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Photo ©N. Lundebjerg

AGS COCARE: ORTHO™ — INTERDISCIPLINARY PROGRAM MAKES STRIDES IMPROVING CARE FOR OLDER ADULTS WITH HIP FRACTURES

Each year, more than 300,000 people aged 65 and older are hospitalized for hip fractures. These older people need high-quality, person-centered care from health systems that understand their unique needs. Supported by The John A. Hartford Foundation, the AGS has been hard at work making that possible with the launch of one of our newest programs, **AGS CoCare: Ortho™**.

The AGS CoCare: Ortho™ model is one in which a geriatrics co-manager is involved in an older adult's care as soon as they're admitted to the hospital with a hip fracture. The co-manager addresses risk factors for harmful events, such as delirium, falls, adverse drug reactions, and infections



during a hospital stay. Thanks to this special attention—and deep commitment to collaboration—the benefits of adopting the core elements of the AGS CoCare: Ortho™ model include:

- Shorter time to surgery
- Reduced length of stay
- Reduced 30-day re-hospitalization
- Reduced complications and enhanced function after patients return home
- Fewer patients requiring intensive care unit (ICU) admissions
- Fewer post-operative infections, including urinary tract infections (UTIs) and pneumonia infections
- Near elimination of restraint use and episodes of delirium
- Reduced in-patient mortality
- Increased proportion of patients discharged home
- Increased institutional cost savings

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WASHINGTON UPDATE

"We provide leadership to health-care professionals, policymakers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy."

That, in a nutshell, is the mission of the AGS—and in clinics, communities, classrooms, and labs across the country, it's pretty easy to see how that leadership is impacting high-quality, person-centered care. But our work in the policy arena is an equally important forum for making geriatrics expertise known—and it's one we've returned to with increasing frequency here at the AGS.

Want to know what advocacy looks like for your profession? Check out the following highlights from our recent action on issues impacting your work (and be sure to bookmark the "Where We Stand" section of

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AGS 360° WITH NANCY E. LUNDEBJERG, MPA

Even though you're reading this on the cusp of 2019, I'm writing just days before the New York City Marathon. Manhattan, AGS's home base, has undergone a pretty dramatic transformation for 50,000+ runners and 2+ million spectators. It makes for great sport, and great photography (you see where my priorities lie).

The race notwithstanding, end-of-year always feels like a bit of a marathon here at the AGS. If the volume of activity on Twitter and MyAGSOnline are any indication, we're not alone. That speaks to what I heard at our Annual Scientific Meeting: That geriatrics itself is "a marathon, not a sprint."

I asked our staff runners (we've had two complete the marathon), and they confirmed: Whether you're a spectator or participant, getting involved in this type of race involves a different mindset. You have to keep your eye on a long-distance goal while also recognizing (and celebrating) every mile along the way. That seems as fitting a description for geriatrics as I could find—and one that sets me up quite nicely for highlighting a few of the mile markers we've passed in 2018.

Running the Gauntlet on the #MPFS2019

If marathons are a test of endurance, then working on the Medicare Physician Fee Schedule (#MPFS) certainly fits the bill. Authorized in 1989 and released annually to outline services and payment under Medicare for the next calendar year, the MPFS is a document only policy wonks could love. Luckily, AGS is home to quite a few wonks—whose hard work paid off for 2019.

When the initial draft was released in July, we recognized pretty quickly that its proposal to collapse evaluation and management (E/M) coding—which represents the "bread and butter" of geriatrics—would have virtually eliminated attention to the length and complexity of care, making many geriatrics practices untenable. So we did what #geriatrics does best: We hit the ground running.

The big news from the final #MPFS (released in November) is that CMS postponed plans to collapse E/M coding—a decision that has AGS and many others breathing a sigh of relief (at least temporarily).

You can learn more about our work (and who made it happen) on page 1 of this newsletter. We're rallying the troops again to determine the impact of the proposed coding collapse that would be implemented in 2021. For now, we appreciate that CMS has indicated it will work with stakeholders on ensuring any changes to payment are equitable for all specialists. I'm grateful for our dedicated experts and leaders who are committed to ensuring older Americans have access to expert geriatrics care by ensuring the #MPFS appropriately reimburses clinicians for providing that care.

Building a Better Course for Public Education

Thanks to your generosity in supporting the AGS Health in Aging Foundation, we'll be launching a redesigned HealthinAging.org in the first quarter of 2019. I don't want to spoil the surprise (you'll have to watch your member listserv, or better yet: Bookmark HealthinAging.org), but one of the newest features is dedicated to supporting the work of The John A. Hartford Foundation and others on creating age-friendly health systems.



The John A. Hartford Foundation, together with geriatrics experts and other stakeholders, identified four essential elements of age-friendly care, which not surprisingly reflect the original "4Ms" of geriatrics—care for the Mind, Medications, Mobility, and What Matters Most to Patients. Here at AGS, we'll also include the fifth M, Multi-complexity, which was identified by our colleagues up north at the Canadian Geriatrics Society in collaboration with Mary Tinetti, MD.

The Ms have always had a place of prominence in our work. On the new HealthinAging.org, they'll also benefit from dedicated space where we can take on the critically important task of helping *older adults and caregivers* understand what they mean, why they matter, and how they can become a reality.

Recruiting More Team Mates

Beyond this commitment to what we do, we've also made a concerted investment in 2018 to ensure we have more future teammates to make it possible. Thanks to your generosity, we supported 60+ trainees attending #AGS18. We're committed to offering even more assistance in 2019, and we hope you'll join us in making that possible at HealthinAging.org/donate—because geriatrics runs best when it runs in greater numbers, with members like you helping push us toward the finish line. ♦

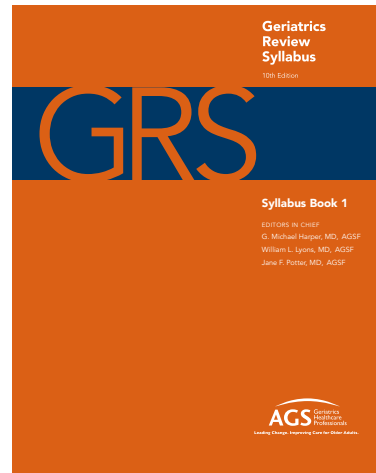
Regards,

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

10 things you should know about the *GRS10*

The New Year is bringing the new 10th Edition of the *Geriatrics Review Syllabus (GRS10)* to GeriatricsCareOnline.org—complete with new content, a new look, and a slate of new features. Available in January 2019 in print and digital formats, or with access to both (and more!) via the program's Complete Package, the *GRS10* is still the field's most comprehensive reference for the latest developments in geriatrics.

