practice in the 21st century. I am so excited to be a part of this work. Collaborating with NBME leaders and staff has been one of the high points of my career.

How has your expertise as a geriatrician helped you in your work with NBME?

Ageism is the "ism" that we all too often don't address when working to advance an equitable health system. Throughout my career, I have focused on integrating geriatrics training into how we train all physicians. I see this as essential to developing the health-care workforce that we need to care for all of us as we age. No matter what field of medicine you practice, you will care for and connect with older people. Even in pediatrics, many children in this country are raised by their grandparents. As an educator, I believe we have a responsibility to teach and assess the skills and behaviors necessary to care for older people and those with serious illnesses across the continuum of medical education.

Is there a take-away message from your election to Chair the NBME Board?

It is critically important that NBME and other health professions education organizations work to center diversity, equity, and inclusion. I believe my new role sends a strong message to the medical community about the work that NBME is doing to ensure that all aspects of assessment are equitable. By that I mean, assessment must factor in the diversity of our profession and the different paths we may each have

followed in our journey to becoming a physician. I hope that diverse young faculty see me and think to themselves that one of the building blocks for a bias-free health care system is education and assessment. NBME is all in on building assessments that are relevant, person-focused, and designed to correct the biases of the past for health professionals of the future. This work is so important, and it is going to take all of us to accomplish the change we want to see.

If you had one piece of advice for early career geriatrics health professionals, what would it be?

Get involved with AGS and with organizations like NBME. AGS is my professional home and I remember in my early days, I asked about having a paper session for educators and then working with colleagues to make that a reality by encouraging submissions and pulling recruiting volunteers to review abstracts. I remain deeply engaged with that paper session because I believe it is critically important to support clinician educators by providing outlets for their work. I love that AGS shares my belief and worked with me to make that a reality. I strongly encourage young learners, particularly those of color and from historically excluded groups, to seek out volunteer opportunities and to articulate what matters to you. Your voices are critically important and AGS leaders and staff seemingly always find a way to make a proposed project happen within the limitations of a small staff and sometimes scarce resources. All AGS members should feel free to reach out to me via MyAGSONline for advice and counsel on getting engaged with AGS or with organizations like NBME.

We are so grateful to Reena for all that she does on behalf of older adults and for her commitment to advancing racial justice. She is an amazing leader, colleague, and friend. ♦

AGS LEADERSHIP STARTS WITH YOU!

Consider Becoming an AGS Board Member: Nominations due October 2, 2023

The AGS Board provides fiduciary oversight for the Society and works collaboratively with the CEO and staff to advance AGS priorities. The Board is responsible for setting the strategic direction for the society, responding to emerging issues, interpreting the organization's mission to the public, and establishing and maintaining programs relevant to the Society's strategic vision. AGS Board members typically will serve on one of the two Standing Board Committees (Investment and Audit) and serve as a liaison to one of the AGS Standing Committees. Other roles that AGS Board members may be asked to fulfill include: (1) serving as a spokesperson for the American Geriatrics Society; (2) serving as an expert liaison to external groups in areas where their interest, expertise and/or experience are a fit with the request from the external group; and (3) serving on ad hoc committees/work groups that align with their interests and expertise. Candidates for the AGS Board typically will have a record of service to the Society and a strong commitment to the AGS mission and vision.

AGS is seeking AGS member nominees to stand for election to the Board by the AGS membership. AGS is also looking for nominations for an ex officio seat, with a preference for someone who can provide the perspective of AGS members who are primarily in clinical practice (this seat will be appointed by the Board upon a recommendation from the Nominating Committee).

Nominations to serve as an AGS Board member are open through **Monday, October 2**. Learn more about the nominations process at <https://bit.ly/AGS-Board>.

Apply to Serve on an AGS Committee: Applications due January 8, 2024

Committee service is an opportunity to strengthen and grow your national network, work on projects that you are passionate about, learn new leadership skills, and so much more. Our committee members are leading writing groups, developing tools, improving payment for geriatrics health professionals, and participating in efforts to improve diversity in the research that is presented at the AGS Annual Scientific meeting. Committees meet virtually twice a year (March/April and September/October). Learn more about our Committees and how to apply at <https://bit.ly/AGS-committees>. Ready to apply? Log into MyAGSONline and submit your application by **January 8, 2024**.

Applicants for committees are asked to rank committees in terms of preference and so here is a quick snapshot of the work that our Committees do:

- The **AGS/ADGAP Education Committee** is currently updating the geriatrics competencies for internal medicine and family medicine residents, overseeing and engaging trainees, leading faculty development projects, and collaborating with the Teachers Section, ADGAP Fellowship Directors Group, and other AGS Committees.
- **Clinical Practice and Models of Care (CPMC) Committee** members work with the AGS Research Committee to review Case Series & Case Studies abstracts for the AGS Annual Scientific meeting, review guidelines and clinical documents from other organizations, and serve as expert responders in quarterly webinars on new research in geriatrics models of care.
- The **Ethics Committee** is currently developing a statement on advanced directives and feeding tubes in

patients with dementia and updating the AGS Unbefriended Position Statement. Recently, with the Public Policy Committee, they led development of a JAGS paper on the Intersection of Structural Racism and Ageism which can be found at <https://bit.ly/JAGS-article-structural-racism-ageism>.

