Healthcare Reform that Includes Medicare Changes, and Better Prevents and Treats Chronic Illnesses—Particularly in Those With Multiple Chronic Health Problems—is Essential, Says Health Policy Expert

With chronic illnesses accounting for three-quarters of US healthcare spending—and more than 90% of Medicare spending—improving the prevention and treatment of chronic conditions must be a priority in healthcare reform, Kenneth Thorpe, PhD, Executive Director of the Partnership to Fight Chronic Disease, told the crowd gathered for the Public Policy Lecture during AGS’ Annual Scientific Meeting in May.

Dr. Thorpe, professor and chair of the Department of Health Policy and Management at Emory University’s Rollins School of Public Health and co-director of the Emory Center on Outcomes and Quality, delivered the lecture, focusing on the need for sweeping changes in chronic disease prevention and management, particularly in Medicare.

“If we’re serious about reform, we can’t leave Medicare out,” Dr. Thorpe said.

Between 25 and 30% of increased healthcare spending in the US, he noted, is due to the dramatically increased incidence of chronic conditions such as diabetes that are related to obesity. “Virtually all the growth in prevalence of key chronic conditions over the last 20 years is linked to obesity,” he noted. “If we could roll obesity rates back to 1987 levels, we’d save $220 billion in healthcare costs.”

To lower those costs, the healthcare system—Medicare included—needs to provide better care for patients with chronic illnesses, particularly those with multiple chronic conditions.
It was the best of times; it was the worst of times.

This, the opening line of Dickens’ *The Tale of Two Cities*, certainly resonates for those of us working to advance AGS’ mission of improving the health of America’s seniors.

We don’t have to stretch too far to grasp the “worst of times” part. The lack of trained health professionals in geriatrics and gerontology is certainly approaching crisis proportions, if it isn’t a crisis already. Our training programs are struggling for funding and faculty, not to mention students. We need more funds for aging research, and a better understanding of the strengths and limitations of various models of care. Meanwhile, state budget woes have gutted many safety-net programs for vulnerable and frail elders.

Amidst all of this, our patients and their loved ones are asking us to “make some sense” of a healthcare system that they find confusing and frustrating. This is often the case when care is most complex—for example, when an older patient must make numerous transitions among settings. The experience can leave seniors and their families bewildered and angry and without the knowledge and tools they need to help ensure these transitions are as successful as possible.

This may seem a bleak way to begin my first column as the American Geriatrics Society’s new president. But I’m not discouraged. In fact, I’d like to propose that we can—and should—view these as “the best of times.” We need to see the potential for progress—it’s there—if we’re to harness the creative energy and public engagement necessary to launch us into a future of healthcare solutions.

We have a new leader in the White House who has made it clear that healthcare reform can’t “wait” until we’ve solved our economic crises—but rather that healthcare reform will *help us* solve our economic crises. President Obama has repeatedly identified healthcare reform as a top priority, as has ailing Senate Health Committee Chair Edward Kennedy (D-MA), who has devoted much of his career to improving healthcare. Senate Finance Committee Chair Max Baucus (D-MO), who has published a comprehensive reform white paper, continues to push for reform legislation before year’s end. This is extremely encouraging.

Exactly how we should reform healthcare to ensure access and quality will be a matter of intense and messy debate. Launches are not quiet, incremental events. They are explosive, disruptive and stressful. But they are also planned, organized and detailed. Thanks to prior planning, good organizing and groundwork, we at AGS are now uniquely positioned to influence healthcare policy and help “launch” a system that offers better care for seniors.

As you know, AGS has significantly increased its public policy advocacy efforts over the last several years. These efforts have established the AGS as the “go to” organization for information and perspectives on elder healthcare. Past Presidents David Reuben, Jane Potter, Todd Semla and John Murphy, along with the AGS Board and staff, have established a critical framework by defining AGS’ public policy priorities. (See related story, “AGS Leaders Reaffirm Society’s Public Policy Priorities,” p. 1) And AGS’ leadership and staff, its members, and others registered with the Society’s online Health in Aging Advocacy Center (at www.americangeriatrics.org/advocacy) have launched numerous successful advocacy campaigns in recent years. These campaigns have helped block potentially devastating cuts in Medicare payments to physicians. They’ve also ensured continued funding for key Title VII Geriatrics Health Professions and Title VIII Nursing Workforce Development training programs. In fact, in a promising development announced just as this issue of *AGS News* went to press in early May, President Obama requested $42 million for Title VII geriatrics programs in his 2010 budget—a 35.5% increase over 2009 funding. The president’s budget also requests $263 million for Title VIII nursing education programs, including an $88 million (237%) funding boost for the Nursing Education Loan Repayment Program and an increase for the Nursing Faculty Loan Program.

There have been other policy successes. AGS, along with its John Hartford and Atlantic Philanthropies partners, was instrumental in establishing the need for an Institute of Medicine (IOM) study examining the healthcare workforce’s readiness to care for an aging nation. The resulting IOM report, *Retooling for an Aging America: Building the Health Care Workforce*, concludes that the nation’s workforce is too small and unprepared to care for the growing number of older adults in the US. Released last spring, the report has captured the attention of the media and Washington.

Since the report’s release, AGS has worked with numerous lawmakers interested in addressing the workforce crisis. It has provided information and assistance to Sen. Barbara Boxer (D-CA), and Susan Collins (R-ME), who recently introduced the “Caring for An Aging America Act of 2009.” This important legislation would allocate $1.250 million over five years to fund educational loan forgiveness and training and career advancement opportunities for healthcare professionals and direct-care workers who make a commitment to caring for older adults. AGS has also provided information and assistance to Reps. Rosa DeLauro (D-CT) and Ileana Ros-Lehtinen continued on page 14
AGS Releases New Clinical Practice Guideline for Management of Persistent Pain in Older Adults; In Departure from Previous Guideline, New Document Advises That NSAIDs and COX-2s Be Considered Rarely, With Caution, And In Select Elderly Only

The American Geriatrics Society (AGS) released a new, updated guideline for the pharmacological management of persistent pain in older adults May 1, during its Annual Scientific Meeting in Chicago. In a significant departure from AGS’ previous guideline, published in 2002, the updated document advises that both non-selective, non-steroidal anti-inflammatory drugs (NSAIDs) and COX-2 selective inhibitors be considered rarely, with extreme caution, and only in highly selected elderly patients.

AGS published its first clinical practice guideline for the management of persistent pain in older adults in 1998. A landmark publication, the guideline became a call to arms for improving pain management in older patients. In 2002, the Society revised the guideline. The new, third version—Pharmacological Management of Persistent Pain in Older Persons—updates the 2002 evidence base and includes recommendations regarding the use of new pharmacologic approaches. Since 2002, new drugs and treatments have been introduced, and management strategies more fully evaluated. Because the most common approach to managing persistent pain in the elderly is through pharmacotherapy, and because this approach also poses the greatest potential risks for seniors, the new guideline focuses on pharmacologic agents.

