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WHEN IT COMES TO #AGS20, OUR VISION FOR LONG BEACH IS 20/20

If you hadn't already heard, #AGS19 was a record-breaker for the AGS, with nearly 3,000 health professionals and geriatrics stakeholders joining us in Portland, OR. The energy and enthusiasm captured at the meeting has our AGS Annual Scientific Meeting Program Committee planning even bigger, better, and bolder updates for #AGS20 (May 7-9 in Long Beach, CA).

"Over the years, AGS meetings have truly become a celebration of the work we do every day to enhance the lives of older adults," said Joseph Shega, MD, #AGS20 Program Chair. "Not only will we be looking at the most recent clinical advances and accomplishments in research, but we'll also be charting a clear course ahead of us for the vision of our field."

For another record-breaking cohort of health professionals, advocates, experts, and trainees who work tirelessly to support high-quality, person-centered care as we age, Long Beach will be an essential destination come May 2020. Read on to find out what's in store for the premier educational event in geriatrics.

Bringing the Best in Educational Experience

As always, #AGS20 will help attendees discover new topics of interest, professional development tools, and career-changing opportunities. Sessions will cover not only the latest in clinical care but also interactive opportunities to expand knowledge in research, public policy, and professional education.



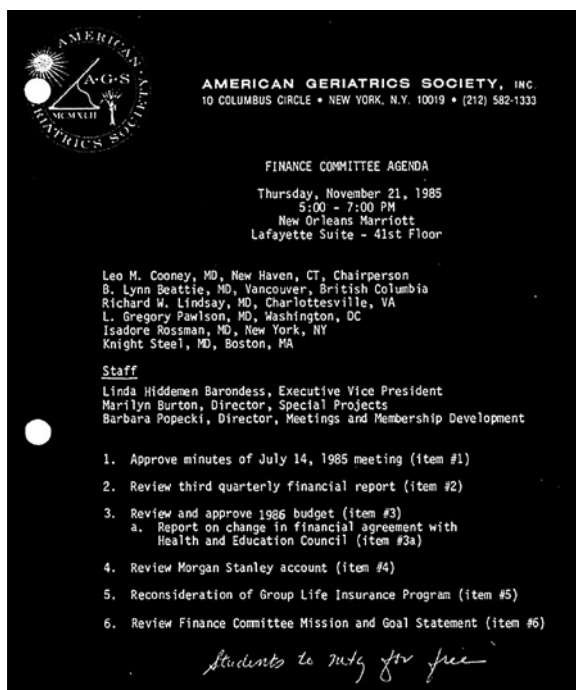
NEW STUDY FINDS NURSING HOME NURSES OFTEN UNABLE TO COMPLETE NECESSARY CARE DUE TO LACK OF TIME, RESOURCES

For years, extensive evidence from hospitals has shown that professionals are more likely to leave necessary patient care undone when employed in settings with insufficient staff and resources. This "missed care" has been linked to poor care quality, increased adverse events, and decreased satisfaction with the health system. Now, new research published in the *Journal of the American Geriatrics Society (JAGS)* finds similar evidence in nursing homes specifically, and identifies the strong relationship between missed care, nurse burnout, and job dissatisfaction.

Colleagues from the Center for Health Outcomes and Policy Research

AGS 360° WITH NANCY E. LUNDEBJERG, MPA

Here's a throwback for you: A picture (below) of a committee agenda from 1985. It's one of the last years we used typewriters (typewriters!) for memos. We've come a long way since then. One thing that hasn't changed, however, is the energy behind our momentum: Members like you.



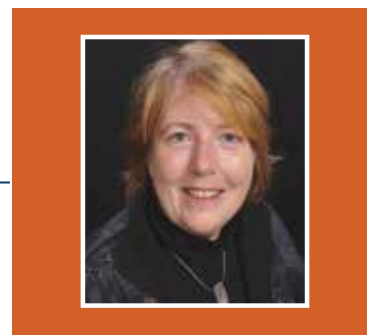
There's a lot of talk about what you give when working with volunteer organizations like the AGS—and as the leader of a society driven by volunteer time, talent, and treasure, I can vouch for the importance of all you share. But we also think there's much *to gain* from making the most of your membership. In this letter, I thought I'd make it even easier to see why (and where). Thus: Our Top 10 Reasons to Get Involved in a National Professional Organization (with thanks to incoming AGS President, Annie Medina-Walpole, for putting the initial list together).

1. You can develop collaborations for research and educational activities. Almost every AGS program has roots in casual conversations between members. *Geriatrics At Your Fingertips* started with an "I wish we had..." conversation decades ago. What ultimately became our white paper on healthy aging originated with discussions in the halls at #AGS15. If you can dream it (or discuss it), you can do it here at the AGS.

