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#AGS19 SNEAK PEEK

May 2-4
(Pre-con: May 1)
Portland, OR

If you haven't circled May 2-4 on your 2019 calendar, now would be an excellent time to do so, suggests Reena Karani, MD, MHPE, Program Chair for the AGS 2019 Annual Scientific Meeting (#AGS19). And that's because May 2019 will see eclectic, exciting Portland, OR, play host to geriatrics' premiere educational event—a must-see for 2,500+ health professionals, advocates, experts, and students working to support high-quality, person-centered care for us all as we age.

AGS News booked some time with Dr. Karani to learn more about what's in store for conference attendees come 2019.



You just wrapped up the #AGS19 Program Committee Meeting. Tell us more!

As always, #AGS19 will be a jewel for uncovering professional development tools, tips, and topics to promote practice-changing opportunities. Attendees will not only learn about the newest insights in the clinical care of older people but will also have a host of opportunities to explore new frontiers in research, public policy, and public and professional education for our growing older adult population—as well as for the health-professional workforce responsible for their care!

What will be some of the most exciting developments for 2019?

Next year will find us hot-on-the-trail of some important updates in geriatrics, many of which we saw on display in their early stages at #AGS18.

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"GROWING" INTO GERIATRICS: A STUDENT'S JOURNEY

Divya Padmanabhan is a second-year medical student and co-president of the AGS Student Chapter at the University of New England (UNE) College of Medicine (COM) in Maine. As a local leader and new voice in geriatrics, Divya spoke with AGS News about what drew her to the field—and what inspires her to learn about high-quality care for older adults.



What interested you in a career working with older adults?

I've always been curious about functional and cognitive development, and more recently my interest in aging surged. As an undergraduate at Emory University, I was involved

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AGS 360° WITH NANCY E. LUNDEBJERG, MPA



Most of you probably know my thoughts on social media. In a nutshell: I think it's a powerful tool—personally and professionally. So you can imagine my surprise when our Communications team noted that health care has been one of the *slowest* fields to adapt to social media. Cases-in-point:

- One survey found that only 65% of health professionals used social media professionally, even though 90% had accounts. (This despite health professionals being cited as among the most trustworthy sources for health information).
- Of the 5,600+ hospitals in the U.S., less than 26% use social media.
- Some of the most commonly cited reasons for avoiding social media include that it's "distracting," "intimidating," or "difficult to determine where to start."

I doubt these data surprise even our seasoned social media gurus. If you're a fan of @GeriPalBlog, check out their recent podcast on this exact topic (<http://ow.ly/tCE030lg6ns>). As @AlexSmithMD and @EWidera discuss with @WrayCharles, social media is being used, and we ignore it as a tool for spreading the word about #geriatrics at our peril! For example:

- Of the 74% of internet users active on social media, 80% are going online for health information.
- More than 40% of people using social media for health info look at consumer reviews when making decisions, seeking second opinions, or selecting providers.
- Social media also exerts growing influence on policy. In one study, 60% of Congressional staffers said they learned about issues online first. One-third of staffers said they

had changed their position on an issue because of online information, and many say it takes less than 30 social media posts about an issue to attract a legislator's attention.

Not convinced you should be on #SoMe? Consider this: @AAHPM did a #Twitter campaign focused on #PCHETA (Palliative Care and Hospice Education and Training Act) this summer, and it generated 2,000 tweets with 4 million impressions in just a few days.

There are lots of ways we can interpret these data. But since I roll with #geriatrics, I'll err on the side of the optimistic and the collaborative:

1. Your presence on social media isn't only wanted—it's needed!

The work you do as a #geriatrics professional already gives you

clout with the general public. That's pretty significant when you consider there are 500 million tweets sent daily.

2. By relying on what makes geriatrics unique—our collaborative, supportive community committed to high-quality, person-centered care—you're also already modeling social media at its best.

A recurring request we get at the AGS offices is for tips to make social media more accessible for newbies and novices. I'm re-sharing our Quick-Start Guide to help.

@NLundebjerg's Twitter Quick-Start Guide



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

Twitter is a great place to start for several reasons. Accounts are easy to set-up, they thrive on pithier content, and—importantly—they are great vehicles for quick action showcasing our authenticity. That's critical, especially as many of us work to strike a balance between individual identities and those we might share (or help support) at our institutions.

At the AGS, for example, we've worked to strike a balance between the voice of @AmerGeriatrics and the voices of our employees, including yours truly (@NLundebjerg). The way I see it: @AmerGeriatrics shines a guiding light on important AGS messages and priorities—and individual accounts like mine add personal flavor and local roots to those expert-backed insights. The balance is key—and it's something you should address with your institution, particularly if it doesn't have a social media presence yet.