“Persistent pain isn’t a “normal” part of aging and should not be ignored,” said AGS President Cheryl Phillips MD, Chief Medical Officer for On Lok, a program that provides all-inclusive healthcare and chronic care services to older adults in the San Francisco Bay area. “As seniors become susceptible to more complex health ailments, the need for a clear and precise pain management plan is key.”

The new guideline was developed and written by the AGS Panel on the Pharmacological Management of Persistent Pain in Older Persons, which included experts in pain management, pharmacology, rheumatology, neurology, nursing, palliative care, and geriatric clinical practice. The recommendations in the new guideline represent the consensus of the panel and are based on a synthesis of the literature and clinical experience in caring for older adults with persistent pain.

The guideline recommends that acetaminophen be considered as initial and ongoing pharmacotherapy for patients with mild to moderate musculoskeletal pain. But in a break from the previous guideline—which recommended a trial of over-the-counter or prescription NSAIDs or COX-2 inhibitors before prescribing an opioid drug—the new guideline concludes that this is too risky a strategy for older people. Citing the latest research, the guideline notes that potential adverse events associated with use of these drugs in the elderly—increased cardiovascular risk and gastrointestinal toxicity, among others—often outweigh the benefits. Based on recent clinical trial findings and clinical observation, the panel recommends that non-selective NSAIDs and COX-2s be considered rarely, and with extreme caution, in highly selected older patients. The new guidelines advise that all patients with moderate to severe pain or diminished quality of life due to pain be considered for opioid therapy, which may be safer for many seniors than long-term use of NSAIDs and COX-2s. The guidelines go on to discuss and offer recommendations regarding the use of adjuvant and other drugs for older persons with recalcitrant pain.

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AGS and FHA Volunteers Screen Older Adults for Risk of Falls During Second Annual “Get Up and Go: A Falls Prevention Program”

Dozens of older Chicagoans began the month of May on surer footing, thanks to the many volunteers who turned out for the second annual “Get Up and Go: A Falls Prevention Program” organized by the American Geriatrics Society (AGS) and the AGS Foundation for Health in Aging (FHA).

More than 30 AGS and FHA volunteers—all visiting Chicago for AGS’ 2009 Annual Scientific Meeting—offered Windy City seniors and others free falls screenings, along with information about falls prevention, elderly health, and the many services the AGS and FHA provide.

“The hospital had flyers in all of its clinics so people came down for screening with the flyers in hand,” said Mark Rothman, MD, a staff geriatrician with Kaiser Permanente in San Francisco who helped coordinate the falls prevention event and volunteered for both the hospital and the Pier screenings.

A number of those screened at Northwestern got scores on the Get Up

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Meet AGS’ New President: Cheryl Phillips, MD

You could say that Cheryl Phillips, MD, who took the helm as president of the American Geriatrics Society in April, got her start in geriatrics in elementary school.

While she was growing up in California in the early 1970s, her mother worked at a local nursing home. So after school, she and her brother headed to the nursing home for “day care,” recalls Dr. Phillips, who is now Chief Medical Officer for On Lok, a nationally renowned program that provides all-inclusive healthcare and chronic care services for older adults in the San Francisco area.

“I grew up never thinking the nursing home was a fearful place, and as a child I developed some really wonderful relationships with residents who I can still remember by name,” she says. “Even then, though, I was aware that many of the residents didn’t see a doctor often enough, and that their quality of life wasn’t as good as it could be.”

Her early experiences at the nursing home figured prominently in her decision to pursue a career in geriatrics, says Dr. Phillips, who has been a member of the AGS Board of Directors since 2003 and was Secretary of the Society. She was AGS’ Primary Health Care Policy Fellow at the Department of Health and Human Services. She was previously president of the American Medical Directors Association and has served on numerous national boards and advisory groups for senior and chronic care. California Gov. Arnold Schwarzenegger has appointed her to the California Commission on Aging, among other panels. She has testified before Congress on elder healthcare.

“AGS is in extremely good hands with Cheryl,” says AGS’ immediate past President John B. Murphy, MD, now Chair of AGS’ Board of Directors. “Not only is she incredibly committed, she also has tremendous clinical and leadership experience and expertise.”

From the start, both the clinical and leadership opportunities that geriatrics affords made the field appealing, Dr. Phillips says. After graduating from the University of the Pacific in Stockton, California, she earned her MD at Loma Linda University School of Medicine. After completing her internship and residency at the University of California at Davis she enrolled in Davis’ geriatric fellowship program.

“I was drawn to geriatrics because I wanted to care for a specific group of people—frail older people,” she explains. “But I also wanted to be in a place where I could blend that work with administrative and leadership roles. I knew there was not only a huge need for good clinical services for older people, but also an obvious need for physicians to set the quality agenda and become leaders in the field.”

After finishing her fellowship in 1989, Dr. Phillips joined Sutter Health, a large, integrated Northern California healthcare system that includes 27 hospitals and more than 3,000 physicians. Her first job was caring for older patients in an office and nursing home practice. Over the course of her eighteen years with Sutter, she took on increasing—and increasingly complex—administrative responsibilities but still managed to see patients, albeit fewer as time went on. Twelve years after joining Sutter she was as asked to serve as Medical Director for the multi-specialty Sutter Medical Group in Sacramento, which then included more than 200 physicians, NPs and PAs. Her next post was as Clinical Director of Chronic Case and Senior Services at the regional level. She was later named Medical Director for Chronic Disease Management at the system level, and finally, Chief Medical Office for Sutter Health Partners.

“The training and interdisciplinary experience we get in geriatrics really enable us to step into leadership roles,” Dr. Phillips says.

While climbing the ladder at Sutter, she learned about systems of care, quality improvement, risk management, and other elements of the business of healthcare, and honed her leadership skills. And she innovated. She developed a risk screening and care coordination program for high risk older adults and those with advanced chronic diseases. As the geriatric education coordinator for the UC Davis-affiliated Family Practice residency program at Sutter, she developed a functional assessment teaching clinic, a nursing home continuity residency practice, and a geriatric didactic curriculum.

Despite her leadership roles in the health care system at Sutter, she felt she was moved farther and farther away from senior care and geriatrics. So when On Lok approached Dr. Phillips in late 2007, offering her a newly created position as Chief Medical Officer, she jumped at it.

“I was privileged to have the opportunities I did with Sutter Health. It was a wonderful learning laboratory in health systems, managed care and physician leadership, but On Lok provided a way to continue on page 11.
Americans are living longer and healthier lives.

Even so, many older adults will eventually develop one or more of a group of related medical problems called geriatric syndromes.

Vision and hearing problems, bladder problems, dizziness, falls, delirium (a kind of temporary confusion) and dementia (an illness characterized by persistent confusion and memory loss, such as Alzheimer’s disease) are examples of geriatric syndromes. These syndromes can limit older adults’ abilities to carry out basic daily activities; threaten their independence; and lower their quality of life.