2. You can expand your networking relationships with other institutions. Searching MyAGSOnline is a bit like playing six degrees of separation (minus Kevin Bacon: Not a member... yet). With 7,000+ members practicing on 6 of 7 continents, if there's a person or a place you need, you can bet there's a connection at the AGS.

3. You can promote your program/school and your personal vision on national leadership. We hear a lot of talk about the workforce shortage in geriatrics. But that shortage hides one of geriatrics' best-kept secrets: An abundance of opportunity. As health care pivots to a geriatrics-based approach (because it must), our volunteer leaders get to say they were there from the start.

4. You can work side-by-side with national leaders who can serve as mentors and role models. If you need an example: Turn to page 10 for Julia Loewenthal's experience connecting with Louise Aronson (and



Julia's harrowing story of care at 30,000 feet).

5. You can build our national agenda and impact national policy. Building a future when we all can look forward to health, safety, and independence goes beyond identifying cutting-edge care. It's also about embedding that care in the fabric of how we practice. We've written extensively about how members make that possible (just search "fee schedule" in JAGS to learn more). How you can get involved is as easy as visiting AmericanGeriatrics.org/where-we-stand.

6. You gain national visibility as a leader. We're an elite workforce discovering care principles, educating colleagues and the public about those principles, and implementing them in health systems, classrooms, and communities. In a world where leadership opportunities can be few and far between, we're more than eager to benefit from what you can share!

7. You can get energized by interacting with like-minded people passionate about similar work. Looking to find them before #AGS20? Just search Twitter (Read: *Join* Twitter, if you haven't already) for #AGSProud and #IAmGeriatrics.

8. You can improve your educational programs by incorporating great ideas from colleagues around the country. MyAGSOnline abounds with peers from around the world sharing

continued on next page

at the University of Pennsylvania School of Nursing used data from 540 nursing homes in California, Florida, New Jersey, and Pennsylvania to examine the relationship between job burnout/dissatisfaction and incidence of missed care reported by registered nurses (RNs).

The researchers found that a sobering 72 percent of RNs reported missing one or more care tasks on their last shift due to lack of time or resources. One in five RNs reported frequently being unable to complete necessary patient care. The activity most often skipped? Sadly, it was comforting/talking with patients, followed by performing adequate patient surveillance, teaching patients and families, and developing care plans.

Missed care was significantly more common among nursing home RNs who were dissatisfied with their jobs or experiencing burnout. Across all RNs, 31 percent were dissatisfied and 30 percent exhibited burnout. Nurses with burnout were five times more likely than their colleagues to miss needed care, whereas RNs who were dissatisfied were 2.6 times more likely to miss care than RNs who were satisfied with their jobs.

The data are sobering, to be sure, but the research team was also quick to note the potential for solutions already in existence. They note that “work environments that provide

adequate staff and resources, involve RNs in quality improvement processes, and support RNs through career pathways and leadership opportunities could help to promote employee engagement, reduce missed care, and improve patient safety in nursing homes.” Additionally, the researchers emphasize that creating a culture emphasizing the need to find a root-cause for systemic problems, rather than punishing staff for individual mistakes, can help identify organizational inefficiencies that result in missed care.

Organizations like the AGS have long advocated for federal programs and policies to address the acute and growing nationwide shortage of geriatrics health professionals, which contributes to insufficiencies. Additional efforts tied to building the interprofessional workforce that supports us all as we age, and ensuring all health providers have a basic understanding of geriatrics principles, will be key to the future of nursing home care quality, satisfaction, and safety.

While their data did not establish a causal link between burnout, job



dissatisfaction, and missed care, the researchers point to a rich body of existing evidence that “RNs are more satisfied and experience less burnout when they have adequate staff and resources, supportive managers, productive colleague relationships, input into organizational affairs, and opportunities for advancement.” Even under tight fiscal constraints, the researchers observe, “nursing home leaders can take steps to improve work environments through a variety of evidence-based interventions.” ♦

➤ To access the full research report from *JAGS*, visit <https://onlinelibrary.wiley.com/doi/10.1111/jgs.16051>. For additional information on efforts to support the health workforce we all need as we age, visit AmericanGeriatrics.org/Workforce.

tools, tips, or resources to improve programs “back home” (wherever “back home” may be).

9. It’s fun and rewarding. Let’s be honest: Where else are you going to find a literature review sing-along, a superhero-themed dance party, and star-studded flashmobs?

10. The more you do, the more you will be asked to do (in a good

way 😊)...and the opportunities for involvement are endless. And that begs the bigger question: Where to start?