Here are our top-10 must-knows before the *GRS10* hits shelves, apps, laptops, and everywhere in between in just a few weeks:



1 The *GRS10* includes 67 chapters covering current issues in aging and clinical approaches to care, as well as updates on care systems, syndromes, psychiatric considerations, and diseases and disorders commonly encountered in geriatrics. New for 2019 is a chapter dedicated exclusively to Prognostication, a growing priority for geriatrics health professionals.

2 The *GRS10* draws on the expertise of nearly 200 field-leading authors.

3 If you're looking for a deeper dive, the *GRS10* comes with a host of annotated resources offering an instant connection to must-know reference tools.

4 The *GRS10* includes 360 brand-new self-assessment questions/cases and supporting critiques, all worth an optional 100 American Medical Association (AMA) Physician Recognition Award (PRA) Category 1 Credit(s)[™] and 100 Maintenance of Certification (MOC) points from the American Board of Internal Medicine (ABIM).

5 The *GRS10* Complete Package and digital edition offer a tailor-made study experience, with exclusive features such as customizable practice tests, continuously updated content, digital bookmarks, note-taking functionality, and the ability to track your progress and instantaneously apply for CME & MOC credit.

6 You can take the *GRS10* with you on-the-go with the brand new *GRS10* mobile app (available with the *GRS10* Complete Package and digital edition).

7 Complete Package and digital edition subscribers also get real-time content updates for the whole of their 3-year subscription.

8 For those who are preparing for the Geriatrics Certification Exam, both the *GRS10* digital edition & the *GRS* Flashcard App (exclusively available with the *GRS10* Complete Package) include a brand-new feature to help navigate content based on the ABIM's new exam blueprint.

9 AGS members can save up to \$181 on their purchase of the *GRS10*.

10 Purchasing the *GRS10* Complete Package is your best bet for the best value. The Complete Package comes with a print copy of the *GRS10* and a 3-year subscription to the continuously updated digital edition, along with exclusive access to the *GRS* Flashcard App (now expanded to include more than 1,300 study facts drawn from *GRS10* self-assessment questions). The complete package also includes the AGS iGeriatrics app, the *GRS10* mobile app, and the AGS Updated Beers Criteria[®] pocket card. ♦

Reserve your *GRS10* today:

Visit GeriatricsCareOnline.org, and you're a mouse-click away from all the latest updates geriatrics has to offer. And don't forget to keep your eyes peeled for upcoming enhancements and updates to our *GRS10*-related suite of tools—including the *Geriatric Evaluation & Management (GEM) Tools* and the *GRS* Teaching Slides. Just browse GeriatricsCareOnline.org for more details.

FROM OUR PRESIDENT

LAURIE G. JACOBS, MD, AGSF

It puzzled philosophers as early as the fifth century B.C.E. The search for an answer cost conquistador Juan Ponce de León his life looking for a fabled fountain. And even today, it generates a global business valued at more than \$191 million. Call it what you like—from the search for the “Fountain of Youth” to the business of “anti-aging”—but the quest to understand how we grow older is well-woven into the human experience.

But we as geriatrics health professionals see that quest a bit differently. While so many others search for ways to *avoid* age, we look for solutions that embrace what aging really means—particularly when it’s supported by our hallmark high-quality, person-centered care.

It’s our job as geriatrics experts to make that care possible, tangible, and actionable. But it’s also our job as AGS

in geriatrics: That longer life provides a great deal of opportunity, but that “healthy aging” must ultimately embrace a broader, person-centered notion of health as something more than the absence of disease.

For us as individual health professionals and AGS members, we know support for “healthy aging” means embracing a lifespan approach to care that helps each aging person live the healthiest life possible—whatever that might mean for the person standing in front of us. Espousing this philosophy—one old hat to us, but new (perhaps radically so) to others—necessitates replacing the current emphasis on staying young with age-friendly concepts of engagement, participation, contribution, interconnectedness, activity, and optimal function. And that’s at the heart of so many AGS efforts—from our recent work to better integrate mobility into the structure of



about more than the business of “anti-aging” or care for individual health concerns. As we learn pretty quickly in geriatrics, it’s really about individuals: Older people with rich physical, emotional, social, spiritual, and cultural identities; older people who have much to share...and an eagerness to share it!

I’ve been thinking a great deal about that lately—not only as my own medical school gears up for the end of its inaugural semester but also as I reflect on my experiences as a trainee, physician, educator, and even as a mom. Building an appreciation for who our patients are and why asking that question matters should be the bedrock of our training. At my own Hackensack-Meridian School of Medicine at Seton Hall, for example, we’re sending our students out into the community so they can learn from who they will serve. They follow three families throughout school, and they get to see healthcare and health from the families’ perspectives.

Programs like these are gaining momentum because they’re priming our future workforce to think differently about age. But, admittedly, I sometimes have to smile at all the attention—because, for all their novelty, these programs rely on a precept that’s really been embedded in geriatrics from the start. And that’s that older adults play an important role—an important, active role—in what our care is, why it matters, and how it takes shape. ♦

Best,

As we learn pretty quickly in geriatrics, it’s really about individuals: Older people with rich physical, emotional, social, spiritual, and cultural identities; older people who have much to share...and an eagerness to share it!

members to make it concrete—and understandable. So I’m happy to see part of this newsletter celebrating one such endeavor: Our work to define what “healthy aging” really means.