Geriatric syndromes usually have more than one cause, and involve several different body systems. In addition, one geriatric syndrome often contributes to another. A bladder problem, for example, may lead to a bladder infection, which may, in turn, cause delirium. For these reasons, providing medical care for older people with geriatric syndromes can be complicated. Geriatricians—doctors who have advanced training in the care of older adults—and other geriatrics healthcare providers can play an important role in diagnosing and managing these syndromes.

Here is the second part of a two-part series on geriatric syndromes and what you should know about them:

**Vision problems** Among older people, common vision problems include nearsightedness, presbyopia, (age-related changes in the eye that make it hard to see close-up), glaucoma, cataracts, diabetic eye disease, and macular degeneration (damage to the center of the eye that can result in a loss of central vision). Among other things, vision problems can lead to falls.

**What you should do:** Get a comprehensive eye exam every one to two years. Vision problems can be treated and the earlier treatment begins, the better.

**Hearing problems** Hearing loss is the most common sensory problem in later life.

**What you should do:** Ask for a screening hearing test once a year, and tell your healthcare provider if you’re having trouble hearing. Treatment improves both hearing and quality of life.

**Dizziness** Dizziness—feelings of spinning, near fainting, falling, or lightheadedness—can make walking more difficult, increase risks of falls, and lessen quality of life. Many things, including low blood pressure, vision problems, inner ear problems, anxiety, and medication side effects can contribute to dizziness. There often is more than one cause.

**What you should do:** If you often feel dizzy, tell your healthcare provider. There are many treatments for dizziness; treatment depends on the underlying cause or causes.

**Fainting** Like dizziness, fainting is increasingly common with age and leads to falls. There are many possible causes, including low blood pressure or low blood sugar levels and irregular heartbeat. In older people there are often multiple causes.

**What you should do:** If you’ve fainted, tell your healthcare provider immediately. He or she can investigate possible causes and recommend treatment tailored to these causes.
Difficulty walking Difficulty walking or “gait impairment” is usually due to a combination of age-related health problems such as arthritis, bone and muscle problems, disorders such as Parkinson’s disease, poor circulation, dizziness, changes due to stroke, vision problems, loss of strength, and even fear of falling.

What you should do: There are many treatments—ranging from exercise to surgery—that can improve gait and walking considerably. So tell your healthcare provider if you are finding it more difficult to walk.

Falls Injuries from falls are a leading cause of death in older people. Among other things, hazards in the home, medication side effects, walking and vision problems, dizziness, arthritis, weakness, and malnutrition can boost risks of falls. Like other geriatric syndromes, falls usually have more than one cause.

What you should do: Tell your healthcare provider immediately if you’ve fallen. He or she will investigate what caused the fall and recommend steps to prevent future falls.

“Thinning bones” Osteoporosis, or “thinning bones,” is a common health problem among older people, particularly women and men older than 80. It can lead to life-threatening fractures. A diet that doesn’t include enough calcium and vitamin D, too little exercise, smoking, too much alcohol, certain medications, and certain bone, thyroid and other health problems can increase risks of osteoporosis. Another bone disorder, osteomalacia, can also lead to fractures, pain and muscle weakness. A lack of vitamin D, certain medications, and kidney, and liver and problems can lead to osteomalacia.

What you should do: Women who are 65 and older, and other people who run an increased risk of osteoporosis, should get a bone mass density (BMD) test for osteoporosis. Increased calcium and vitamin D intake, strength training exercises and weight-bearing exercise (such as walking) can boost BMD. Your healthcare provider may also recommend medications or other treatments. Vitamin D is used to treat osteomalacia.

Pressure Ulcers Also known as “bed sores,” pressure ulcers are skin and tissue damage caused by uninterrupted pressure on skin and the “soft tissue” underneath it. Older adults who are unable to move for long periods of time (because they’re in bed, or a wheelchair) run an increased risk of pressure ulcers. These can be painful and lead to life-threatening infections. Smoking, underweight, malnutrition, low blood pressure, diabetes, heart disease, kidney failure, and bladder problems can raise risks of pressure ulcers.

What you should do: If you or a loved one is confined to a bed or a wheelchair, healthcare providers should evaluate the risk of pressure ulcers periodically. There are many things healthcare staff can do to help prevent pressure ulcers, including treating malnutrition; providing appropriate skin care and pressure reducing bedding and cushions; repositioning you or the loved one often; and encouraging appropriate exercise.

For the first part of this 2-part tip sheet, and others from the AGS Foundation for Health in Aging’s series of health tip sheets for older adults, visit http://www.healthinaging.org/public_education/latest_tip_sheets.php.

Foundation for Health in Aging

Established by the American Geriatrics Society

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The Foundation for Health in Aging builds a bridge between the research and practice of geriatrics health care professionals and the public. The Foundation advocates on behalf of older adults and their special needs through public education, clinical research, and public policy.

The American Geriatrics Society is dedicated to improving the health and well-being of older adults. With a membership of over 6,000 health care professionals, the AGS has a long history of improving the health care of older adults.
AGS Co-Convenes National Eldercare Workforce Alliance

Alliance Endorses Key Healthcare Legislation and Urges Change in Labor Policy that Would Lessen Turnover Among Home-Care Workers

To address growing shortages of healthcare professionals, direct-care workers, and family caregivers who are adequately prepared to care for older adults, the AGS and more than two dozen other leading organizations joined together to form the Eldercare Workforce Alliance (EWA) in November.

The Alliance’s member organizations represent older adults and the healthcare professionals, direct-care workers, and family members who care for them.

“The Alliance was formed in direct response to the Institute of Medicine’s groundbreaking 2008 report finding that the nation’s eldercare workforce is dangerously understaffed and unprepared to care for the rapidly growing number of older adults in the US,” said AGS Deputy Executive Vice President and Chief Operating Officer Nancy Lundebjerg. “Being part of the Alliance provides the AGS with an opportunity to work with a broad range of stakeholders to advance enhanced funding for initiatives that will help create a workforce that is better prepared to care for our nation’s aging population. At the same time, AGS can lend its voice to efforts to strengthen the direct-care workforce and support family caregivers.”

Ms. Lundebjerg and Steven Dawson of PHI—a national nonprofit working to improve the quality of eldercare and disability services by supporting quality jobs for direct-care workers—were named co-conveners of the EWA. The Society and PHI are among the 28 national organizations that comprise the Alliance, which is supported by grants from the Atlantic Philanthropies, the John A. Hartford Foundation, and member contributions.

In immediate response to the eldercare workforce crisis, the Alliance’s goals are to:

- Strengthen the direct-care workforce through better training, supervision and improved compensation;
- Address clinician and faculty shortages through incentives such as loan forgiveness, increased public funding for training, and better compensation;
- Ensure a competent workforce by encouraging agencies and organizations that certify and regulate the eldercare workforce to require demonstrated and continued competence; and
- Redesign healthcare delivery by adopting cost-effective care coordination models.