Start small: Post a question or discussion to MyAGSOnline. Offer to serve as an #AGS20 abstract reviewer. Contact your legislators about geriatrics priorities. From there, the sky’s the limit: We’re accepting applications through 12/15 to join AGS committees, for example—a

feeder opportunity to additional leadership and recognition within our ranks. Looking to learn more? Everything you need is just a click away from the “Get Involved” tab at MyAGSOnline.AmericanGeriatrics.org. ♦

FROM OUR PRESIDENT

SUNNY LINNEBUR, PHARMD, FCCP, FASCP, BCGP, BCPS

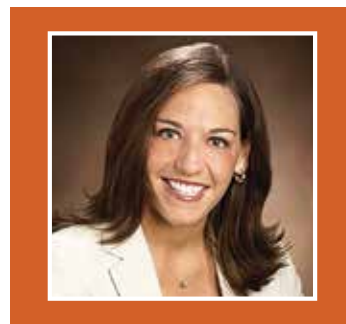
I'm biased—but just look at the photo [below] and you'll understand why. Fall here in Colorado is a sight to behold (or, for my social media aficionados, a source of #InstaEnvy). So much of health care today seems aimed at hiding age and change. But fall is an example of the exact opposite: With nature on full display, one can see the beauty of change and the beauty of aging. That's what makes it so eye-catching. Sure, we still miss the warmth of summer and worry about the chill of winter from time to time, but fall is just one of those seasons when change happens so naturally and so beautifully that it's worth noticing in a positive way. We should embrace that perspective when it comes to the personal journey of growing older, too. Hopefully, the ever-increasing prominence of geriatrics will help make that possible.



As President of the AGS, I also appreciate fall because it's a point when so much progress and so many projects start to come to fruition. This newsletter—and all of the AGS updates since we convened for #AGS19—are certainly a testament to that! I'd like to call your attention to just a few highlights:

■ **New Research in JAGS Points to Importance of Investing in Workforce Satisfaction:** Regardless of where we practice, we know inadequate patient care can lead to poor health outcomes and decreased satisfaction. But inadequate care in nursing homes hasn't been well studied—until now. A new article in *JAGS* shows how some nursing-home staffers may be more likely to leave necessary care unfinished due to overburden and limited resources. In the words of our journal's fearless Executive Editor, Joe Ouslander, MD, AGSF: "The data should raise a clarion call to health policy makers and those who own and manage nursing homes," and the article offers some evidence-based suggestions to get them started. You can learn more on page 1 of this newsletter.

■ **Editorial Tackles What Clinicians Should Know About Long-Term Care Insurance:** Counseling older adults and caregivers about long-term health conditions can be complicated—but what about counseling on *the insurance* they may need to cover that care? Navigating long-term care insurance can leave many of us with more questions than answers (and we're experts!). Thankfully, another update from *JAGS* has experts from the Department of Health Care Policy at Harvard Medical School sharing responses to frequently asked questions from older adults and caregivers. Without advocating for any specific solution, the editorial provides a useful framework for helping clinicians re-orient conversations away from myths about long-term care coverage and toward greater appreciation for the need to plan ahead. You can learn more on page 5 of this newsletter.



■ **Learning More About the Older Adults of Today...and Building Better Public Policy for Tomorrow:** Shortly after #AGS19, the Administration for Community Living released its 2018 "Profile of Older Americans." This summary of critical statistics related to the older adult population highlights our country's shifting demographics—and what those demographics mean for our research and care. See page 8 of this newsletter for highlights from the report. These data are important on their own, but I think it's also critical for us to consider them in the context of the AGS's work, particularly when it comes to public policy. In the past few months, for example, the continued growth of the older adult population has prompted renewed attention for the healthcare workforce. At the time this letter went to press, we were on the cusp of moving forward with two important and related priorities: Efforts to codify the EMPOWER for Health Act of 2019 into law (legislation which would support workforce training and expansion), and work to analyze and address the Medicare Physician Fee Schedule for 2020. It's likely by the time this letter reaches you there will have been even more traction on both fronts; be sure to visit AmericanGeriatrics.org/Where-We-Stand for the latest updates.

As you move forward into fall, take time to enjoy the changing seasons and reflect on what changes are positive for your patients, yourself, your friends, and your family. ♦

Sunny A. Linnebur

WHAT DO CLINICIANS NEED TO KNOW ABOUT PRIVATE LONG-TERM CARE INSURANCE? NEW JAGS ARTICLE TAKES A DEEP DIVE INTO ANSWERS

A new article from the *Journal of the American Geriatrics Society (JAGS)* offers a deep dive into some of the hard-hitting questions geriatrics clinicians face when discussing long-term care insurance with older adults and caregivers. Despite common misperceptions, financing for long-term care is largely left to individuals in the U.S. But with services and supports varying almost as much as fact-versus-fiction, providers often struggle with keeping patients informed while also helping them make *informed decisions* that best support personal needs. Without advocating for any specific solution, the new *JAGS* article—authored by Brian McGarry, PT, PhD, and David C. Grabowski, PhD, of the Department of Health Care Policy at Harvard Medical School—addresses seven important questions older adults and caregivers may have, and how health professionals can orient their responses to high-quality, person-centered care.