Led by Paul Mulhausen, MD, MHS, FACP, AGSF, colleagues from our Clinical Practice and Models of Care and Public Education Committees recently developed a new white paper calling on the AGS and our members to play a more active role in promoting healthy aging (see p. 10). Published in our journal earlier this year, their work highlights an important truth

our health systems (see p.12) to our ongoing efforts ensuring health policy, particularly the Medicare Physician Fee Schedule, supports a world attuned to the needs of us all as we age (see p. 1). These and so many other endeavors championed by our members create the type of environment where healthy aging can flourish.

That too is a quest well-woven into the fabric of our experience—but for reasons that might surprise those outside geriatrics. The care we research, the care we teach, the care we advocate and put into practice is

AmericanGeriatrics.org for the latest AGS news from Washington, D.C.—and beyond!).

CMS Delays Proposal to Restructure Physician Payment Until 2021

The Centers for Medicare and Medicaid Services (CMS) released the 2019 Medicare Physician Fee Schedule (MPFS) Final Rule on November 1, 2018. The big news coming out of the Final Rule is that CMS postponed the evaluation and management (E/M) coding “collapse” for at least two years—a decision that has AGS and many others in the medical community breathing a sigh of relief (at least temporarily).

In July 2018, CMS proposed massive revisions to reimbursement for E/M services, revisions that would have created a single-rate payment for almost all outpatient office visits irrespective of their length or complexity. By offering the same pay for all patients, such a change would have reduced access to care for older Americans—particularly those with multiple chronic conditions who require more time and attention in order to receive the care they need.

In response, the AGS spent much of the summer and early fall compiling feedback for CMS, as well as launching a large-scale effort focused specifically on the proposed E/M changes. This effort included an AGS-led multispecialty coalition that met with CMS leadership and submitted two joint letters: One to CMS signed by 41 groups and a second letter to Congress signed by 40 organizations. Our core message across these letters urged CMS to withdraw its proposal and work with stakeholders on a better solution. We are pleased that AGS, the multispecialty coalition, and other key stakeholders will now have that opportunity.

In other good news, CMS is finalizing E/M documentation reforms

we supported starting in 2019, and noted in its Final Rule plans to reduce provider burden further through 2021. For 2019, the following changes will take effect for physicians and other qualified health professionals:

- Required documentation of an established patient’s history will be limited to the interval history since the patient’s previous visit.
- The requirement to re-document information included by practice staff or the patient in the medical record will be eliminated.
- The requirement to document justification for a home visit instead of an office visit will be eliminated.

As this update went to press, the AGS was still reviewing the more than 2,200 pages of the Final Rule, including the proposed E/M changes for 2021 and other updates made to the MPFS and the Quality Payment Program for 2019. We’ll keep members apprised as we learn more.

More details about our response to the CMS E/M proposal can be found in a recently published article in the *Journal of the American Geriatrics Society*, “Putting Complex Older Persons First: How the CMS 2019 Payment Proposal Fails Older Americans” (DOI: 10.1111/jgs.15651).

Continuing to Support Training for the Geriatrics Workforce

The AGS continues to advocate for federal programs and policies addressing the acute and growing nationwide shortage of geriatricians and all geriatrics professionals. We’re also working to support programs ensuring other healthcare providers have training that prepares them to meet our needs as we age.

Most recently the Health Resources and Services Administration (HRSA) announced two important funding opportunities—both critical to the future of the geriatrics workforce, and both representing

hard work and advocacy on behalf of the AGS and our members. The new grants support the Geriatrics Workforce Enhancement Program (GWEP), the only federal program designed to increase the number of health professionals with the skills and training to care for older adults and the Geriatrics Academic Career Award (GACA) Program, a previously funded program that enabled career development for hundreds of clinician-educators before it was eliminated in 2015.

Additional efforts—orchestrated in collaboration with the Eldercare Workforce Alliance (EWA) and the National Association for Geriatric Education (NAGE)—have focused on legislative proposals in the House and the Senate to establish and authorize funding for the GWEP and reestablish and enhance GACAs.

The AGS, EWA, and NAGE have made significant progress towards that goal. In September 2017, Representatives Jan Schakowsky (D-IL), Doris Matsui (D-CA), and David McKinley (R-WV) introduced the Geriatrics Workforce and Caregiver Enhancement Act (H.R. 3713). A similar bill, the Geriatrics Workforce Improvement Act (S. 2888) was introduced in the Senate in May 2018 by Senators Susan Collins (R-ME) and Bob Casey (D-PA). Additionally, in July 2018, the House passed the Educating Medical Professionals and Optimizing Workforce Efficiency and Readiness (EMPOWER) Act, which included geriatrics-specific language from H.R. 3713.

We’re proud of the movement we’ve made this Congress and the support we’ve built among key members of Congress and their staff. We’re already discussing next steps for our strategy and planning visits on Capitol Hill to ensure geriatrics programs are supported. ♦

Several institutions around the country have implemented AGS CoCare: Ortho™ since its official launch in 2018. *AGS News* sat down with four of the early adopters for an inside scoop on their success.

Northwell Health (Long Island, NY): Laying the Groundwork for Success

Northwell Health has been working with the AGS CoCare: Ortho™ program as a pilot site since 2017. They worked closely and extensively with AGS CoCare: Ortho™ experts to prepare their system for adoption and implementation, and to ensure a successful rollout strategy that would act as a model for additional AGS CoCare: Ortho™ adopters. Northwell Health launched the program at their first hospital site, Long Island Jewish, in early 2018 and at their second hospital site, Long Island Jewish Valley Stream, in Fall 2018. They are currently working on adopting the program at two additional hospital sites, slated for launch in 2019.

The launch of the AGS CoCare: Ortho™ program at their first hospital site was built on lots of preparatory work based on what they saw across the AGS CoCare: Ortho™ network, note Liron D. Sinvani, MD, and Maria T. Carney, MD, who were instrumental in bringing Northwell's program to life.

The team says their rollout was successful from the start. They began with monthly calls with AGS leaders and hospital experts to make sure the team received support from Northwell Health System and the hospital. "The program was well-received, and all involved were pleased that we were targeting this vulnerable population," said Dr. Sinvani.