The Alliance has already endorsed proposed legislation that would expand geriatrics training for medical school and other health professions faculty, physicians, nurses, social workers, clinical psychologists, and other allied health professionals; as well as for nurses’ aides, home health aides and other direct-care workers and family caregivers. Sens. Herb Kohl (D-WI), Blanche Lincoln (D-AR), Bob Casey (D-PA) and Rep. Jan Schakowsky (D-IL) introduced the legislation, “The Retooling the Healthcare Workforce for An Aging America Act,” in the House and Senate early this year.

In a March 27 letter to Labor Secretary Hilda Solis and Health and Human Services Secretary Kathleen Sebelius, AGS and 24 other members of the EWA urged a reevaluation of Labor’s controversial “companionship exemption” policy, and asked to meet with the administrators to explore the issue. Under the policy, which dates to 1975, home- and community-based care workers can be classified as “companions” – thereby exempting their employers from federal minimum wage and overtime standards. Since 1975, however, the nature of the work many home care aides perform has changed dramatically, with these workers providing far more than companionship to the many seniors for whom they care. As The New York Times noted in a recent editorial, exempting home care workers from minimum wage and overtime protections is unwise, among other reasons, “because poor pay for long hours leads to high turnover, which undermines the quality of care.” In its letter to Secretaries Solis and Sebelius, the EWA acknowledges that the exemption is a “complex issue” and that “a number of issues must be considered in addressing” it.

As this issue of AGS News went to press, EWA members were voting on motions to support the “Caring for An Aging America Act of 2009” and the “Geriatrics Loan Forgiveness Act.” Introduced by Sens. Barbara Boxer (D-CA) and Susan Collins (R-ME), the “Caring for An Aging America Act of 2009” would allocate $110 million over five years to fund educational loan forgiveness and training and career advancement opportunities for healthcare professionals and direct-care workers who make a commitment to caring for older adults. The “Geriatrics Loan Forgiveness Act,” proposed by Reps. Rosa DeLauro (D-CT) and Ileana Ros-Lehtinen (R-FL), would enable healthcare professionals pursuing advanced training in geriatrics to participate in the National Health Service Corps Loan Repayment Program. This program currently forgives up to $25,000 on behalf of an individual for the first two years of obligated service.

At press time, EWA was also finalizing its positions on potential reauthorization and expansion of Title VII Geriatrics Health Professions and Title VIII Nursing Workforce Development training programs. Title VII Geriatrics Health Professions Programs include geriatric faculty fellowships for physicians, dentists, and behavioral and mental health professionals; the Geriatric Academic Career Awards (GACA) program; and

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New AGS Officers

Sharon Brangman, MD, FACP, AGSF Named President-Elect at AGS Annual Scientific Meeting; AGS Board Appoints Secretary and Treasurer

The American Geriatrics Society named three officers during AGS’ Annual Scientific Meeting in May.

Members of the Society elected Sharon Brangman, MD, FACP, AGSF—Professor of Medicine, Chief of the Division of Geriatrics, and Fellowship Director of geriatric medicine at the State University of New York Upstate Medical University in Syracuse—President-Elect. Dr. Brangman will begin her term as President in May.

AGS’ Board of Directors appointed James T. Pacala, MD, MS—Director of the Family Medicine and Community Health Medical Student Education program at the University of Minnesota in Minneapolis—Treasurer.

The Board also re-appointed Barbara Resnick, PhD, CRNP, FAAN, FAANP—Associate Professor at the University of Maryland in Columbia, MD—to a second term as Secretary.

2,600 Attend AGS’ 2009 Annual Scientific Meeting in Chicago

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training, and public policy developments affecting the care of older patients.

“It’s wonderful to be here with all of you,” said Ellen Flaherty, PhD, APRN, BC, the 2009 Annual Meeting’s Program Chair, welcoming attendees from around the world. “Over the next few days, we’ll be covering a very wide range of subjects, including topics of interest to geriatrics professionals in all disciplines.”

The 2009 Annual Scientific Meeting featured more than 600 geriatrics researchers and clinicians who presented cutting-edge scientific papers and posters, symposia, core curriculum sessions, clinical workshops and updates, and expert lectures on such topics as transitional care, cancer screening for the elderly, and healthcare reform.

At the meeting, AGS recognized a number of individuals at the meeting (see related story online story at www.americangeriatrics.org).

The 2010 annual meeting runs from May 12 through May 15 at the Walt Disney World Swan and Dolphin Hotel in Orlando, Florida. For more information, visit www.americangeriatrics.org.

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With Generous $500,000 John A. Hartford Foundation Grant, AGS Establishes New Geriatrics Workforce Policy Studies Center; Center’s First Survey Asks AGS’ Physician Members Which Patients Benefit Most from Care of Geriatricians

Adults older than 85, and frail and complex older patients are likely to benefit most from the care provided by geriatricians, according to a recent survey of AGS’ physician members by the Society’s newly established Geriatrics Workforce Policy Studies Center (GWPSC).

With a three-year, $500,000 grant from the John A. Hartford Foundation, AGS established the GWPSC in December. The center’s mission is to generate information about the geriatrics workforce that, among other things, supports policy and advocacy efforts aimed at expanding the geriatrics workforce and improving the quality of care older adults receive. The center’s work will build on the Association of Directors of Geriatric Academic Programs’ (ADGAP’s) Longitudinal Status of Geriatrics Workforce Study, which has provided essential, up-to-date information concerning geriatrics training, the geriatrics workforce, and related issues over the last eight years.

“The new Geriatrics Workforce Policy Studies Center will help us accomplish essential goals set forth in the Institute of Medicine’s groundbreaking report, *Retooling for an Aging America*,” said AGS President Cheryl Phillips, MD, referring to the seminal 2008 report in which the IOM concluded that the nation’s geriatrics workforce is too small and unprepared to care for the growing number of older Americans. “We are extremely grateful to the John A. Hartford Foundation for its generous support of the new GWPS Center, which will build on the ADGAP longitudinal study data, and more closely integrate that and new data into AGS’ public policy activities. This closer integration will enable AGS to more quickly and proactively provide information about geriatrics workforce and care issues to policymakers, government agencies, the media and others.”

The new GWPS center is contracting with the University of Cincinnati team—led by Drs. Gregg Warshaw and Elizabeth Bragg—that conducted the Hartford and Donald W. Reynolds’ foundation-funded Status of Geriatrics Workforce Study. AGS is coordinating the project, integrating GWPS center activities into targeted legislative and media efforts, and enhancing dissemination of study data.

“We are very pleased that the new GWPS Center will enhance our ability to generate data that sheds further light on the state of geriatrics training and the geriatrics workforce—that data can raise awareness among the media and policymakers, and help guide needed changes in the nation’s healthcare delivery system,” said Gregg A. Warshaw, MD, GWPS co-investigator, with Dr. Bragg and Director of the Office of Geriatric Medicine at the University of Cincinnati College of Medicine. Nancy Lundebjerg, AGS Deputy Executive Vice President and COO, is serving as the Center’s Principal Investigator given the overarching goal of integrating its work into the AGS’ public policy activities.