Suffice it to say the skills you need to be successful on Twitter—and the cacophony of voices representing individuals and institutions—will be important for some of the challenges we'll face in the rest of 2018. In particular, we'll be reiterating on social media the concerns we have about potential changes to payment in the 2019 Medicare Physician Fee Schedule. Having multiple voices make the same point is always helpful in policy efforts.

As always, your work to raise awareness for high-quality, person-centered geriatrics expertise isn't just critical—it's what keeps us going at the AGS offices and across all the communities where our members are working to improve care and lead change. ♦



NEW ONLINE TOOLS PROVIDE BEST PRACTICES IN SURGICAL CARE FOR OLDER ADULTS

The American Board of Medical Specialties (ABMS) and the AGS, with funding from The John A. Hartford Foundation, earlier this year unveiled a new suite of online tools to aid surgeons and related medical sub-specialists who care for older people. With the number of older adults undergoing surgery increasing faster than the rate of the population aging itself, the new AGS series of nine Geriatrics Virtual Patient Cases (VPCs) for Surgical and Related Medical Sub-Specialties are geared toward helping the entire healthcare system better understand the needs of older adults.

"To advance the care we all want as we age, we need to work together to ensure *all* healthcare professionals have a basic understanding of geriatrics principles," said Thomas Robinson, MD, one of the three leads for the multi-specialty editorial board responsible for developing the VPCs. "This new set of online tools reflects the partnerships we need to spread learning and transform care."

The VPCs will be available for free through 2020 to the first 1,000 subscribers at GeriatricsCareOnline.org. The Geriatrics VPCs focus on aspects of surgical care unique to older individuals, a growing patient population for all healthcare professionals, including those without formal geriatrics training. Both continuing medical education and Maintenance of Certification (MOC) credit are available to those who successfully complete each VPC.

The nine interactive multimedia clinical scenarios explore key challenges and opportunities that health professionals may encounter when working to improve care for older people facing surgery—from the proper management of medications to issues surrounding surgical delirium and the need to document end-of-life care preferences and

expectations. The VPCs were developed by a diverse group of content experts, including medical specialists from general surgery, urology, ophthalmology, orthopaedics, geriatrics, anesthesiology, and emergency medicine.

"In addition to presenting realistic clinical tasks, the Geriatrics VPCs for Surgical and Related Medical Sub-Specialties also offer learners real-time feedback on their choices, alternative solutions, and more," noted Andrew Lee, MD, another co-lead editor for the project. "Opportunities for using the cases to fulfill MOC requirements also are helping to embed tools like these patient cases—and hence geriatrics expertise—more broadly within the framework of how our health professionals sustain ongoing education."

"Addressing the unique health care requirements in this rapidly growing patient population is an important and evolving public health need," stated Richard E. Hawkins, MD, ABMS President and Chief Executive Officer. "ABMS is pleased to be a partner in developing these educational tools and offering MOC credit to engage Board Certified physicians in learning about the specific needs of geriatric surgical patients."

Co-lead editor Myron Miller, MD, AGSF added: "Proactive health systems know that healthcare's future requires bold approaches that value older adults, address their unique needs, and provide the best care and support possible. Assistance from The John A. Hartford Foundation has enabled diverse partners, such as ABMS and AGS, to ensure that geriatrics expertise can move and grow with us across the continuum of our care."

For more information or assistance establishing an account on GeriatricsCareOnline.org, contact GCOinfo@americangeriatrics.org. ♦

FROM OUR PRESIDENT

LAURIE G. JACOBS, MD, AGSF

I've often thought of Fall as the "back-to" season. Our clocks "fall back." We go back to shorter days, warmer clothes, and—of course—back to school (something that still feels bittersweet, even when you aren't a student anymore!).

For me, though, "back to school" has new meaning in 2018. This marks the first official academic year for the Hackensack Meridian School of Medicine at Seton Hall in N.J., where I've just begun my tenure as Chair and Professor in the Department of Internal Medicine. I'm proud to be a geriatrician in an academic leader-

Linda P. Fried, MD, MPH, who has been Dean of the Mailman School of Public Health at Columbia University since 2008.

I'm also not the only one to notice this trend. News headlines this year have been rife with language about leadership appointments that "Give Geriatrics More Attention" or represent a "Sea of Change" for the country's "Aging Population."