Their next steps involved creating a multidisciplinary steering committee comprised of colleagues from IT, orthopedics, geriatrics, nursing, and several other disciplines. The group met monthly to ensure that all teams

were on-board. "When anything new like this comes along, you have to work hard to get people involved. We did that with nightly huddles and biweekly meetings, and we made sure everyone was up to speed on what we were planning," noted Dr. Sinvani.

As a result, says Dr. Sinvani, there's been more communication and collaboration because all the teams formed close bonds. They also created their own standardized order sets: "Initially this was a big hurdle, but IT helped to make it happen," she notes.

"Now we have geriatrics-focused, vetted order sets that can be pulled up in all our hospitals," observes Dr.

"We also created a biweekly newsletter. We highlight an AGS CoCare: Ortho™ education module with a link in each issue. In this way, we can proactively educate the orthopedics, medicine, and the nursing teams," she adds.

"I recommend that other institutions considering AGS CoCare: Ortho™ ensure they have buy-in from the administration. Also, make sure you can collect data to show progress and benefits," advises Dr. Sinvani.

One way to get buy-in from the "boots on the ground" is to include everyone in your initial conversa-



Sinvani. "We have access to preliminary data that show that order sets are being used at high rates, showing the time to surgery, length of stay, and readmissions data we need."

So far, AGS CoCare: Ortho™ has improved Northwell's patient care by reducing the time to surgery. "Surgery is associated with better outcomes—and the patients are getting better care," notes Dr. Sinvani.

For Northwell, a valuable aspect of AGS CoCare: Ortho™ are the monthly calls with experts—an exclusive benefit of the AGS program. Getting expert experience, advice, and coaching is invaluable, reported Dr. Sinvani.

"At the start of our launch, we focused on talking to the higher-level orthopedic staff without initially talking to the orthopedic residents—the people who do the daily work. They must be looped in and on board with your plans," says Dr. Sinvani.

"I can't speak highly enough of the program and the fact that it's extremely supportive. We got valuable advice and support working with national leaders in hip-fracture co-management. AGS CoCare: Ortho™ provides the tools you need to be successful," Dr. Sinvani concluded.

An Early Start at Penn State Health (Hershey, PA)

The Penn State Health AGS CoCare: Ortho™ program used a team approach to care for older adults with hip fractures even before AGS CoCare: Ortho™'s official rollout.

The team developed criteria to determine if a patient should be admitted to orthopedics or to internal

care can vary greatly among skilled nursing facilities, as well as among home health providers. Our team is working with preferred partners to maximize recovery and function, as well as to manage patients proactively to avoid preventable readmissions," says Dr. Osevala.

Has implementing AGS CoCare: Ortho™ benefitted Penn State Health?

Dr. Osevala suggests other hospital teams considering AGS CoCare: Ortho™ might benefit from the program's centralized site for all the necessary education, tools, and resources, along with professional coaching.

medicine. The criteria included age as well as specific diagnoses that indicated increased medical complexity. In addition, orthopedics worked to take patients to the operating room within 24 hours.

"Once we had the AGS CoCare: Ortho™ resources and tools, however, we were able to integrate additional improvements to our program," said Nicole Osevala, MD, Assistant Professor of Medicine, Medical Director, Post-Acute Care Service, Penn State Health-Hershey Medical Center at Penn State College of Medicine.

"We developed and submitted standardized order sets for geriatric hip fractures," she notes. The team also focused on delirium screening and helped increase patients' post-operative mobility.

Beyond building a greater sensitivity to geriatrics, the team's interdisciplinary meetings also enhanced collaborative work between orthopedics and anesthesia. Together, they worked to leverage new methods to minimize post-operative bleeding and improve recovery and post-surgery medication management.

"We're also focused on post-acute care for hip-fracture patients. Quality standardized post-acute

According to Dr. Osevala, the program has helped achieve standardization from admission through discharge via AGS CoCare: Ortho™'s framework, tools, and resources. Of particular help were the program's educational modules, order sets, and quality metrics, noted Dr. Osevala.

Reflecting on their successes, Dr. Osevala suggests other hospital teams considering AGS CoCare: Ortho™ might particularly benefit from the program's centralized site for all the necessary education, tools, and resources, along with professional coaching.

"It will substantially increase your likelihood of success," Dr. Osevala notes.

A Fully Integrated Team at Strong Memorial Hospital (Rochester, NY)

The AGS CoCare: Ortho™ program at Strong Memorial Hospital benefited from a really successful launch, says Marsha Jensen, MS, RN, CPHQ, project nurse and quality assurance liaison. As a result, the hospital's Geriatric Fracture Center (GFC) team is fully integrated and has excellent participation from all disciplines and their leadership.

"Our meetings have packed

agendas and improve coordination and overall care for our geriatric fracture patients," says Jensen.

"We've improved coordination and cooperation among the disciplines and now have standardized care for hip-fracture patients," Jensen added. "This improves health outcomes, reduces length of stay, and improves patient and family satisfaction."

Highlights from Strong Memorial AGS CoCare: Ortho™ successes include:

- Getting patients to the operating room within 24 hours of arrival
- Reducing the use of/removing urinary catheters on a timely basis
- Improving patients' abilities to bear weight after their fractures have been stabilized
- Reducing length of stay
- Reducing delirium by focusing on specific potentially harmful medications and avoiding night-time sleep interruptions

Jensen says that implementing the AGS CoCare: Ortho™ toolkit has helped give Strong Memorial's GFC a plan to follow. Having templates for notes, order sets, data templates, and scorecards were great assets: "We didn't have to reinvent the wheel," she notes.

Jensen's advice for others who are considering implementing AGS CoCare: Ortho™: "Use the tools and resources provided by AGS CoCare: Ortho™. Get buy in from the leaders who will support the process and identify champions from the disciplines involved."

UCSF (San Francisco, CA): A Year Later, Measurable Results

From the very beginning, the AGS CoCare: Ortho™ program was well received at UCSF, says Stephanie Rogers, MD, Assistant Professor of Medicine. "The Orthopedic department appreciated the collaboration of Geriatrics, and the Rehabilitation and

continued on page 8

Case Management teams appreciated the interdisciplinary rounds we established," says Dr. Rogers.