Read on for a teaser of Dr. McGarry and Dr. Grabowski's analysis. For a deeper dive (and a #mustread), visit <https://doi.org/10.1111/jgs.16075>.

1. How is long-term care financed in the U.S.?

Long-term care constitutes a range of services and supports that provide assistance with activities of daily living. Unlike coverage for other types of medical care, no universal coverage of long-term care services exists for older adults. Given the lack of universal long-term care coverage and limitations on the feasibility of self-finance for many older people, state-administered Medicaid programs have become *de facto* forms of long-term care coverage after households have spent down their income and assets to meet eligibility.

2. What is private long-term care insurance?

Private long-term care insurance is the primary product available to U.S. consumers to help protect against financial exposure associated with long-term care. Individuals purchase a defined set of benefits that can be accessed once a predefined level of disability is met. In return, beneficiaries pay an annual premium until benefits are triggered (failure to pay the premium typically results in termination of the policy and forfeiture of the benefits). In 2015, the average annual premium was \$2,700; premiums increase with individuals' age at the time of purchase. Only 11% of individuals 65-years-old and older currently own a long-term care insurance policy.

3. Does long-term care insurance make financial sense?

That depends. For households with limited income and assets to protect from "spend down" to Medicaid eligibility, long-term care insurance has limited financial benefit. Very wealthy households likely also have little need for long-term care insurance, since they have the means to self-insure. As a result, long-term care insurance primarily targets the "middle-mass" of aging adults with sufficient wealth to protect but with insufficient wealth to pay comfortably for long bouts of care.

4. Who is healthy enough to purchase long-term care insurance?

Prior to selling policies, long-term care insurers perform extensive screenings of mobility, the ability to perform activities of daily living, cognitive health, medical history, health behaviors, weight and height, and other health

markers. The results of this "underwriting" process (the process an insurer uses to assess the financial risk associated with a potential customer) determine whether to offer a long-term care policy. It's estimated that 40 percent of individuals 50 years old and older would be deemed ineligible to purchase long-term care insurance based on screening.

5. What are the benefits of long-term care insurance?

The primary benefit of long-term care insurance is that it protects against catastrophic spending for long-term care needs. Additionally, having private coverage likely provides greater autonomy over where (and from whom) a person receives long-term care services. Long-term care insurance also can provide policy holders with peace of mind, particularly when discussions about long-term care take place while the policy holder is still healthy and able to articulate preferences and needs. For some, long-term care insurance may also alleviate concerns about the ethics of relying on Medicaid for long-term needs.

6. What are the pitfalls of long-term care insurance?

Long-term care insurance policies are expensive, and premiums often increase with time. The risk protection they provide is also incomplete as benefits have predetermined caps. Given the nature of long-term care, policy holders also run the risk that insurers will not be in business when benefits are needed (an average of 24 years separate policy purchase from long-term care claims). Finally, benefits depend critically on continued premium payments, which

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AGS RECOGNIZES MINNESOTA STATE AFFILIATE FOR OUTSTANDING ACHIEVEMENT AT #AGS19

Relaunched last year, the State Affiliate Awards Program recognizes outstanding State Affiliate achievements in membership recruitment and retention, educational programming, public outreach, advocacy, or affiliate growth. This year, we congratulate the Minnesota Association of Geriatrics Inspired Clinicians (MAGIC) for its outstanding work revitalizing its organizational structure and expanding opportunities for interdisciplinary collaboration.

Giving new life to a membership structure in place since the 1970s, MAGIC opened its doors to a strategic initiative that would attract non-physicians—including a significant merger with the Metro Alliance of Geriatrics Providers, an organization led primarily by nurse practitioners. Under this new coalition, MAGIC effectively revised its mission statement and vision, focusing on strategic goals in clinical quality and education as well as state advocacy. After adding interdisciplinary representation to its Board of Directors and reconstructing its bylaws, MAGIC expanded its reach to a broad range of new members and created several new resources to address quality improvement in skilled nursing facilities. MAGIC continues working toward its strategic goals, with a milestone timeline planned through 2020.

All State Affiliates are invited to apply for the Outstanding Achievement Award on an annual basis. Award winners are selected by co-chairs of the Council of State Affiliate Representatives (COSAR) and approved by the AGS Executive Committee. The chosen affiliate receives a \$1,500 prize and the opportunity to share successful programs and activities in person at the AGS Annual Scientific Meeting COSAR session. ♦



Edward Ratner, MD, poses with Sunny Linnebur, PharmD, FACP, BCPS, FASCP, BCGP, President of AGS, after accepting the State Affiliate Achievement Award for Minnesota.