But perhaps another AGS leader, Past President Sharon Brangman, MD, AGSF, put it best in a recent article announcing her appointment as the first Chair for SUNY Upstate Medical



on MyAGSONline, the fruits of those labors are vividly apparent—from our new online forum for women in geriatrics to the ongoing efforts of our Ethnogeriatrics Committee and a host of Special Interest Groups dedicated to issues ranging from homelessness to equitable care for LGBT adults.

Ultimately, I think all that work—all that leadership—points to a unique characteristic of geriatrics: Namely, that our brand of leadership is happening all the time, in all corners of care, and often *without* official titles or the recognition it deserves.

Indeed, the single-digit cadre of certified geriatricians in states like Montana and Wyoming are leaders. They have to be.

The countless members who reach out to Senators and House Representatives on policy changes that jeopardize care for older adults and caregivers are leaders. They have to be.

The resource-constrained educators who take time out of their busy schedules to conduct rural geriatrics trainings are leaders. They have to be.

All 5,000+ of us—working daily in clinics, communities, and classrooms to improve care for millions of older people—are leaders.

We have to be—in any season and across any setting, because it harkens back to what we do best...together. ♦

Regards,

A handwritten signature in black ink that reads "Laurie G. Jacobs". The signature is written in a cursive, flowing style.

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ship position—one that will allow me to embed geriatrics into the bedrock of our students' education—but I'm prouder still that such a position isn't a rarity for a geriatrics expert. Indeed, 2018 alone has been a banner year for recognizing how our doctors, nurses, physician assistants, pharmacists, social workers, and other interprofessional colleagues are more than equipped to lead change and improve care for us all, but especially for us all *as we age*.

Our very own Laura Mosqueda, MD, for example, was recently installed as Dean of the Keck School of Medicine at the University of Southern California. She joins an elite cadre of past and present geriatrician deans, including colleagues like Richard Besdine, MD, AGSF, who served as Interim Dean of Medicine and Biological Sciences at Brown University from 2002 to 2005, and

University's new Department of Geriatrics. As Dr. Brangman observed, the medical world "is starting to understand the impact older people are having on our healthcare system," and the impact *we* can have by extension when given the time, talent, and resources to prioritize what it means to support health in aging.

It's encouraging and important to see so many geriatrics professionals and AGS members entrusted with responsibility to shape the future of care. And it's even more heartening that this leadership comes from a field that works hard to celebrate diversity. Many of the colleagues highlighted above have been ardent champions not just for geriatrics but also for efforts to advance better care and greater leadership among women, minorities, and a range of other underrepresented communities. At our Annual Scientific Meeting and even

CRACKING THE (REIMBURSEMENT) CODE: NEW EDITORIAL OUTLINES A DECADE OF HARD WORK, BIG CHANGES TO ADVANCE COVERING CARE WE NEED AS WE AGE

For millions of older adults who rely on Medicare, the federal health insurance program for people 65-years-old and older, it happens seamlessly and almost always behind-the-scenes: The care we receive from expert clinicians becomes six-digit “billing codes,” which in turn ensure our clinicians can be reimbursed for their work supporting our health, safety, and independence. But even billing codes have a story to tell—an important one at that, as experts from the AGS describe in a new *Journal of the American Geriatrics Society (JAGS)* editorial. The editorial outlines how several key health services—from those for managing chronic care to those for assessing cognitive health—came to be recognized as part of Medicare through an important but oft unsung facet of geriatrics expertise: Its leaders’ engagement in building a better public policy environment to support the care we all need as we age.

“It’s hard to believe but as recently as the late 1990s, Medicare—our primary federal insurer for older people—lacked the means to reimburse or even recognize several core services essential to older Americans,” notes Alanna Goldstein, MPH, Director of Advocacy & Public Policy at the AGS and one of the authors for the retrospective editorial. “In reviewing which forces and what players were instrumental to AGS-led change from then to now, we hope geriatrics health professionals and older adults alike will have a better appreciation for what it takes to improve care by making sure it can be recognized—particularly at a time when more of us than ever before will need access to new, innovative health services.”

As the editorial authors explain, much of that work began with an investment by the AGS of time, talent, and resources in two important entities: the Current Procedural Terminology (CPT) Editorial Panel and the Relative Value Scale Update Committee (RUC), both coordinated by the American Medical Association (AMA).

Though you may not know the CPT Editorial Panel or RUC by name, you are certainly familiar with their work. Respectively, they develop and continually review billing codes (referred to as “CPT codes”) for health services and procedures and ensure reimbursement for those codes accurately reflects provider work. Together, these groups shape what services Medicare will cover (and at what value) from one year to the next.