The program started as a pilot in which older hip-fracture patients were co-managed by orthopedics and geriatrics. Then the team took full ownership of patients with hip fractures under the AGS CoCare: Ortho™ umbrella, managing all the patients' medical concerns.

"We helped patients control delirium, and we discussed goals of care. We had in-depth discussions about whether surgery was a reasonable option, and we prepared the family for what the process could look like. We also helped families set up home care support after discharge and explained what home care would entail," Dr. Rogers reported.

Thanks to AGS CoCare: Ortho™, "We have decreased length-of-stay by two days, our patients experience less delirium, and more patients are discharged to their homes instead of to nursing homes," says Dr. Rogers.

Dr. Rogers especially likes some of the AGS CoCare: Ortho™ learning modules and plans to use them through the onboarding process for new geriatricians in the program. "Completing the modules will help get them up to speed quickly as they join the team and ensure they are practicing the AGS CoCare: Ortho™ principles." ♦

**Interested in learning
more about
AGS CoCare: Ortho™
and building your
own success story?**



Contact Deena Sandos, LMSW,
AGS Manager of Special Projects, at
DSandos@americangeriatrics.org.



New on MyAGSOnline: Connecting with Colleagues More than Ever Before with the Volunteer Portal

Getting involved with the AGS has never been easier thanks to MyAGSOnline's new Volunteer Portal! From applying for committee service to following AGS on social media, the portal provides a full listing of every way you can remain in touch and engaged with your geriatrics community—and it's all just a click away.

To access the portal, log in using your member account at AmericanGeriatrics.org. Then, click "Get Involved at AGS" in the top toolbar, and click "Volunteer Opportunities" from the drop-down menu to be directed to the volunteer portal. View the listing of active opportunities and apply for anything that interests you. Don't forget to configure your volunteer interests and sign up for email alerts so you know when new opportunities open that match your interests and expertise!

Have questions or a volunteer opportunity you'd like to offer to fellow AGS members? Contact Lauren Kopchik, Senior Membership Communication Coordinator, at LKopchik@americangeriatrics.org. ♦

Join the MyAGSOnline Virtual Mentorship Program

Are you...

- *A trainee looking for someone to help with residency or fellowship decisions?*
- *An early-career professional wondering about next steps?*
- *A seasoned professional looking for a career change?*
- *A late-career professional looking for advice on transitioning into retirement?*

At AGS, we know everyone has experience to share—and beginners aren't the only people who need mentors. That's why we're piloting a Virtual Mentor Program exclusively on MyAGSOnline!

To sign up for the program as a mentor, mentee, or both, log in using your member account at AmericanGeriatrics.org. Then, click "Get Involved at AGS" in the top toolbar, and click "Mentorship Opt-in" from the drop-down menu. Configure your mentorship settings and click "save" after checking off your choices. Your preferences will automatically be saved to your MyAGSOnline profile.

After opting into the program, mentees will have access to a directory of mentors. It's as simple as that—happy networking! ♦



GET READY FOR AGS'S FIRST-EVER TRIP TO PORTLAND!

You likely remember the magic of #AGS18 at Walt Disney World's Swan and Dolphin Resort in Orlando, FL. In 2019, we're exchanging the Mickey Mouse ears for Portlandia flannels as we gear up for the AGS 2019 Annual Scientific Meeting (#AGS19), May 2-4 in Portland, OR!

More than 2,000 of the best and brightest in geriatrics will be joining us at the Oregon Convention Center for the AGS's first meeting to be held in Portland. There's always something interesting to see or do in a new place—so here are some must-know meeting tips to help you have a smooth adventure!

Don't Wait...Register Today!

Register before March 27, 2019, to receive an early-bird discount on #AGS19 attendance in addition to your already discounted member rate. Registration for #AGS19 guarantees access to all sessions, exhibits, presentations, and posters, as well as food/beverage breaks and exciting attendee-only receptions! Check out Meeting.AmericanGeriatrics.org to reserve your place.

As the Locals Say... "You Can, in Portland!"

Portland is known for its bustling local business scene, delicious cuisine, and community spirit. Whether you're interested in a guided tour of the city, a place to relax in the great outdoors, or an opportunity for tax-free shopping, Portland has something for everyone! Come for the geriatrics updates, and stay for the great experience Portland offers. Visit TravelPortland.com to get inspired about all of the fun awaiting you.

The AGS also offers great deals at a number of hotels both downtown and near the Oregon Convention Center. Go to Meeting.AmericanGeriatrics.org and click on "Hotel and Travel" for more details!

See it and Tweet it

If you didn't post it, did it even happen? Use #AGS19 to spread the word about your meeting plans and keep us updated on your Portland experience on Twitter, Facebook, and Instagram. Look for updates from @AmerGeriatrics, @AGSJJournal, @HealthinAging, and AGS CEO @NLundebjerg to remain in-the-know about all things #AGS19.

Remember to follow meeting updates on MyAGSONline, the exclusive online forum for AGS members. Log in at AmericanGeriatrics.org and view the AGS Member Forum to learn about sessions and sights that already have your colleagues talking. ♦



Multnomah Falls, only 30 miles from Portland



Portland Japanese Garden

WE ALL WANT “HEALTHY AGING,” BUT WHAT IS IT & HOW DO WE PROMOTE IT? NEW AGS REPORT LOOKS FOR ANSWERS & SOLUTIONS

“Healthy aging” sounds like a priority everyone can share, but for geriatrics healthcare professionals, that term often represents something specific, and something worth defining. Led by Paul Mulhausen, MD, MHS, FACP, AGSF, colleagues from the AGS set about doing just that as part of an expert panel convened to look critically at what “healthy aging” really means. Their definition—published in a white paper earlier this fall in the *Journal of the American Geriatrics Society* (DOI: 10.1111/jgs.15644)—explores the intersection between our personal care goals and innovations in science, education, and public policy as the place where healthy aging may be understood best.



“Longer life is a priority for individuals and society because it provides opportunities for personal fulfillment and contributions to our communities. But as we learn more about concrete ways to increase longevity,” Dr. Mulhausen observed, “we need to work on ways to improve the quality of that time as well.”