The AGS State Affiliate program was launched in 1991 and has increased the visibility of geriatrics medicine throughout the country. The 27 AGS State Affiliates offer professional education, networking, and advocacy at the local and state levels. 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 to view a full list of AGS State Affiliates, go to AmericanGeriatrics.org/StateAffiliates.

RESOURCES FOR TRAINEES: BEST OF LUCK IN THE YEAR AHEAD!

To our health professional students and trainees headed back to school: All our best for a happy, healthy, and educational year! Don't forget all the AGS has to offer to help you and your peers along the way:

- **Free and discounted membership.** Students and residents are eligible for free e-membership with the AGS. E-membership offers exclusive access to MyAGSOnline, our online member forum, as well as several digital resources and subscriptions to AGS e-mail updates. Paid memberships for students and residents come at a significant discount, and offer additional member resources such as a subscription to the *Journal of the American Geriatrics Society*. For more information, visit AmericanGeriatrics.org/Membership.
- **Create a Student or Resident Chapter of AGS at your institution.** Local geriatrics interest groups are eligible

for affiliation with the AGS. Apply for your chapter's affiliation and receive renewable funding, as well as access to a network of student and resident chapter leaders across the country. For more information, contact Lauren Kopchik at lkopchik@americangeriatrics.org.

- **A world of opportunity awaits on MyAGSOnline.** Trainee members can access the AGS Member Forum on MyAGSOnline. This discussion community consists of more than 7,000 health professionals focused on geriatrics, many of whom are eager to serve as mentors on everything from your education to your future career. Additionally, MyAGSOnline's newest community was created specifically for student, resident, and fellow-in-training members. Log in at MyAGSOnline.AmericanGeriatrics.org and check out the AGS Trainees Community today! ♦

For starters, #AGS20 will bring back the greatest hits from our cadre of meeting sessions. These include:

- Our annual pharmacotherapy update, one which reflects two years of experience with the latest AGS Beers Criteria®.
- Our ever-popular Geriatrics Literature Review—more than just a round-up of the year's most innovative scholarship, this session outlines literally (and, often, lyrically) where we've been and where we're headed in research and practice.

Importantly, #AGS20 will also poise attendees to pivot to important priorities for the year ahead. Public policy updates in Long Beach, for example, will set the stage for the 2020 presidential race. The meeting also will explore new updates and expansions on everything from models for geriatrics co-management to tools for ensuring more colleagues understand the fundamentals of working with older patients.

Welcoming Trainees & First-Time Attendees

Our meeting remains powered by professionals who have been with us since the start, but a growing trend in attendance among early-career professionals and professionals outside geriatrics holds more than promise for our field. As we work to improve health, safety, and independence for us all as we age, this trend speaks volumes about our work expanding the depth and breadth of where we lead.

For trainees exploring career opportunities, the AGS Health in Aging Foundation (HealthinAging.org/Foundation) has set its sights on ambitious goals for providing more travel stipends than ever before. And for those looking to learn more about where geriatrics is headed in an inter-professional world, updates on important progress with programs like the Geriatrics Academic Career Awards (GACAs) and the Geriatrics Workforce Enhancement Program (GWEP) will offer a bellwether for where we all may be headed in the years ahead.

Soak Up the Sun in Long Beach

We last saw Long Beach, CA, way back at #AGS16. And while the AGS's ranks have grown and changed dramatically since then, we have to admit we're glad that Long Beach is still as sunny and memorable a setting as any we've had for all-things geriatrics. We can't wait to return for #AGS20, mixing learning opportunities with Pacific Coast strolls, sandy beaches, and everything else Southern California has to offer. Check out VisitLongBeach.com to start planning your "downtime"—though we're pretty sure everything planned and accessible from Meeting.AmericanGeriatrics.org will have your schedule packed in no time flat! ♦



Top inset: A longhorn cowfish in the Aquarium of the Pacific. *By Polylerus, CC BY-SA 4.0, wikimedia.* Bottom inset: World's largest mural "Planet Ocean" by Wyland on the Long Beach Arena. *By Mark Mauno, CC-BY-SA-2.0, wikimedia.*

Long-term Care Insurance continued from page 5

may be challenging as personal and financial needs change over time.