The AGS editorial presents a case study in working with groups like the CPT Editorial Panel and the RUC to ensure our clinicians are able to implement best practices because these services can be tracked and reimbursed

appropriately. Around 2011, the AGS became actively involved in the work of the CPT Editorial Panel and RUC. Since then and with significant support from the AMA and several key medical societies, the AGS had been instrumental in securing recognition and reimbursement for several of today’s most important geriatrics services.

Service	CPT Code(s)	Recognized for Reimbursement by Medicare
Transitional Care Management Describes non-face-to-face services to help older people transition from a hospital stay to care at another health facility or at home.	99495; 99496	2013
Chronic Care Management Describes care addressing the medical, psychological, and social needs of older people receiving long-range treatment for two or more chronic health concerns.	99490	2015
Complex Chronic Care Management Describes an elevated level of chronic care management for older people who require substantial revisions to care plans or who have particularly complex decision-making needs.	99487; 99489	2017
Cognitive Assessment and Care Plan Services Describes a thorough evaluation of medical, psychological, and social factors for older people exhibiting signs of cognitive impairment, as well as efforts to develop care and education plans.	99483	2017

As for what lies immediately ahead: CMS’s proposed Medicare Physician Fee Schedule for 2019 (which outlines changes to payment policies for the upcoming calendar year) includes some sweeping—and potentially disconcerting—changes to evaluation and management codes, which encompass many of the core services health professionals provide in routine office visits.

Look for more AGS efforts to address these changes at AmericanGeriatrics.org/Where-We-Stand. ♦

#AGS19 will be our first meeting following the release of the 2018 Updated AGS Beers Criteria®, for example, so medication management is likely to be a hot topic for us all.

Our 2019 gathering will also see us through the results of this year's mid-term elections, so it will be important to hear what our colleagues in advocacy and public policy say about the legislative outlook for geriatrics, equitable payment models, and priorities on the horizon for new Congressional leaders.

And, as always, our Geriatrics Literature Review will continue to highlight some of the year's most innovative scholarship. The science we hear in this session often forms the cutting-edge of our expertise 365 days (or less!) from the time it's presented, so it's always exciting to get a quick preview of what the future might hold for us all—as we practice geriatrics, but also as we age.

What trends do you see shaping the meeting experience next year?

In particular, I think #AGS19 will shine a light on the educational needs of professionals from an increasing array of disciplines. Physicians, nurses, pharmacists, physician assistants, social workers, long-term care and managed care providers, healthcare administrators, and others should attend to update their knowledge and skills through state-of-the-art educational sessions and research presentations.

What's more, we're exploring a host of exciting new continuing education sessions, including invited symposia, workshops, and meet-the-expert forums. And this year's schedule may set a record for networking opportunities! When we talk to attendees, we consistently hear about the importance of connecting and collaborating with partners from across the country. To that end, the meeting will set a new standard for built-in programming to make networking easier: We're building formal

time into the program to recognize the importance of making connections, especially for our trainees.

What has you personally excited for #AGS19?

I'm just really delighted to serve as this year's Program Chair. I've been an AGS member for many, many years and I'm very committed to the organization and its mission to advance high-quality, person-centered care for us all as we age. I was on the Education Committee for years and now I look forward to helping build a national meeting platform that meets the diverse needs of our members. The Program Committee works hard each year to think about what's timely and relevant to members and to consider the long view of our field—it's amazing to have seen that work in action behind-the-scenes!

What early advice do you have for our attendees?

First, don't miss AGS emails about registration and housing for the meeting. Second, make your reservations ASAP so you don't miss out on deals (and ideal locations!). Also, start planning your experience early: Make sure to review the different sessions as they're released, and be sure to set aside some time for networking—or just reconnecting with friends. Finally, challenge yourself to try something new at #AGS19. We have so many tremendous Sections and Special Interest Groups, for example—attending one of their meetings might be your spark of inspiration for a future research project, clinical practice improvement, or career opportunity. ♦

AGS & CSIS HEALTH CORP PARTNER ON NEW HEALTHCARE SOFTWARE SOLUTION FOR AGS BEERS CRITERIA®

In an exclusive agreement, the AGS has partnered with CSIS Health Corp, a healthcare software firm, to provide the first and only licensed software application of the AGS Beers Criteria® for Potentially Inappropriate Medication Use to the U.S. healthcare market.