As the AGS expert panel reports, older adults often live with an array of health concerns, which means that “healthy aging” for a contemporary audience must embrace a broader, person-centered notion of health as something more than the absence of disease or infirmity. Healthy aging involves pivoting to age’s influence on our physical, mental, and social needs *and* expectations, ultimately embracing a “lifespan approach” to care that helps each aging person live the healthiest life possible. This new focal point necessitates replacing our current cultural emphasis on staying young “with age-friendly concepts of engagement, participation, contribution, interconnectedness, activity, and optimal function,” as the AGS white paper explains.

Healthy aging also extends beyond clinical services, embracing a complex and interconnected ecosystem that both impacts and is impacted by how we grow older. In this respect, AGS experts highlight several priority areas where communities, health systems, and clinicians can work together to foster engagement and independence for us all as we age. These include:

- **Greater advocacy supporting policy solutions for older people.** Healthy aging requires a coordinated response not only to care but also to community priorities that can promote health, safety, and independence in age-friendly environments. For the AGS expert panel, this means collaborating as advocates across society and professions to align our health systems with the needs of older people while also promoting healthy aging when we are younger.
- **Better public and professional education to make healthy aging an actionable priority.** Care that can promote healthy aging rests on ensuring future generations of health professionals and older adults understand and embrace best practices focused on keeping us healthy and independent. This can become even more of a reality today by working early and often to combat ageism (discrimination against older people due to negative and inaccurate stereotypes about age), particularly when it comes to older adults’ self-perceptions.
- **A deeper commitment to the geriatrics expertise we need as we age.** Embracing biology, psychology, and socio-cultural considerations to optimize functional status must remain a top healthy-aging priority. “We should work to replace the current cultural emphasis on staying young...with age-friendly concepts of engagement, participation, contribution, interconnectedness, activity, and optimal function,” the AGS report notes.
- **Renewed attention to social and scientific research that can build our understanding of what healthy aging really means.** According to AGS experts, research on aging at the cellular, individual, and community levels represents one of our best opportunities for advancing healthy aging. “We also need better evidence to inform our understanding of the biomedical and psychosocial determinants of healthy aging,” the AGS experts conclude.

As for why geriatrics health professionals are uniquely qualified to stake a claim on defining healthy aging and putting it into practice, Susan Friedman, MD, MPH, a member of the panel responsible for the AGS white paper, observes that many principles at the heart of the AGS's definition have been part of geriatrics from the start.

"Geriatrics is a collaborative profession built by clinicians, educators, health system experts, older adults, and

caregivers," Dr. Friedman said. "We understand complexity. We are experts in culturally competent, person-centered care. We are skilled in assessing preferences and values, and translating them into prevention, intervention, and advance care planning. Regardless of how society chooses to define 'healthy aging,' these are the practices that make it something we can see—and ideally experience, especially through geriatrics-led insights." ♦

NEW GERIATRICS RESEARCH OFFERS ROADMAP TO "REVOLUTIONARY CHANGE" FOR PERSON-CENTERED CARE

Published in the *Journal of the American Geriatrics Society (JAGS)*, two new research articles and a corresponding commentary from *JAGS* leaders describe ways to make person-centered care—a novel approach to health that puts personal values and preferences at the forefront of decision-making—more actionable for older people. With our national health system at a tipping point favoring care focused on personal priorities, these new studies are among the first to celebrate "thoughtful, systematic, and incremental" approaches to ending fragmented care.

"Making person-centered care a reality for older adults with complex care needs will take time and effort, including significant research to move promising approaches from the lab bench to the clinic," said William B. Applegate, MD, MPH, AGSF, Editor-in-Chief of *JAGS* and lead author on the editorial addressing the two new studies (DOI: 10.1111/jgs.15536). "This work is helping test innovative strategies, which will move us toward a broader and more balanced approach to care."

Though critically important, eliciting and documenting personal values remains uncommon in routine older adult care, particularly for people with multiple health concerns that complicate pinpointing broader health priorities. In "Development of a Clinically Feasible Process for Identifying Patient Health Priorities" (DOI: 10.1111/jgs.15437) a research team led by Anand Naik, MD, describes Patient Priorities Care, a novel process to identify health goals and care preferences for older people with multiple health conditions. The process introduced by Dr. Naik and his colleagues used expertly trained facilitators to help older adults and caregivers work through health priorities sensitively, in a process that could be completed across just two sessions totaling 45 minutes or less. According to the research team: "Results of this study demonstrate that healthcare professionals can be trained to perform the patient priorities identification process as part of their clinical encounters...[through a process that

is] rewarding and enjoyable but requires training and formal feedback."

Separately, a team led by Caroline Blaum, MD, MS, put the processes described by Dr. Naik and his colleagues into practice, reporting their findings in "Feasibility of Implementing Patient Priorities Care for Patients with Multiple Chronic Conditions" (DOI: 10.1111/jgs.15465). Their study involved using Patient Priorities Care among more than 100 patients working with nine primary care providers and five cardiologists in Connecticut. While researchers still hope for improvements in the time needed to complete the process and in avenues for embedding it within practice workflows, they noted that the vast majority of patients returned to their physician with clear goals and care preferences. Follow-up discussions between patients and providers suggest that moving from disease-based to priorities-aligned decisions is "challenging but feasible."

This work represents several of the latest steps forward for high-quality, person-centered care for older people, and also builds on an even lengthier legacy at *JAGS* and the AGS. In 2016, for example, *JAGS* published findings from an expert panel convened by the AGS with support from The SCAN Foundation to define person-centered care and its essential elements (DOI: 10.1111/jgs.13866). According to the panel, person-centered care "means that individuals' values and preferences are elicited and, once expressed, guide all aspects of their care, supporting their realistic health and life goals. Person-centered care is achieved through a dynamic relationship among individuals, others who are important to them, and all relevant providers. This collaboration informs decision-making to the extent that the individual desires." Many of these attributes are already on display in the work of Dr. Naik, Dr. Blaum, and their colleagues, pointing to the high value but also the high priority placed on accelerating person-centered care in geriatrics and beyond. ♦



NEW REPORT ON ASSESSING MOBILITY HAS EXPERTS MOVING TOWARD CONSENSUS ON CARE WE NEED AS WE AGE

Experts at the AGS this year unveiled a list of recommendations to help health systems prioritize a vital function for us all as we age: mobility (our ability to move freely and easily, on our own or with assistance). Published earlier this fall in the *Journal of the American Geriatrics Society (JAGS)*, the AGS white paper (DOI: 10.1111/jgs.15595) focuses on assessing mobility for hospitalized older adults, offering a roadmap for shifting health care's focus *away* from negative markers of mobility loss and toward a deeper appreciation of ways mobility can be proactively assessed—and often preserved.