7. Who should buy long-term care insurance?

There's no easy answer. When faced with this question, clinicians may be served best by helping individual patients reorient their thinking toward future care needs, including care preferences and financing options. Because many adults wrongly believe Medicare covers long-term care

services—and because people tend to underestimate the risk of ever needing long-term care—providing basic facts may be an important place to start any long-term care conversation. In addition, clinicians should acknowledge the complexity of long-term care insurance decisions and encourage patients to seek advice from unbiased financial advisers who can help to quantify the trade-offs this choice entails. ♦

Meet the Older American of 2018

As more Americans look forward to the prospect of living longer and contributing to our communities, high-quality, person-centered healthcare will be key to making that vision a reality. That means understanding more about what it means to be an older adult in the United States.

The "Profile of Older Americans" is an annual summary of critical statistics related to the older population in the United States, pulled together by the Administration for Community Living (ACL). The Profile illustrates the shifting demographics of Americans age 65 and older. Check out highlights from the most recent report below...

Caregiving Needs

In 2018, the percentage of older adults age 85+ needing help with personal care (20%) was more than twice that of adults ages 75-84 (9%) and five times that of adults ages 65-74 (4%).

Household Income

The median income of older persons in 2017 was \$32,654 for males and \$19,180 for females.

In 2017, 4,681,000 older adults (9.2%) lived below the federal poverty level.

Marital Status

In 2018, a larger percentage of older men were married (70%) as compared with older women (46%). Divorced and separated older persons represented only 15% of all older persons in 2018. However, this percentage has increased since 1980.

Life Expectancy

Persons reaching age 65 have an average life expectancy of an additional 19.5 years (20.6 years for females and 18.1 years for males).

Gender

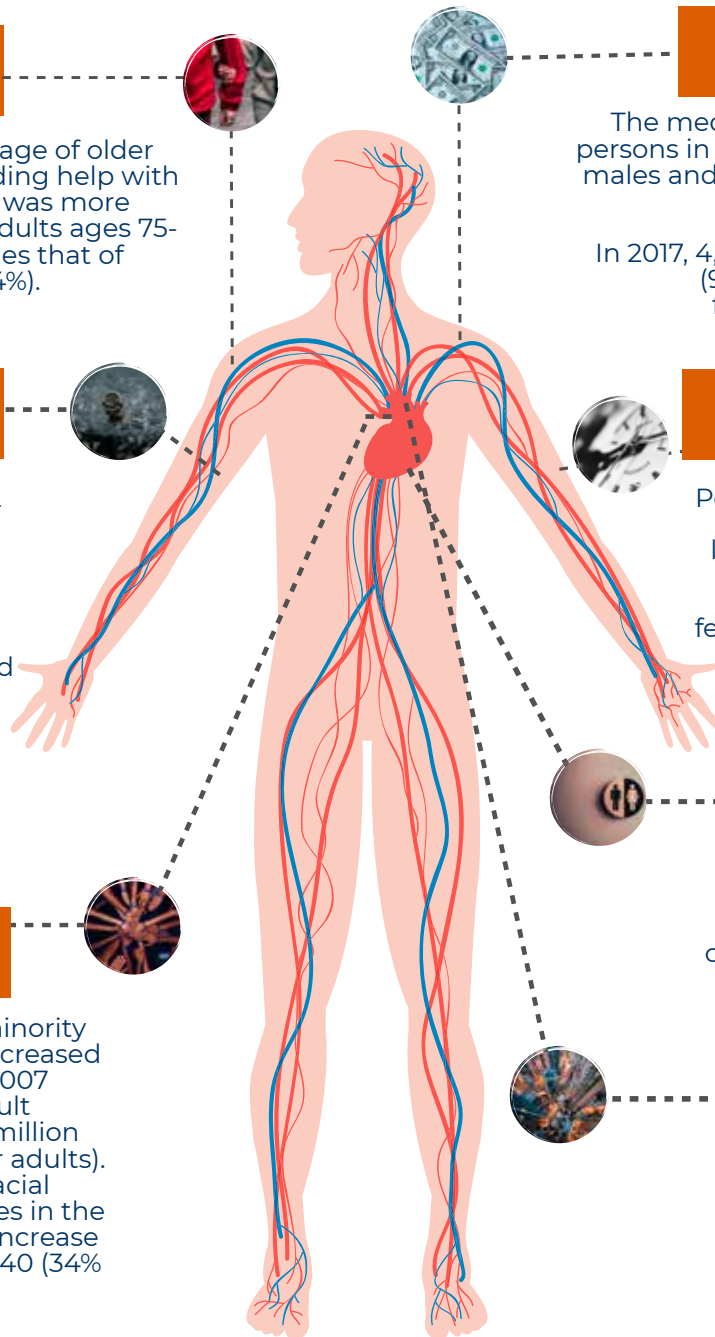
Older women outnumber older men at 28.3 million older women to 22.6 million older men.