For this new resource, CSIS Health Corp has worked with the AGS to develop the first AGS Beers Criteria® Medication Review Solution, which easily integrates with Electronic Health Records, as well as Population Health Management and Care Management platforms. The solution is person-centered, providing a real-time review of each patient for more than 150 of the AGS Beers Criteria® insights on potentially inappropriate medications. Through the use of this new tool, each patient's medication list, diagnoses, biomedical readings, and morbidity can be considered before recommendations are made, thereby identifying the potential for inappropriately prescribed medications that can put patients at risk.

Overall, this new AGS Beers Criteria® Medication Review solution aims to help clinicians and healthcare providers improve prescribing quality for complex patients in accordance with the AGS Beers Criteria's widely recognized, evidence-based guidance. In particular, the software solution focuses on preventing Adverse Drug Events by identifying potential inappropriate, harmful, and unnecessary prescribing according to the AGS Beers Criteria®.

CSIS Health develops person-centered Medication Review Solutions focused on assessing the appropriateness of medication use for older people or individuals living with multiple chronic conditions and polypharmacy. The company develops medication review solutions that incorporate only evidence-based best-practice guidelines developed independently and through consensus by expert clinician groups like the AGS. Visit www.csishealth.com or email info@csishealth.com to find out more ♦

AGS RECOGNIZES TWO STATE AFFILIATES FOR OUTSTANDING ACHIEVEMENTS AT #AGS18

Relaunched in 2018, the State Affiliate Awards Program recognizes outstanding State Affiliate achievements in membership recruitment and retention, innovative educational programs in geriatrics, public outreach, advocacy, or affiliate growth. All State Affiliates are invited to apply on an annual basis. Award winners are selected by the Council of State Affiliate Representatives (COSAR) co-chairs and approved by the AGS Executive Committee. The chosen awardee affiliates receive a prize of \$1,500 and are given the opportunity to share successful programs and activities in person at the COSAR session at the AGS Annual Scientific Meeting. This year, due to the excellence of submissions, we congratulated two outstanding State Affiliates for their contributions.

The **Oregon Geriatrics Society (OGS)** developed an Alliance Building Program, which raised brand awareness for OGS and the AGS. The program achieved targeted membership growth and conducted outreach to geriatrics-related organizations, programs, and campaigns to educate and support providers. OGS has developed an extensive list of resources that provide services and value for healthcare professionals, made publicly available on their website to ensure all providers can access information that could benefit their practices. Through their exhibit and showcase partnerships, OGS has added a number of non-profit organizations to their annual conference attendance and increased their presence throughout the region at meetings where providers are seeking resources in geriatrics.

The **Pennsylvania Geriatrics Society Western Division (PAGSWD)** continued growing of its educational programs. Pennsylvania developed the largest Continuing Medical Education (CME) event in the region—the annual Update in Geriatric Medicine, now in its 26th year—along with a variety of other educational events, attracting more than 500 participants from multiple disciplines. Pennsylvania has a number of measures in place to make continued education accessible, including a scholarship program that allows members to attend the Divisions's annual symposium for free. Additional funding is provided to assist medical students, residents, and some fellows to attend the AGS Annual Scientific Meeting to present research. To date, PAGSWD has awarded more than \$80,000 to trainees. These efforts, along with PAGSWD's annual Geriatrics Teacher of the Year Award, have contributed to a robust community of health professionals throughout the region.



Kathy Frank, RN, PhD, AGSF COSAR co-chair, with Fred Rubin, MD, AGSF & Neil Resnick, MD, AGSF (PAGSWD)

The AGS State Affiliate program was launched in 1991 and has increased the visibility of geriatrics medicine throughout the country. AGS' 27 State Affiliates offer professional education, networking and advocacy at the local state level. COSAR serves as the governing body of the AGS State Affiliates and is comprised of elected member representatives from each affiliate. To learn more and view a full list of AGS State Affiliates, go to AmericanGeriatrics.org/StateAffiliates. ♦



Kathy Frank, RN, PhD, AGSF, COSAR co-chair, with Mary Olhausen, OGS Executive Director, & OGS's Lisa Miura, MD

WHY I'M AN AGS MEMBER | JOHN R. BURTON, MD, AGSF

Professor of Medicine, Co-Director of the Johns Hopkins Geriatrics Workforce Enhancement Program

My membership in the AGS has without question played an essential role in my nearly 50 years in health care.

When I joined AGS in the 1980s, it was just a small group of like-minded professionals, and the organization was about the only place we could come together to discuss the growing field of geriatrics. Then as now, AGS membership provided the infrastructure for our professional growth and development. You can't function as an island—it's important to have a place to share and hear ideas.