“Being able to maintain mobility is a top priority for many older adults facing a hospital stay,” said Heidi Wald, MD, MSPH, one of the lead authors on the AGS white paper. “So it’s surprising that mobility still isn’t a widely recognized *outcome* when we look at quality of care. With this new summary of research and recommendations, we hope we can move our health system toward assessing mobility more appropriately and ideally preventing mobility loss as we age.”

Most people already lose muscle strength and mass as they age, for example, but hospitalized older adults can lose up to 10 percent of their muscle strength per week of bed rest during a hospital stay. More than a third of hospital patients over age 70 are discharged with a major disability that *was not* present before their admission, with many also experiencing increased hospital stays and poorer

abilities to perform the activities of daily living due in part to mobility loss.

Yet while the loss of mobility is common as we age, AGS experts note that nothing is *commonplace* about the impact of this trend on overall well-being.

“Mobility loss is critical in the cascade to dependence—a slippery slope that can start with small declines in movement but can ultimately lead to falls, further hospitalizations, and a general loss of independence,” Dr. Wald observed. “Thankfully, there are ways we can prevent and perhaps even reverse that cascade—but that means doing more to assess and address mobility in a coordinated fashion.”

In their new white paper (available for free from *JAGS*), representatives from the AGS Quality and Performance Measurement Committee reviewed existing research on mobility loss during hospitalization, including the implications of low mobility, the current state of mobility assessment, and ways we can use new and existing tools to promote routine evaluation of how well mobility is preserved following hospital stays. While standardized programs across *all* hospitals may be difficult to develop, the AGS expert panel arrived at the following seven recommendations they believe leverage the best existing science in effective ways for the whole of our national health system.

More than a third of hospital patients over age 70 are discharged with a major disability that *was not* present before their admission

Recommendation 1: Promote mobility assessment in acute care.

Regulations put in place by agencies like the Centers for Medicare and Medicaid Services (CMS) often shape how care will be put into practice. These agencies can promote greater attention to mobility by incentivizing the use of validated assessments that integrate with existing tests to minimize the burden on providers.

Recommendation 2: Advocate for more research funding.

Federally funded groups like the National Institutes of Health and the Agency for Healthcare Research and Quality also can shape the future of improved mobility by prioritizing research to translate mobility assessment and quality measurement into intervention programs that can protect and promote our ability to continue moving freely as we age.

Recommendation 3: Develop consensus on standard methods to assess mobility.

Existing programs to assess and promote mobility vary greatly—and standardizing them across hospitals is difficult and perhaps even unnecessary. Stakeholders can help improve care, however, by promoting broader consensus around specific assessments that are validated; appropriate for acute-care settings; and capable of providing health professionals, older people, and caregivers with meaningful, actionable data.

Recommendation 4: Minimize the burden of mobility measurement.

Hospitals and health professionals already balance a range of measures and metrics to assess the care they provide. To promote mobility more appropriately, stakeholders will need to focus on optimizing workflows and documentation to minimize redundancy.

Recommendation 5: Evaluate the feasibility of a mobility quality measure.

By developing a specific quality measure for mobility, CMS could incentivize hospitals, staff, and providers to prevent loss of mobility even more proactively.

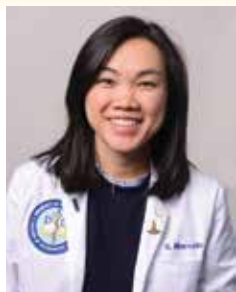
Recommendation 6: Reframe the current regulatory focus on falls in acute care to a focus on safe mobility.

The current focus on preventing falls at all costs has led to unintended consequences that may actually impede efforts to protect and preserve mobility. AGS experts recommend reconsidering falls as an indicator of quality care in the absence of a corresponding measure to assess mobility more fully.

Recommendation 7: Develop resources for acute-care providers.

Organizations like the AGS and its stakeholders have also been encouraged to create new tools, processes, and strategies to assist healthcare professionals and hospitals with implementing mobility assessments and interventions. ♦

AGS STUDENT SPOTLIGHT



Sonia Marcello

Sonia Marcello is a third-year medical student at the University of New England College of Medicine (UNECOM) in Maine. She was the recipient of the Edward Henderson Student Award at #AGS18. Sonia recently caught up with AGS News to discuss her passion for geriatrics—and what her community of fellow students, mentors, and patients has done to inspire her along the way.

What led you to a career working with older adults?

I grew interested in the geriatric population while working in a nursing home as a Certified Nursing Assistant. I realized there how much I enjoyed working with older adults, and discovered that while medicine is important for curing diseases, it's equally important for impacting an individual's quality of life.

Fast forward to the summer after my first year of medical school, and I found myself admitted into a nursing home by my professor, Dr. Marilyn Gugliucci (No, really 😊). For 10 days, I was immersed as a nursing home resident and I began to understand that old age is the product of resilience and adaptation. My passion for the geriatrics community grew as I realized that I would have the ability to influence health care by the way I practiced.

What was your #AGS18 experience like?

#AGS18 was incredibly exciting for me. It was my first time at a national conference. Not only did I participate in a poster presentation, but I was also honored to receive the Edward Henderson Student Award. It was truly encouraging to be around so many people who were also passionate about the geriatric community, education, and health. There was an inspiring sense of being part of something bigger. This provided much-needed motivation during my preparation for board exams.

Do you have a mentor? How have they helped your career path?

My biggest mentor in medical school has been Dr. Marilyn Gugliucci. As the Director of Geriatrics Education and Research at UNECOM, she has offered an approach to learning about older adults that reaches beyond the clinical patient and explores the individuality and vibrant lives of older adults. My time with Dr. Gugliucci has helped me examine my own interest in the geriatric population as well as address the assumptions I made about older adults. I hope to take what I have learned about myself and others and apply it to my future role in health care.