Race/Ethnicity

Racial and ethnic minority populations have increased from 7.2 million in 2007 (19% of the older adult population) to 11.8 million in 2017 (23% of older adults). The population of racial and ethnic minorities in the U.S. is projected to increase to 27.7 million in 2040 (34% of older adults).

Housing

About 28% (14.3 million) of older persons lived alone (9.5 million women, 4.8 million men).



AGS EXPERTS REVIEW AND COMMENT ON 2020 MEDICARE PHYSICIAN FEE SCHEDULE PROPOSED RULE

As they do every summer, the Centers for Medicare and Medicaid Services (CMS) this past July released the Medicare Physician Fee Schedule (MPFS) Proposed Rule, which outlines updates to Medicare reimbursement and payment policies for the next Calendar Year.

Reviewing and responding to the MPFS is a significant undertaking, and one of our top policy priorities at the AGS—for good reason! Our comments over the past few years have been instrumental in ensuring the needs and expertise of geriatrics health professionals inform CMS plans *and* guide how those plans take shape in care for us all as we age.

As this newsletter went to press, AGS experts, staff and consultants were still reviewing the 1,700+-page proposed rule for 2020 and developing our feedback. Our initial impression: **We are pleased with several of CMS's proposals, which we believe would benefit our members and the care of older adults if implemented as drafted. We've highlighted a few of these proposals below.**

EVALUATION & MANAGEMENT UPDATES: CMS is proposing to make extensive changes to the office/outpatient evaluation and management (E/M) visits codes. **These changes apply to office visits only and are to be implemented in 2021.** E/M services are the “bread and butter” of geriatrics (and were a central point of concern for the AGS last year, when CMS proposed collapsing E/M coding in a way that would have jeopardized care for us all as we age). Changes in the 2020 MPFS Proposed Rule are consistent with recent proposals from the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel. The

AGS provided ongoing input on these proposals, which, if finalized, would facilitate the following changes in 2021:

- Retain 5 E/M levels of coding for established patients but reduce the number of E/M levels to 4 for new patients. The proposal also revises the code definitions.
- Revise the time and medical decision-making process, and require performing history and exam only as medically appropriate.
- Allow clinicians to choose the E/M visit level based on either medical decision-making or time.
- Adopt a new add-on CPT code for prolonged services.
- Adopt the AMA RVS Update Committee (RUC)-recommended values for E/M visits, which would increase payment for these codes. The AGS played a key role in the survey of these codes, which resulted in this increase.

TRANSITIONAL CARE MANAGEMENT PAYMENT INCREASES: CMS is proposing to increase payment for Transitional Care Management (TCM) services, which involve coordinating Medicare beneficiaries' transitions from inpatient to outpatient settings. The AGS was instrumental in getting TCM recognized by CMS in 2013.

REVISIONS TO CHRONIC CARE MANAGEMENT: CMS is also proposing a number of revisions to Chronic Care Management (CCM) services (another service recognized for reimbursement by Medicare in 2015 thanks in part to hard-fought victories at the AGS), including revisions to what a comprehensive care plan includes. The changes would also allow for the creation of a new service

to reimburse clinicians for providing care management to patients with a single serious, high-risk condition.

There are a number of additional proposed changes we are reviewing in detail, including updates to the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs), both part of the Quality Payment Program (or QPP) under Medicare.

Final comments on the 2020 MPFS Proposed Rule, due to CMS by 9/27, can be found at [AmericanGeriatrics.org/payment-services](https://www.americangeriatrics.org/payment-services). The Final Rule should be released in November, to take effect 1/1/20. ♦

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WHY I'M AN AGS MEMBER

JULIA V. LOEWENTHAL, MD

A few months ago, Julia Loewenthal, MD, a recently graduated fellow of the Harvard Multi-Campus Geriatrics Fellowship, was flying off for vacation when drama ensued. Over the speaker came the question: "Is there a doctor or nurse onboard?"

Dr. Loewenthal, the only physician on board, answered the call, along with a cardiac nurse. They discovered their patient was a middle-aged passenger in the throes of crushing chest pain.

Dr. Loewenthal and the nurse managed to stabilize the passenger and recommended that the plane divert for landing. Thankfully, the passenger made it to the hospital alive.

"I'd done plenty of emergency simulations during my internal medicine residency at Brigham and Women's Hospital, but this situation demonstrated how my geriatrics training was particularly helpful," said Dr. Loewenthal. "As a geriatrics fellow, we learned how to handle cases where there's a lot of ambiguity. Geriatrics teaches you how to embrace whatever happens and how to provide compassionate care for an older person, the family—and yourself," said Dr. Loewenthal.