In the early days of our field, gaining acceptance for geriatrics was an uphill battle—most specialists didn't think there was anything interesting about treating older adults and didn't think that older adults needed different medical consideration compared to younger individuals.

Now, largely thanks to the AGS's advocacy, that perception has shifted dramatically. In fact, many medical and surgical specialties now recognize how vital it is to consider older adults and the health challenges we all may face as we age.

The strong and sustained support from The John A. Hartford Foundation often in collaboration on specific projects with other organizations such as The Gary & Mary West Health Institute, the National Institute on Aging, the American College of Surgeons, and Atlantic Philanthropies has led to the creation of many valuable programs and products for improving the care of older adults. Examples include:

- **The Geriatrics for Specialists Initiative.** Now in its 25th year, this program has fostered the development of geriatrics for all clinicians caring for older adults through programs such as career development awards, educational initiatives, advocacy within specialty organizations, and a Section within the AGS.

- **The Geriatric Emergency Department Collaborative.** This program is a collaboration between several leading medical societies and a number of health systems to enhance emergency department care (and research on the same) for older adults.

- **AGS CoCare: Ortho™.** This innovative program aims to improve hospital care for older adults with hip fractures.

Interdisciplinary programs like these reflect the visionary guidance of the late David H. Solomon, MD, a pioneer in the field of American medicine and an early AGS leader. Dr. Solomon helped spearhead the geriatrics movement; one of his signature efforts was ensuring surgical and other specialties and disciplines take older adults' complex medical concerns into consideration. I was extraordinarily honored at the 2018 AGS Annual Scientific Meeting to receive, along with George Drach, MD, AGSF, a leading urologist, the David H. Solomon Memorial Public Service Award.

At the AGS Annual Scientific Meetings, you get the chance to catch up with friends and peers, and to share and refine your own ideas. I find that the meeting is a cauldron of energy, altruism, and optimism. The communal interest is not "What's best for me?," but "What's best for our older patients?"

The sessions are exciting and focused. Over the decades of my attendance, the AGS Annual Scientific Meetings have spawned ever-more scientific research, new initiatives, and new educational programs—all of which have helped generate new knowledge for AGS members. The increasing expansion of membership to all specialists and healthcare professionals has enriched the AGS greatly



John Burton, MD, AGSF, left, poses with George Drach, MD, AGSF, co-awardee for the 2018 David H. Solomon Memorial Public Service Award, and Laurie Jacobs, MD, AGSF, current AGS President.

and helped generalize geriatric principals broadly. It's especially exciting to see the many young people who are entering our field with such enthusiasm, energy, and focus.

At the end of June 2018, I stepped down from my full-time role after decades practicing geriatric medicine. Reflecting on these years, I can happily say that not a day passed that I didn't enjoy caring for older people. Day in and day out, I was richly rewarded by getting to know older adults well and by trying to guide them through health issues, helping them achieve their unique goals of care. I can't imagine a more rewarding life in medicine. ♦

The AGS congratulates Dr. Burton on being named the inaugural recipient of The John A. Hartford Foundation Trustees Award. Dr. Burton generously gifted his award to the AGS Health in Aging Foundation to support the Silverstein Award for Emerging Investigators in Surgical and Related Medical Specialties. The Silverstein Award recognizes emerging investigators whose research is focused on the role of geriatrics expertise in their specialties, and who are committed to careers in aging research. Visit HealthinAging.org/donate to learn more about how you can help support the next generation of geriatrics health professionals, too.

in cognitive and neuroanatomical development research while learning about the latest on neurodegenerative diseases in the classroom. After graduating from college, I worked as a medical scribe at a family practice and as a clinical research coordinator. Through both of these experiences I realized I enjoyed interacting with older adults and their families. I also began to appreciate the challenge associated with caring for older people, as oftentimes we live with a number of comorbidities as we age. In addition, I grew interested in conversations related to quality of life, especially after reading *Being Mortal* by Atul Gawande, MD, MPH.

As a medical student, I continue to explore geriatrics. Currently, I serve as an Elder Buddy at a local nursing home, and I volunteer for the Maine Senior Games (an Olympic-like program for people 45-years-old and older). I embrace opportunities to learn more about aging, which most recently included attending a thought-provoking symposium on interdisciplinary approaches to reducing polypharmacy in older adults with dementia.

Tell us about your student chapter at UNE.