One of the Center’s first initiatives was to survey AGS’ physician members, asking them, among other things, which older adults are likely to benefit most from the care geriatricians provide. While the US counts only 7500 or so geriatricians it’s now home to more than 38 million adults who are 65 and older. And that number is expected to nearly double, to 77 million, in the next two decades. With so few geriatricians and so many older Americans, ADGAP surveyed the directors of US geriatric academic programs in 2008, asking them how best to make use of available geriatricians. Their answer: Given the shortage of geriatricians, these physicians should focus on the most complex and most vulnerable older adults.

Investigating further, the new GWPS survey asked AGS’ physician members to identify the kinds of patients who would most benefit from geriatricians’ services in each of three practice situations: primary care, consultations, and care in the hospital. For each practice situation, members were asked to consider whether older adults with any of several clinical conditions or characteristics would benefit from a geriatrician’s care, and if so, to what extent; or if, on the other hand, there would be no significant difference between care provided by a geriatrician and that provided by a family physician or general internist. Physicians surveyed were also asked questions regarding the kinds of older adults they would prefer to care for given the current reimbursement system, and given an idealized reimbursement system.

More than 75% of the 939 AGS physician members who completed the survey identified the same groups of older patients as those who would greatly benefit from care provided by a geriatrician—regardless of the clinical setting. These patients were: those older than 85, and those with severe functional impairments, complex biomedicai problems, frailty, or a geriatric syndrome. When asked whether seeing a geriatrician—as opposed to a family physician or general internist—would make a significant difference for younger, healthier adults, respondents were evenly divided.

The majority of respondents indicated that an ideal reimbursement system would adequately reimburse physicians for evaluation and management of older patients, and for preventive care. Regardless of the type of older patient, physicians responding indicated that they would prefer to care for patients in the primary care setting, rather than in the hospital or in a consultation, if they were reimbursed adequately.

This data and other data the GWPS Center gathers will be disseminated via website, bi-monthly graphic reports, press releases, expert alerts, legislative briefing materials, meeting presentations, and journal articles, among other vehicles. The Hartford Foundation’s generous grant will be matched by $175,000 in in-kind services, provided by AGS in public policy advocacy, communications, Web development, and project administration. ☀️
Eleven leading organizations with special interest and expertise in the management of pain in older adults—including the American Academy of Pain Medicine, the American College of Clinical Pharmacy, the American Medical Association, the American Medical Directors Association, the American Society of Anesthesiologists, and the Gerontological Society of America—provided peer review of the new guideline.

“None of them had a significant complaint or a problem,” panel Chair Bruce Ferrell, MD, told the more than 1,500 healthcare providers who attended the plenary symposium at which the guideline was released during AGS’ annual meeting. “The consensus was that our recommendations were reasonable and they agreed with them,” noted Dr. Ferrell, Professor of Clinical Medicine in the Department of Medicine and Division of Geriatrics at the UCLA David Geffen School of Medicine, Associate Chief for Education in the Division of Geriatrics, and Director of Palliative Care Services for both the Ronald Reagan UCLA Medical Center and the UCLA Santa Monica Medical Center and Orthopedic Hospital.

The AGS’ guideline panel included a representative of its Clinical Practice and Models of Care Committee, David Mehr, MD, Professor and Director of Research in the University of Missouri School of Medicine’s Department of Family and Community Medicine. Dr. Mehr is the Chair of the Guideline Development Subcommittee, which is responsible for oversight of AGS guideline development. After the external review, members of the CPMC and the Society’s Executive Committee reviewed the guideline which will be published in the August issue of the Journal of the American Geriatrics Society. A full listing of the recommendations, along with a full panel list, executive summary and links to newly updated public education resources on pain management can be found on the AGS website on the clinical practice webpage.

Healthcare Reform is Essential, Says Health Policy Expert

“Traditional fee for service Medicare was never designed to deal with this patient profile,” Dr. Thorpe said.

To address the problem, Medicare should be overhauled with the rest of the system so it’s more innovative. Among other things, Medicare needs to make greater use of health information technology (HIT), and must place greater emphasis on prevention, care coordination and transitional care. Medicare reimbursement needs to be reformed as well, to support these and other needed changes.

There has been some progress in some of these areas thus far, Dr. Thorpe noted. The $789 billion economic stimulus package that President Obama signed into law in February allocates roughly $20 billion to encourage the widespread adoption of HIT. The package also allocates funds to create community primary prevention programs and could make programs such as the successful Diabetes Prevention Program (DPP) available in many communities in the US, he explained. But further innovation is needed, particularly in healthcare delivery.

Innovations like those that have been incorporated into the care of homebound patients—changes that have improved access to care ‘round the clock, so patients have options other than calling the ambulance when they fall ill at 2 in the morning—are essential. So are innovations that incorporate care coordination and transitional care into Medicare. These innovations alone could result in a 5% savings in Medicare expenditures, Dr. Thorpe estimated.

“The biggest challenge is how to build care coordination into fee-for-service Medicare,” Dr. Thorpe said.

One promising approach employs community-based health care teams, he noted. These teams, led by primary care physicians, include care coordinators, mental health workers, nurses, nurse practitioners, and other healthcare professionals. Working together, team members provide transitional care and a focus on prevention. North Carolina has been using the model with promising results, as have Vermont, Pennsylvania and Rhode Island. Investing the $2.3 billion it would take to introduce the approach nationwide could save $10 billion, Dr. Thorpe estimated.

Other changes that would improve chronic care and rein in Medicare spending include bundling payments, and reimbursing or offering financial incentives for time spent developing and implementing comprehensive coordinated care plans, tracking patients’ progress, and supporting patient self-management.

Despite an unprecedented consensus—among lawmakers, business and labor organizations, healthcare providers, and consumers—that healthcare reform is necessary, there are significant differences over how to bring it about. Whether the government should offer a public healthcare plan, and how to finance reform are among the biggest “flashpoints” in reform, Dr. Thorpe noted, and there are many more.

Even so, prospects for reform are good.

“They’re so much better this time than last time,” he said, referring to the Clinton Administration’s failed attempt to overhaul healthcare. The fact that Congress, rather than the White House, is drafting reform legislation improves the odds that reform will happen, he said. So does the ailing Sen. Edward Kennedy’s commitment to seeing healthcare reform become a reality, and the frequency with which President Obama has identified reform as a top priority in his Administration.

Dr. Thorpe delivered his lecture just days after The Senate Finance and other committees began a “walk through” of healthcare proposals they hope to advance this year.

“As it stands in the opening salvo, there’s nothing in the current walk-through in the Senate that would change the way we work with Medicare patients,” he said. He quickly added, “We’ll redouble our efforts on this.”
AGS Co-Convenes National Eldercare Workforce Alliance  

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the nation’s Geriatric Education Centers (GECs). Title VIII Nursing Workforce Development Programs support training and continuing education for nurses who care for the elderly and the development and dissemination of curricula concerning geriatric care. Congress last reauthorized Title VII programs, for five years, in 1998 and the reauthorization process would provide an opportunity to expand and refine the programs. In addition to advocating for reauthorization, AGS has long advocated for increased Title VII and VIII funding. In an encouraging development in early May, President Obama requested $42 million for Title VII geriatrics programs in his 2010 budget proposal—a 35.5% increase over 2009 funding. The president’s budget plan also requests $263 million for Title VIII nursing education programs, including an $88 million (237%) increase for the Nursing Education Loan Repayment Program and an increase for the Nursing Faculty Loan Program.