But taking care of a patient in crisis wasn't Dr. Loewenthal's only challenge post-flight. As a Twitter user, Dr. Loewenthal knew that her experience would be useful to other healthcare providers, so she tweeted out anonymized details of her harrowing in-air rescue, using the "tweetorial" format because it allowed her to tell the story in a way that suited the case. Dr. Loewenthal started using Twitter to keep up with research literature, because doing so helped her read more articles and engage in discussions about them.

And then her tweets went viral. "I thought my 20 or so followers would enjoy reading about my

experience—but I ended up getting over 18,000 "likes" and just over two million total views," says a still-stunned Loewenthal. The overwhelming response she garnered shed lots of light on the whole responding-to-an-flight-emergency situation. "I heard from lots of folks who'd been in similar situations—even a former surgeon general left a comment," she said.



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Social media has a positive role to play in our medical careers, Dr. Loewenthal notes. "It gives professionals who aren't researchers a voice and a platform to share their experiences. Typically, researchers have always had a place to share their work, but I think using social media helps give us all a forum—particularly for stories that may not fit neatly in a journal," she adds.

In some respects, that same openness is what makes a community like the AGS so important. Dr. Loewenthal became an AGS member right after she decided to apply for a geriatrics fellowship in her last year of residency. "I hadn't met a lot of people who were interested in geriatrics, so this was a great way to meet like-minded folks," she said. "Once I joined, I found lots of online groups to engage with and share ideas with," she says.

At #AGS19 in Portland, Dr. Loewenthal presented some of her research, and attended the Healthy Aging Special Interest Group session.



"I had the wonderful opportunity to hear Louise Aronson speak about using personal narratives and how stories can impact our practice," she says.

Looking ahead to the future, Dr. Loewenthal can see how the trajectory of geriatrics is trending toward the positive. "It used to be that we focused on the 'negative' syndromes, like falling, incontinence, and dementia. Now we're also focused on healthy aging, and I look forward to helping my patients realize the positive aspects of the aging process." ♦



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Flu Prevention and Treatment Tips

Influenza, or the “flu,” is a contagious respiratory illness caused by a virus that infects the nose, throat, and sometimes the lungs. Although symptoms in some people are mild, the flu can cause severe illness, and even death. Older adults bear the greatest burden from the flu. Compared to younger people, older adults are at higher risk for serious flu complications, including bacterial pneumonia, dehydration, and worsening of other medical conditions such as heart failure, diabetes, and lung disease. People age 65 and older account for 50-70% of flu-related hospitalizations, and 70-90% of flu-related deaths. The best way to prevent the flu is by getting a flu shot every year at the start of the flu season (early fall).

Flu Symptoms

The flu is different from a cold. Cold symptoms are usually milder than flu, and people with colds are more likely to have a runny or stuffy nose than people with the flu. The flu comes on suddenly and the symptoms are more severe. Some common flu symptoms include:

- **Fever or chills** (older adults may not have a fever)
- **Cough**
- **Sore throat**
- **Vomiting and diarrhea** (more common in children)
- **Runny or stuffy nose**
- **Muscle or body aches**
- **Headache**
- **Fatigue**

Stop the spread of flu with these simple precautions:

- **Wash your hands** often with soap and water, or with an alcohol-based hand rub, especially after coughing or sneezing, and before eating.
- **Cover your mouth and nose** with a tissue when you cough or sneeze. If you don't have a tissue, use the upper part of your sleeve.
- **Avoid touching** your eyes, nose, and mouth.
- **Avoid close contact** with people who are sick.
- **Stay home** when you are sick.
- **Get plenty of sleep**, be physically active, manage your stress, drink plenty of fluids, and eat nutritious food.
- **Clean and disinfect** frequently-touched surfaces, especially when someone is sick.

What to Do if You Get the Flu

Call your healthcare provider

If you or someone you care for has symptoms of the flu, contact your healthcare provider immediately. Your provider can prescribe an antiviral drug to make the symptoms milder, shorten the time you are sick, and prevent complications from the flu. These medications work best when started early - within 2 days of becoming sick - so call your provider as soon as possible.

Stay home

If you think you might have the flu, stay home for seven days since your symptoms began, or until your symptoms have been gone for 24 hours. This will keep you from spreading the virus to others.

Get some much needed rest

To help your body fight the flu, get enough sleep and drink plenty of fluids, such as juice, water, and soup, to prevent dehydration. Because you might be cold one minute and hot the next, wear layers so you can easily add or remove clothes as needed.

Look out for Emergency Warning Signs

Call your healthcare provider or go to the emergency room immediately if you have any of these symptoms:

- High or prolonged fever (above 101-102°F or a fever lasting more than 3-5 days)
- Difficulty breathing or shortness of breath
- Pain or pressure in the chest
- Fainting or near-fainting
- Confusion
- Severe or persistent vomiting and/or the inability to keep down food or water

Anyone living alone should get help quickly, instead of waiting.