Every year we present a Humanism in Aging Leadership Award, which recognizes a prominent geriatrician who exemplifies humanism and innovation in their approach to improving the lives of older adults. This year our club is honoring Linda P. Fried, MD, MPH, from Columbia University. Students have the opportunity to attend a dinner with the winner and submit an essay addressing what they've learned from this role model in the field and how they will apply those insights to future practice. The top three student submissions are awarded the AGS/UNE COM Student Chapter Humanism in Aging Action Award.

Our club also hosts an annual Murder Mystery Dinner Fundraiser supporting the Gosnell Memorial Hospice House, an 18-bed inpatient acute palliative and end-of-life care environment. Gosnell supports our student chapter through the UNE COM 48-Hour Hospice Home Immersion Project, allowing medical students to live on-site for 48 hours so we can actively participate in patient care, family support, and post-mortem care.

Other activities we engage in include our annual coat drive. For every coat donated, L.L. Bean provides fuel assistance for older adults in need, who also receive a voucher from the Maine Association of Area Agencies on Aging for a free winter coat. Around Valentine's Day, we write out cards, fill socks with candy and little gifts, and distribute them to older-adult residents at a local nursing home. In addition, we have monthly discussions with our Chief of Geriatrics, who shares her unique clinical experiences.

Who are your mentors and how have they helped you in your path through geriatrics?

Marilyn Gugliucci, PhD, has served as my mentor in my time at UNE COM. I came into medical school with an interest in geriatrics, but thanks to the AGS and Dr. G, my passion for the field has only grown. I can still remember attending my first AGS meeting and learning from Dr. G why it was important to refer to older adults as "older adults" rather than the "elderly" or "geriatric patients." This was the start of many conversations about the intricacies of our specialty. Dr. G has connected me with a number of educational, clinical, and research opportunities. I am particularly looking forward to participating in the 48-Hour Hospice Home Immersion Program next month.

What advice do you have for other students?

Take advantage of as many extracurricular and career-development opportunities as you can. These experiences have been some of my favorites. As a medical student in my pre-clinical years, I participated in preceptorships and attended conferences, which allowed me to connect what I was learning in the classroom with what my patients needed for the future!

Describe geriatrics in 3 words...

Growing. Thought-provoking. Challenging. ♦

Students/Residents receive free e-membership with the AGS. Visit AmericanGeriatrics.org/Membership for info.

For details on how to start an AGS-affiliated student or resident chapter, email Lauren Kopchik, at lkopchik@americangeriatrics.org.

The logo for MYAGS ONLINE features the text "MYAGS" in a bold, dark blue font above the word "ONLINE" in a bold, orange font. A thin, dark blue curved line arches over the "MYAGS" text.

**Looking to connect with trainees
and young professionals?**

Log on to

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today and engage with our student,
resident, fellow-in-training, and early
career professional communities!**

COULD LINKS BETWEEN OUR SENSES & COGNITIVE HEALTH EXPLAIN PARTS OF HOW WE AGE? EXPERTS LIKE THE SOUND (& SIGHT) OF THAT, ACCORDING TO NEW REPORT

Experts at a prestigious medical conference hosted by the AGS and funded by the National Institute on Aging (NIA) hope their work—reported in the *Journal of the American Geriatrics Society*—will have colleagues seeing eye-to-eye on an important but under-researched area of health care: The link between impaired vision, hearing, and cognition. With vision and hearing loss already affecting up to 40 percent of older adults—and with one-in-ten older people already living with Alzheimer’s disease, a cognitive condition of principal concern for many—the conference reviewed the current state of science regarding how these common health challenges might be connected, why the answer might matter, and what can be done to reduce sensory and cognitive impairments to preserve our health for as long as possible.

“As we live longer, we know that sensory and cognitive impairments will become more prevalent,” said Heather Whitson, MD, MHS, Associate Professor of Medicine & Ophthalmology at Duke University Medical Center and one of the lead researchers for the AGS-NIA conference convened in 2017. “While we know a great deal about these impairments *individually*, we know less about how they are related—which is surprising, since impaired hearing and vision often go hand-in-hand *and* are associated with an increased risk for cognitive trouble.”

One obstacle to optimizing sensory and cognitive health is our poor understanding of the two-way street connecting both. For example, we know the brain relies on sensory input to understand our environment and make decisions. Researchers also

know that cognitive processes—such as connections in the brain that allow us to locate visual targets—guide our visual and auditory attention. Yet we have a limited understanding of how these inter-related processes are affected by age-related changes in the brain, eyes, and ears.

Is the connection between sensory impairment and cognitive decline linear, with one health concern leading to the other, or is it cyclical, reflecting a more complex connection? AGS-NIA conference attendees think an answer to these questions is critical, which is why their conference report maps the state of sensory and cognitive impairment research while also outlining important priorities for future scholarship and clinical practice (see box).