Meet AGS’ New President:  
Caryl Phillips, MD  
continued from page 4

focus on geriatrics again, and to move into what I believed then and believe now is one of the premier models of geriatric care for frail elders,” says Dr. Phillips, whose husband, James Lett, MD, also a geriatrician and AGS member, is now the chief medical officer for chronic and long-term care in the California Prison Health System.

In the early 1970s, On Lok pioneered the Program of All-Inclusive Care for the Elderly, widely known as PACE, that has served as a model, nationwide, for the care of frail and chronically ill older adults. PACE programs offer comprehensive care, with the goal of enabling these adults to continue living in the community. As Chief Medical Officer at On Lok, Dr. Phillips provides medical leadership and is responsible for all medical affairs and clinical functions of both employed and contract medical providers. She is also playing a key role in determining where the program goes from here.

“Part of the reason I was asked to come to On Lok was to help answer questions like, “What is the next innovation—where does the PACE model go from here? What should it look like in 20 years? How do we meet the needs of the next generation of seniors? How do we adapt to changes in payment and other policies?” Dr. Phillips explains.

Healthcare is likely to change dramatically over the next decade, she notes. Given President Obama’s commitment to comprehensive health reform, this is a prime opportunity for the AGS to play a leading role in bringing about broad, much needed changes in elder healthcare, she says. (See related story, “From the President,” p 2) AGS and its members have the clinical knowledge, training and expertise; the experience with coalition building and public policy advocacy; and the leadership skills needed to play that role, Dr. Phillips says. The Society is also well positioned to mobilize seniors and the 50- and 60-somethings she calls “emerging seniors”—a group that could, by organizing and demanding better elder care, play an essential part in making it a reality.

“AGS is uniquely positioned because we represent that committed group of healthcare professionals who are actually doing the care,” she says.

It’s imperative that AGS seize the opportunity to advance its mission—ensuring quality care for all older adults —while Washington works to redesign healthcare. But this doesn’t mean the Society will neglect its other historic priorities, Dr. Phillips is quick to add. (See Related story “AGS Leaders Affirm Society’s Priorities,” p 1) 😊

“Does this opportunity mean we give up on AGS’ research agenda? Absolutely not,” she says emphatically. “We have to continue to push for new knowledge and understanding and push to train the next generation of healthcare professionals to serve seniors. We’re also doing those things very well, and will continue to do so.”

AGS Leaders Reaffirm Priorities During February Policy Summit  

continued from page 1

should continue to focus on the five priorities. Since the last policy summit, healthcare reform has moved to center stage, with President Obama calling for an overhaul of the nation’s healthcare system.

“These priorities have served us well and remain valid,” Public Policy Committee Chair Peter Hollman, MD, noted prior to the unanimous vote reaffirming the five.

Drafted during the Society’s first public policy summit in 2007, the priorities include:

• Advocating for and promoting a more comprehensive, less fragmented healthcare system.
• Identifying and advocating for needed Medicare reforms, including reforms in Medicare’s protocols for paying for services provided to beneficiaries.
• Addressing the shortage of academic healthcare professionals specializing in geriatrics who are involved in research and training.
• Pursuing research concerning, and efforts toward, improved healthcare design.
• Promoting needed practice redesign.

AGS began stepping up its policy advocacy work in recent years and has tallied numerous policy successes since then. (See related “From the President” column, p 1, for a brief summary of recent successes.) 😊

For more information about the EWA, and a list of its members, visit www.eldercareworkforce.org.
With Great Music, Desserts, Drinks, Dancing and Improv, 2009’s “An Evening With Friends” Raises More Than $22,000 And Helps 143 Promising Student-Researchers Present Their Findings at AGS’ Annual Scientific Meeting

More than 200 guests enjoyed great music, dancing, drinks, countless desserts, and a performance by a talented improv troupe during this year’s An Evening with Friends (EWF) benefit. In the process, they made it possible for 143 talented student-researchers to present their research at the American Geriatrics Society’s 2009 Annual Scientific Meeting in Chicago.

EWF, a perennial highlight of AGS’ annual meetings, benefits the AGS Foundation for Health in Aging’s Student Researcher Fund. The fund helps defray the travel expenses of students who have been invited to present their research at a special student poster session during the meeting. A valuable recruitment tool, EWF helps introduce promising students to geriatrics and the many research and other opportunities a background in the field affords. This year’s EWF raised more than $22,000 for the fund.

“This is the seventh year the Foundation has hosted this event—an annual tradition of gathering with our friends and colleagues in the geriatrics community to support young researchers in the field,” said Jan Busby-Whitehead, MD, Chair of the FHA’s Board of Directors. “One hundred and forty-three students will be presenting their research this year—up from 126 last year! That’s terrific! This is our future!”

The Hyatt Regency Hotel’s Crystal Ballroom was EWF’s 2009 venue. The 12-piece Blooze Brothers, featuring the Sweet Home Chicago Band, performed Classic Rock, Swing, Motown, Soul R&B, and, naturally, Blues Brothers covers.

EWF guests were also treated to a performance by the Titanic Players—student performers from Northwestern University, the University of Illinois, and the University of Wisconsin renowned for their improv and scripted performances. The Players performing at the benefit—including the talented Marie Semla, daughter of Dr. Todd Semla—all hailed from Northwestern and wowed the room. The troupe specializes in “long form improvisation,” in which improvised scenes are linked to create a continuous narrative. Their performance of cleverly interlocked vignettes was hilarious, occasionally bizarre, sometimes poignant, and always captivating.

“That was The Titanic Players!” cheered EWF emcee Dr. Sally Brooks, as the troupe took bows to sustained applause. “The next Tina Fey will be coming out of that group!”

Eveningwear predominated at EWF, but, standing out from the crowd, AGS staff wore shocking lime green T-shirts that read, “AGS Foundation for Health in Aging... 2009 JP Morgan Chase Corporate Challenge.” Seventeen members of the AGS/FHA staff will be running, jogging and walking in the Corporate Challenge on June 11, with all funds they raise through the Challenge benefiting the Student Researcher Fund.

Dr. Brooks encouraged those at the event to show their support for the runners and walkers—and student researchers—by making further contributions to the fund. Outgoing AGS Board Chair, Dr. Todd Semla, strutted his stuff in a lime green T-shirt—collecting the extra donations from the crowd. All told the AGS Staff raised just over $1,300 as they made their way through the crowded room.
AGS Thanks Outgoing Board and Committee Members

During AGS’ annual members’ business meeting in May, incoming Chair of the Society’s Board of Directors, John Murphy, MD, thanked outgoing Board and committee members for their service to the Society.