- Our **Ethnogeriatrics Committee** oversees our Geriatrics Cultural Navigator and the members of this Committee serve as liaisons to the other committees where they provide important perspectives on our efforts to ensure that all the Society's programs and products reflect attention to diversity, equity, and inclusion.
- The **Health Systems Innovation & Technology Committee** is currently working on an AGS position statement on telehealth policy for older adults and a position statement on EHRs. They review emerging technologies of interest to geriatrics health professionals as well as older adults' access to technology using a DEI lens.
- Our **Public Education Committee** is overseeing the content update on HealthinAging.org to reflect the 11th edition of the Geriatrics Review Syllabus and is working with our staff to develop a compendium of public education resources based on our Geriatrics Cultural Navigator.
- Our **Public Policy Committee** oversees the Society's public policy efforts. To learn more about what we have been up to in 2023, please visit: <https://bit.ly/AGS-policy-highlights>.
- Members of the **Quality and Performance Measurement Committee (QPMC)** review quality measures proposed by CMS and other organizations and are often nominated to serve as members of technical expert panels, workgroups, and committees convened by the National Quality Forum, Battelle's Partnership

WHY I'M AN AGS MEMBER

Arbis Rojas, MD

My grandmother's battle with progressive dementia made an enormous impression on me as a teenager. I saw first-hand how the disease and its behavioral disturbances affected her and my family as we coped with the inadequacies facing older adults in our health care system. The unhelpful doctor visits and unnecessary trips to the emergency department were particularly difficult for all of us. The awareness I developed during this experience triggered my interest in a career as a geriatrician.

I see geriatrics as a personalized form of medicine, and I appreciate the way trainees are exposed to many different medical specialties, including neurology, psychiatry, and physical medicine and rehabilitation.

I joined the AGS when I began my private practice in 2016. As a board-certified geriatrician, I have found that my membership helps me stay abreast of the latest advancements in our field. For example, AGS helps members learn the intricacies of CPT-coding (Current Procedural Terminology) and helps prepare them for chronic care management, annual wellness visits, and advance care planning.

There has to be continual change in how geriatricians in private clinics practice medicine. Value-based medicine is the future. Where is the value in

geriatric medicine? AGS is essential to us all for maintaining the focus on the value of caring for older adults.

The AGS mission aligns with my professional mission: to meet the health needs of our older adult population and to focus on their independence and quality of life. I hope to contribute more to this great cause in the future as a leader, sponsor, and partner.

The benefits of my AGS membership are many: attending the annual scientific conferences, exchanging ideas on the AGS website forum, and contributing as much as I can to improving the health and wellness of older adults. AGS has certainly contributed to my personal and professional growth and for this I am forever grateful.

One major benefit of my AGS membership is attending the annual meetings. I particularly enjoy meeting new colleagues and exchanging ideas. The lectures are excellent because they present various specialty fields I might not otherwise be exposed to. I take that information and create my own subspecialty clinics to assist homebound patients who cannot physically see specialists but who benefit immensely from new clinical approaches.

I am working on improving the operations of the clinic from a chronic care management standpoint. I am working on a mobile and cloud application that



is doctor-friendly to help better manage offices. This calls on my understanding of chronic care management in our older-adult population.

Finally, I believe that the culture of how medicine is practiced has had many challenges. The cloud-based application I'm working on will hopefully mitigate many of these challenges in our office. Chronic care management is instrumental in my clinic but requires months of work in training staff and understanding systems/standard operation procedures. I believe that staff education in our outpatient offices is key to allowing our physicians to focus on patient care.

Work/family balance is essential to me. I am blessed to have a wonderful wife and two great kids, Camila, 5, and Diego, 8. I enjoy my time off by exploring the world with my family and taking part in outdoor activities. I'm actually writing this from Europe, where we're visiting places like Annecy, France and Gruyere, Switzerland. ♦

Leadership continued from page 7

- for Quality Measurement, and other CMS contractors.
- Our **Research Committee** oversees the abstract submission and selection process for the AGS Annual Scientific meeting, which includes making recommendations to our Awards Committee for some of our key awards. Committee members also participate in subcommittees focused on highlighting research to

the general public, increasing diversity in research presented at the AGS Annual Meeting, and commenting on requests for comment from NIA and other agencies that support research.

› If you have questions on Board nominations or the committee application process, please don't hesitate to reach out to Mary Jordan Samuel (mjsamuel@americangeriatrics.org). ♦



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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. Questions and comments about the newsletter should be directed to info.amger@americangeriatrics.org or 212-308-1414.

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Necessary Vaccines for Older Adults

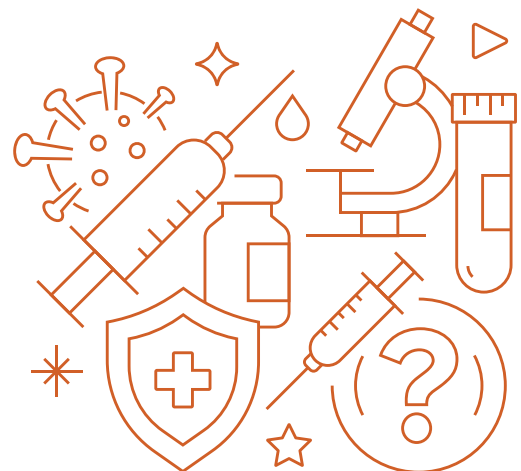
Getting vaccines to protect you from illness is one of the most important things you can do to stay healthy. Vaccines are often injections, sometimes called “shots.”

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 65 years old or older 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 received the updated Pfizer-BioNTech or Moderna COVID-19 vaccine. The updated vaccines are called “updated” because they protect against both the original virus that causes COVID-19 and the Omicron variant BA.4 and BA.5. The updated vaccines are also called bivalent vaccines.

■ 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 (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 or received the older Zostavax shot which is no longer available in the US.

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>.



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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.

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