“The evidence we have at present indicates that vision, hearing, and cognition occur more often together than would be expected by chance alone,” summarized Frank Lin, MD, PhD, Associate Professor of Otolaryngology-Head and Neck Surgery at Johns Hopkins Medicine and another lead researcher at the AGS-NIA conference. “Figuring out why—and what can be done about a potential link—represents a critical new leap for the care we all will want and need as we age.” ♦

Identifying the Mechanisms Responsible for Sensory and Cognitive Impairments (and Their Connections)

- Is there a cause-and-effect relationship between cognition, vision, and hearing?
- What biological factors or characteristics of our nervous system affect both sensory and cognitive health?

Better Equipping Clinicians and Researchers to Measure Forms of Sensory and Cognitive Impairment

- What standards currently exist for measuring sensory impairment and cognitive decline? How are they used among diverse populations, particularly those who might already struggle with access to health care?
- How can we develop and validate new tools and protocols to measure cognition for people who also live with vision impairments, hearing impairments, or both? Similarly, how can we better measure hearing and vision health in older people managing cognitive health concerns?
- How can we work to ensure broad measures of cognitive and sensory impairment are included in existing research studies as a way to better adapt findings to the realities of older-adult health?

Better Preparing Older Adults and Health Professionals to Address Sensory and Cognitive Impairments

- How effective, feasible, and accessible are existing options for assisting older people living with cognitive impairment, hearing impairment, and/or vision impairment?
- What innovations will be necessary to develop new resources, tools, and protocols to improve cognitive and sensory health or to accommodate those who live with these health concerns?


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Tips for Preventing Serious Falls

Falls are a leading cause of serious injuries in older adults that can lead to hospitalization, nursing home admission, and even death among older people.

The chance of falling increases as we get older. Health problems such as arthritis, heart disease, muscle weakness, poor balance or vision, foot problems, Parkinson's disease, dementia and even certain medications can increase your chance of falling. Dangerous things around the home – slippery throw rugs, and poor lighting, for example – make falls more likely as well. If you are an older adult or you are in charge of care for an older person, please follow the steps below, and also get a “falls checkup” on a regular basis from your healthcare provider.

Did you know?



One in every
three adults age
65 and older
falls each year.

TELL YOUR HEALTHCARE PROVIDER IF YOU HAVE HAD A FALL

If you fall, let your healthcare provider know right away. It is important for you to tell them what might have caused the fall – whether you tripped over something, for instance, or got dizzy and lost your balance, or felt your legs “go out” from under you. This important information will be used to help you avoid falling again.

REVIEW YOUR MEDICATIONS

Put all of your medications –prescription drugs, over-the-counter medications, vitamins or any other pills that you take– in a bag and bring them with you to your next visit with your healthcare provider. Together you can review your medications to see if any might increase your chance of falling. If so, your provider may change the dose, or prescribe another type of medicine for you.



MAKE A FALLS PREVENTION PLAN WITH YOUR HEALTHCARE PROVIDER

During your visit, your healthcare provider may also check your balance, leg strength and function, your blood pressure, heart rate and rhythm; examine the way you walk; and test your vision.

Based on what your provider finds he or she may recommend certain exercises, physical therapy, balance training, a cane or walker, a change in the kind of shoes you wear or in your eyeglasses prescription, or prescribe new medication to lower your risk of falls.

MAKE YOUR HOME SAFE FROM FALLS

- Keep cords away from areas where you walk
- Remove loose carpets and rugs or tack down the carpets and only use rugs with nonskid backing
- Add lights in dimly lit areas and at the top and bottom of stairs
- Use nightlights in bedrooms, halls and bathrooms
- Clean up clutter – especially near staircases
- Put hand rails on both sides of any steps or stairs in or outside of your home
- Add “grab bars” near the toilet and bath tub, and no slip decals or a rubber mat in the tub or shower
- Wear firm shoes that are not slippery on the bottom
- Don’t walk around in loose slippers or socks

What to Do if You Fall

GET IMMEDIATE MEDICAL ATTENTION

Even if you do not have an obvious injury, if you have a major blow to the head, any loss of consciousness, of any sign of confusion after falling, seek immediate medical attention.

NOTIFY YOUR PRIMARY HEALTHCARE PROVIDER

Even if you have no injury, make an appointment with your healthcare provider. Your fall could be related to a medical problem, and a falls evaluation will be needed to find the cause and help prevent another fall.