“Thank you for so generously giving your time and talents, which have been crucial to our successes this past year,” said Dr. Murphy. Outgoing Board and committee members are:

Outgoing Board Member
Marie Bernard, MD, AGSF
Linda Fried, MD, MPH
Todd Semla, PharmD, MS, Outgoing AGS Board Chair
Stephanie Studenski, MD, MPH, AGSF

Outgoing Committee Members

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SeniorSMART™ Endowed Chairs

The SeniorSMART™ Endowed Chair in Community and Social Support: SmartHOME®
The University of South Carolina invites applications at the rank of professor or associate professor for the Endowed Chair in Community and Social Support: SmartHOME® in the College of Social Work (www.seniorsmart.org). The SmartHOME® initiative will enable older adults to live independently in home environments through the use of new technologies, social support, and community services.

The successful applicant must have an earned terminal degree in social work, computing/engineering, nursing, medicine, public health, architecture, or a similar discipline and a demonstrated track record of interdisciplinary scholarly productivity and programmatic support from competitive extramural funding sources. Experience is essential in one or more of the broad fields of geriatrics/gerontology, disabilities, social support, built environment, home technology, and community services.

Further information is on the Web site, www.seniorsmart.org. Address specific inquiries to Arlene Bowers Andrews, Ph.D. (Arlene.Andrews@usc.edu), College of Social Work, Chair, Search Committee for SmartHOME®

How to apply: All applications should be submitted electronically to feismart@mailbox.sc.edu. Applications should include a) a curriculum vitae, b) a list of 3–5 references, and c) a letter summarizing applicant qualifications, current research activities and interests, potential or realized economic value of their research, and the candidate’s qualifications to exert a leadership role.

The SeniorSMART™ Endowed Chair in Memory and Brain Health: SmartBRAIN™
The University of South Carolina invites applications for the Endowed Chair in Memory and Brain Health: SmartBRAIN™ (www.seniorsmart.org). The SmartBRAIN™ initiative will focus on developing methods to promote brain health and reduce the impact of age-associated diseases such as Alzheimer’s, Parkinson’s, and stroke.

The successful applicant will have an MD and/or Ph.D. degree, have a demonstrated track record in interdisciplinary scholarly productivity, and programmatic support from competitive extramural funding sources. Extensive experience in the broad field of neuroscience is essential. Familiarity with the mechanisms for enhancing research value through economic development (e.g., intellectual property, interaction with relevant businesses, translational research activities, etc.) is an important attribute that will build on the South Carolina Centers of Economic Excellence Program.

Further information is on the Web site, www.seniorsmart.org. Address specific inquiries to G. Paul Eleazer, MD (paueleazermd@gmail.com), Chair of Search Committee for SmartBRAIN™

How to apply: All applications should be submitted electronically to smartbrain@uscmed.sc.edu. Applications should include a) a curriculum vitae, b) a list of 3–5 references, and c) a letter summarizing applicant qualifications, current research activities and interests, potential or realized economic value of their research, and the candidate’s qualifications to exert a leadership role.

The University of South Carolina is an equal opportunity institution.
(R-FL), whose recently introduced “Geriatrics Loan Forgiveness Act,” would enable healthcare professionals pursuing advanced training in geriatrics to participate in the National Health Service Corps Loan Repayment Program. And the Society has offered information and assistance to the sponsors of the “Retooling the Health Care Workforce for an Aging America Act.” This legislation, introduced by Sens. Herb Kohl (D-WI), Blanche Lincoln (D-AR), Bob Casey (D-PA) and Rep. Jan Schakowsky (D-IL), would expand, train and support all healthcare providers who care for older adults.

That’s not all AGS has been doing to address eldercare workforce shortages. In response to the IOM report, the Society and 24 other leading organizations representing healthcare providers, direct-care workers, and family caregivers recently formed the Eldercare Workforce Alliance (EWA). The EWA, which AGS is co-convening with PHI, is now working to address clinical and faculty shortages in the field, ensure a competent eldercare workforce, strengthen the direct-care workforce, and redesign healthcare delivery. The Society has worked in partnership with other organizations, including AARP, the American Medical Association, the American College of Physicians, and the American Academy of Family Physicians, to advance shared goals as well. Collaboration works. (See related story, “AGS Co-Convenes National Eldercare Workforce Alliance,” p 7)

To further enhance its efforts to address workforce issues, the AGS recently established the new Geriatrics Workforce Policy Studies (GWPS) Center as well. With a three-year, $500,000 grant from the John A. Hartford Foundation, the GWPS will build on the work of the Association of Directors of Geriatric Academic Program’s (ADGAP’s) longitudinal data study—the University of Cincinnati Department of Public Health Sciences’ Status of Geriatrics Workforce Study—which was funded by both the Hartford Foundation and the Donald W. Reynolds Foundation. Like the workforce study, the GWPS will provide up-to-date information concerning geriatrics, geriatrics training, the geriatrics workforce, and related healthcare delivery issues—information AGS can share with policymakers and the media, and that will help guide AGS’ advocacy work. (See related story, “With Generous $500,000 John A. Hartford Foundation Grant, AGS Establishes New Geriatrics Workforce Policy Studies Center,” p 9)

AGS has also been a persistent and influential advocate for team-based assessment and care coordination for seniors who are vulnerable and have multiple chronic conditions. Among other things, the Society worked with the sponsors of the “RE-Aligning Care Act” (Reaching Elders with Assessment and Chronic Care Management and Coordination Act), essential healthcare reform legislation that was introduced at press time. Sponsored by Sens. Blanche Lincoln (D-AR) and Susan Collins (R-ME) and Rep. Gene Green (D-TX), the bill would fill a significant gap in traditional Medicare by covering comprehensive geriatric assessment and care coordination services for beneficiaries with two or more chronic conditions.”

This is but a partial list of the policy success AGS—with the help of its policy consulting firm, Nelson Mullins, Riley & Scarborough, its partners, and likeminded organizations—has tallied in recent years. We have momentum. We have influence. We need just one more thing before we can give our utmost to the healthcare reform launch: We need the support of the seniors we serve and their families.

Our challenge now is to both continue the work we’ve begun and to mobilize a chorus of united voices—of care professionals, seniors, and their loved ones—all calling for improved eldercare. To do this will take continued leadership and ongoing involvement in policy advocacy. It will also take public education.

That’s why we need your voice, your passion, and your help. If you haven’t yet registered with the Health in Aging Advocacy Center (www.americangeriatrics.org/advocacy/), please do so now. If you have, keep up the good work. I encourage all of you to spread the news about the center and AGS’ policy work among your friends, among civic and business leaders in your communities, and among your patients and their caregivers. Many family caregivers are what I think of as “newly emerging seniors.” They’re in their 50s or early 60s and in relatively good health. They’re aware of the problems with elder healthcare, and want something better by the time they’re eligible for Medicare. In short, they’re ideal advocates for the kinds of changes we advocate. Let’s get them involved in the process.