One of the first things that I learned from Dr. Gugliucci is that "the most important 3-letter word is ASK." This is a mantra that I used a lot going through my first two years of medical school, and it's something that I have been reminding myself frequently. Having a great mentor during such a stressful time has been invaluable and I greatly appreciate all the help and time Dr. Gugliucci has dedicated not only to me but also to countless other students.

What does the geriatrics community mean to you?

Older adults provide us with the

opportunity to learn and grow from their experiences. As our population of older adults increases, it will be important to learn about their specific needs and how we can better serve that patient population. As a future physician, I hope to use the lessons I've learned to be a mentor to my peers and an advocate for the geriatric community.

What advice do you have for other students?

Get involved with your medical school's AGS chapter, and if you don't have one, then start one. The UNECOM AGS chapter was where I met my mentor and my fellow peers with the same interests. It's where I've learned lots about geriatric medicine, and I attribute my success to getting involved and taking advantage of the opportunities offered within the club. ♦

Interested in applying for a student chapter with AGS? Contact Lauren Kopchik, Senior Membership Communication Coordinator, at lkopchik@americangeriatrics.org.



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Emergency Preparedness for Older Adults

Older adults are among the most vulnerable when disaster strikes. That's why it's critical that older people, and those who care for them, prepare for emergencies. If you're an older adult, or care for an older person, follow the steps below to prepare for and respond in an emergency.

STEP 1: CREATE AN EMERGENCY PLAN

HAVE AN EMERGENCY COMMUNICATIONS PLAN

- Create a "phone call chain," a plan in which you make an initial call to one person and they in turn call the next person, and so on.
- This will make sure that all relatives and friends know what is happening in the event of an emergency.

KEEP CONTACT INFORMATION COMPLETE AND UP-TO-DATE

- Have the current home, work, and cell phone numbers of people you'll need to contact in an emergency. Make sure those people have your phone number, and the numbers of nearby friends or neighbors.
- Put an extra copy of these numbers in a travel wallet, purse, or suitcase.

DESIGNATE A MEETING PLACE IN CASE YOU HAVE TO EVACUATE YOUR HOME

- Pick two meeting places — one near your home, the other outside the neighborhood — where you can wait and relatives can find you. Make sure everyone has the address and phone number of the meeting location.
- If you are caring for an older adult who lives in a facility, find out where he or she will be taken in case of evacuation.

CONSIDER ORDERING A MEDICAL ID BRACELET

- Consider ordering a medical ID bracelet or pendant for people with chronic health problems. Information on medical conditions, allergies, medications, and emergency contacts can be engraved on the surface.
- For very elderly or disabled adults, put the identification information, list of diagnoses, and medications in a traveler's wallet that can be worn in an emergency.

GET LOCAL EMERGENCY AND EVACUATION INFORMATION IN ADVANCE

- Get a community disaster/emergency plan for your area, if there is one.
- Learn where evacuees might turn for medical care or emergency supplies of medications.
- Obtain a map of evacuation routes and keep it in your car.
- Stay tuned to local radio stations for evacuation instructions.

MAKE TRAVEL ARRANGEMENTS IN CASE OF EVACUATION

- Talk to family members (or the directors of the facility where you live) about what you would do in the event of an evacuation.
- Will you be able to drive or will you need someone to pick you up? If so, who, and at what meeting place? Who can provide a back-up ride, and how will that person be contacted?
 - You may also want to ask the director to designate staff who will stay with a very elderly adult during an evacuation.



STEP 2: STOCK AN EMERGENCY MEDICAL KIT

An emergency medical kit should include:

MEDICATIONS	<ul style="list-style-type: none">• A 3-6 day supply of your medications along with an up-to-date medication list that includes the names (brand and generic) of any drugs you're taking and the doses.• An insulated bag big enough to hold a two-week supply of any medications that require refrigeration, such as insulin. Keep ice packs in the freezer for the emergency medical kit.
MEDICAL EQUIPMENT AND NECESSITIES	<ul style="list-style-type: none">• Blood sugar monitoring equipment.• Blood pressure cuff.• Hearing aids and hearing aid batteries.• Extra pair of eyeglasses and/or dentures.
WRITTEN INFORMATION ABOUT TREATMENT	<ul style="list-style-type: none">• Ask your healthcare provider for copies of your medical records and lists of all active medical problems you have and how they're being treated.• Extra copies of Medicare, Medicaid, or other medical insurance information.

STEP 3: MAKE A DISASTER SUPPLIES KIT

A disaster supplies kit should include your medical kit equipment and:

WATER	Plan for at least 1 gallon per person per day, and at least a 3-day supply.
FOOD	At least a 3-day supply of canned and dried foods that won't spoil. Juices, soups, and high-protein shakes may be particularly helpful for older adults.
BASIC SUPPLIES	A manual can opener, flashlight, battery powered or hand cranked radio, batteries, waterproof matches, knife, resealable plastic bags, tin foil, disposable cups, plates, utensils, basic cooking utensils, emergency whistle, and cell phone with chargers or solar charger.
MAPS	Local and regional maps in case roads are blocked and you need to take detours.
CHANGE OF CLOTHING & BLANKETS	A complete set of clothing per person: a long sleeved shirt, long pants, shoes, a coat, hat, mittens, and scarf. Also include one blanket per person.
PHONE NUMBERS, CONTACT INFO, AND KEY PAPERS	Numbers and addresses of friends and relatives you might need to contact, your healthcare provider, and any specialists you see. Also include copies of your credit and identification cards.
CASH	It's a good idea to have at least \$50 on hand; if that's not possible, include as much as you can.
FIRST AID KIT AND MANUAL	See the Red Cross's comprehensive list of what to pack in your first aid kit, at www.redcross.org . The Red Cross also sells prepackaged first aid kits.
BASIC HYGIENE PRODUCTS	Soap, toothpaste, toothbrushes, sunscreen, hand sanitizer, toilet paper, baby wipes, and a few trash bags for garbage.