I also encourage you to tell your patients and their caregivers about the AGS Foundation for Health in Aging’s (FHIA) excellent public education Web site, www.healthinaging.org. The site includes a wealth of easily understandable information about health and healthcare in later life. One particularly important section of the site, the “Health in Aging Stories” page, showcases the stories of older adults. Many of these adults are frail or have multiple health problems, and have benefited from the unique care that geriatrics healthcare professionals provide. I urge you to encourage your patients and their caregivers not only to visit the page but to post their stories on the page (an email link makes this easy). Personal anecdotes are extremely influential with the media and lawmakers, and AGS shares these stories with both journalists and policymakers.

Not in times that we can remember has there been such potential for building essential elements of reform into our current system of “sickness care,” which poorly supports the needs of our growing senior population. If we can continue our efforts, maintain our momentum and help mobilize an informed and vocal public, we will be able to look at these as truly the “best of times.”

This promises to be an exciting and challenging year. Let’s get ready to launch!

Cheryl L. Phillips
American Geriatrics Society, John A. Hartford Foundation, Atlantic Philanthropies & AGS Foundation for Health in Aging Award More Than $1.5 Million for Medical Research to Address Urgent Healthcare Needs of Growing Elderly Population

Through three important awards programs, the American Geriatrics Society (AGS) and the AGS Foundation for Health in Aging (FHA) have awarded more than $1.5 million to advance research and foster the careers of clinicians and scientists committed to improving healthcare for the rapidly growing population of older adults. The awards went to 10 noted physician-researchers.

“These awards play the essential roles of supporting clinician-scientists and their research in geriatrics at time when the population of older adults is growing at an unprecedented rate,” says AGS President Cheryl Phillips, MD, Chief Medical Officer of On Lok, a nonprofit organization that provides all-inclusive healthcare and chronic care services for older adults in the San Francisco area. “Over the next two decades the number of adults 65 and older in the US alone will nearly double, exceeding 70 million.”

Dennis W. Jahnigen Career Development Scholars Awards
Seven academic researchers were named recipients of 2009 Dennis W. Jahnigen Career Development Scholars Awards. These awards are intended to help address the shortage of academicians in surgical and other medical specialties who have a special interest in, and knowledge of, the care of older adults. Administered by the American Geriatrics Society, the awards are supported by grants from The John A. Hartford Foundation and The Atlantic Philanthropies.

Over the course of two years, Jahnigen scholars receive $150,000 each, with their institutions providing an additional $50,000 in matching support. The awards help promising academic specialists start and sustain careers in both education and research focused on aging issues. The Jahnigen awards go to faculty in the specialties of: anesthesiology, emergency medicine, general surgery, gynecology, ophthalmology, orthopedic surgery, otolaryngology, physical medicine and rehabilitation, thoracic surgery, and urology. The average age of patients seeking care in these specialties is already increasing significantly.

This year’s Jahnigen Award recipients—specialists in general surgery, emergency medicine, ophthalmology, thoracic surgery, orthopedic surgery, urogynecology, and urology—are pursuing research focusing on macular degeneration, improving care for geriatric trauma patients, urethral sensory contributions to lower urinary tract function, and other areas critical to senior health but poorly represented in research on the national level.

Please see the online edition of AGS News for a complete list of Jahnigen award recipients.

Hartford Geriatrics Health Outcomes Research Scholars Awards
Two physician-researchers were named winners of 2009 Hartford Geriatrics Health Outcomes Research Scholars Awards. The awards support physician-scientists committed to improving healthcare for older adults while making the critical transition from junior faculty to independent researcher. Each Hartford Outcomes award winner receives $200,000 over two years in salary and research support.

This year’s Outcomes Research award winners are conducting research concerning modifiable factors in nursing homes that are associated with better mental health among the relatives of facility residents; and evaluating a new decision-making tool designed to help elderly and chronically ill patients weigh the risks and benefits of Implantable Cardioverter-Defibrillators (ICDs).

Please see the online edition of AGS News for a complete list of Health Outcomes award recipients.

T. Franklin Williams Research Scholars Award
Peter Abadir, MD, of Johns Hopkins University, was named the 2009 T. Franklin Williams Research Scholars Award winner. The award goes to an academic geriatrician conducting research applicable to care provided by internal medicine specialists. Dr. Abadir is conducting research focusing on age-related changes in angiotensin receptors and their contribution to age-related, late-life inflammation.

The Williams Award, administered by the FHA in collaboration with the Association of Specialty Professors (ASP) and supported by The Atlantic Philanthropies and the John A. Hartford Foundation, is intended to help academic geriatricians begin and sustain careers in research and education. The award goes to an academic geriatrician conducting research—in collaboration with a specialist in internal medicine—on a specialty-related health problem affecting older patients. The recipient receives $75,000 to support his or her research over two years.
and Go Test—a quick test that estimates falls risk—that indicated that they were at moderate or high risk of falling. The test measures how long it takes to get up from a chair, walk 10 feet, turn around, and return to the chair. All of those screened were provided with a written copy of their results and a suggestion to follow up with their physician if there were any concerns regarding their falls risk.

“The people at the Northwestern screening were extremely interested in their health and their risk of falling,” said Sunny Linnebur, PharmD, an Associate Professor in the Department of Clinical Pharmacy at the University of Colorado Denver School of Pharmacy. Dr. Linnebur, like Dr. Rothman, volunteered for last year’s falls screening and helped coordinate the Northwestern event. “They seemed really motivated to learn as much as possible about preventing falls.”

Out at the Navy Pier, those stopping by the inviting blue-roofed tent where the screenings were conducted tended to be younger and healthier than those who got screened at the hospital.

“People who come here like to walk; they’re in pretty good shape, so you encourage them to take this information back to their parents,” said volunteer Carolyn Welty, MD. An Associate Clinical Professor of Medicine in the Division of Geriatrics at the University of California San Francisco School of Medicine, Dr. Welty and fellow volunteers were wearing bright purple “Get Up and Go” T-shirts that matched the large purple “Free Screening; Get Up and Go: A Falls Prevention Program” signs on either side of the tent.

Dr. Welty and fellow volunteer Arvid Modawal, MD, an Associate Professor of Family Medicine and Geriatrics at the University of Cincinnati College of Medicine, screened a 53-year-old from Shanghai who zipped through the test. She was about to head back down the pier when they asked if she had older parents. Yes, she did, she replied. They were 86 and 87.

“Then you can do this test with them,” Dr. Modawal explained, offering her a blue card illustrating how to conduct the Get Up and Go Test, advice, an easy-to-follow FHA “tip sheet” (available at http://www.healthinaging.org/public_education/falls_tips.php) on preventing falls, and information about the services the FHA and AGS provide.

“Yes! I will try it!” the woman said, enthusiastically, waving the blue card as she made for a nearby water taxi stand.

The falls screening program was a joint project of the AGS Public Education Committee and the AGS/Association of Directors of Geriatric Academic Programs (ADGAP) Education Committee.