

AGS NEWS

NEWSLETTER OF THE AMERICAN GERIATRICS SOCIETY

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Number 3

THE GERIATRICS 5Ms

MULTICOMPLEXITY

...describes the whole person, typically an older adult, living with multiple chronic conditions, advanced illness, and/or with complicated biopsychosocial needs



Geriatrics health professionals focus on these 4Ms...

MIND

- Mentation
- Dementia
- Delirium
- Depression

MOBILITY

- Amount of mobility; function
- Impaired gait and balance
- Fall injury prevention

MEDICATIONS

- Polypharmacy, deprescribing
- Optimal prescribing
- Adverse medication effects and medication burden

WHAT MATTERS MOST

- Each individual's own meaningful health outcome goals and care preferences

INSIDE

- 2 AGS 360°
- 4 AGS Members Share State Advocacy Stories
- 6 From Our President
- 7 AGS/ADGAP Mentor Match Fosters Connections, Opportunities for Growth
- 8 GeriatricsCareOnline.org Releases New Resources & Product Updates in 2021
- 9 Meet the Older American of 2020
- 14 Why I'm an AGS Member
- 15 Caregiver Tip Sheet

Image: Updated AGS Minimum Geriatrics Competencies for Graduating Medical Students are based around the Geriatrics 5Ms.

MARIE BERNARD: LEADING INCLUSIVITY INITIATIVES ACROSS THE NIH

Past AGS board member and former ADGAP president Marie Bernard, MD, PhD, AGSF, may not see patients these days, but she will always be a geriatrician at heart. The deputy director of the National Institute on Aging has worn numerous hats at the National Institutes of Health (NIH): she is currently Chief Officer for Scientific Workforce Diversity (diversity.nih.gov), and co-chair of the NIH UNITE initiative (www.nih.gov/ending-structural-racism/unite.) In these roles, she leads the NIH's effort to promote diversity, equity, and inclusivity (DEI) in biomedical research across the country. Practicing geriatrics and taking action on DEI are both complex, nuanced endeavors; luckily Dr. Bernard has always gravitated towards a challenge. AGS News sat down with her recently to discuss her impressive career and her vision for the future of aging research and DEI initiatives.



Q: What drew you to geriatrics as a career?

A: So, I kind of backed into it. I started off as a faculty member in a general internal medicine section, where I had done my house staff training, and discovered that I really was not particularly inspired by the urinary tract infections and the upper respiratory infections that younger patients presented with. The patients who I found most interesting were my older patients, who had interesting life histories

continued on page 10

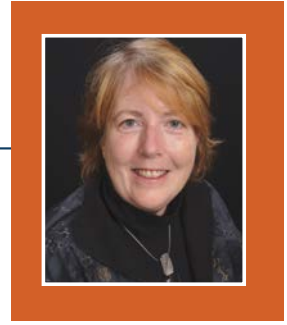
AGS PUBLISHES UPDATED AGS MINIMUM GERIATRICS COMPETENCIES FOR GRADUATING MEDICAL STUDENTS

The American Geriatrics Society has published an updated version of the AGS Minimum Geriatrics Competencies for Graduating Medical Students, which were created to ensure that medical school graduates across the U.S. are prepared to provide high-quality care for us all as we age. A refresh of the original set first published more than a decade ago, the 27 competencies integrate new concepts that have emerged more recently in the field of geriatrics, including frailty and person-centered care, and are framed around five key areas of focus for all geriatrics health-care professionals.

"The updated competencies reflect an evolution in how we frame

continued on page 3

AGS 360° WITH NANCY E. LUNDEBJERG, MPA



In July, the American Geriatrics Society (AGS) applied to be a participant in an ACGME Equity Matters learning community that is being offered by the Council of Medical Specialty Societies and the Organization of Program Director Associations (CMSS/OPDA) in collaboration with the Accreditation Council for Graduate Medical Education (ACGME). The application (which was approved) was a good opportunity to review our progress on our initiative that is focused on the intersection of structural racism and ageism and on infusing attention to equity into the fabric of AGS (see summary below). We are committed to achieving our vision for a future where we all are supported by and able to contribute to communities where ageism, ableism, classism, homophobia, racism, sexism, xenophobia, and other forms of bias and discrimination no longer impact healthcare access, quality, and outcomes for older adults and their caregivers.

As background for our focus on intersectionality, this term was first coined by Kimberlé Crenshaw and describes the complex, cumulative way in which the effect of multiple forms of discrimination combine, overlap, or intersect especially in the experiences of marginalized individuals or groups. For the AGS, with its long commitment to addressing ageism in healthcare, addressing how other “-isms” intersect with ageism was a natural way to focus our collective commitment to achieving our vision. We have been intentional about including immediate action steps in our plan even as we engage in a more deliberative process of:

- understanding intersectionality within the context of healthcare and our own work to address ageism in health care;

- identifying a set of broad priorities that will allow us to be responsive to opportunities to achieve change in our internal and external environments; and
- engaging our AGS members and other stakeholders in developing strategies that support achieving our future vision.

We recognize that each of us may be at different points in our own journey to becoming better allies. Our hope is that AGS members will engage with our efforts and their local communities as we work together to achieve meaningful change. We believe we have a collective responsibility to:

- **Recognize** that addressing discrimination and bias in healthcare is a responsibility that we all share.
- **Understand** our own implicit and explicit bias by assessing ourselves.
- **Learn** frameworks for racial equity and use that knowledge in our own lives.
- **Acknowledge** that we are each on a learning journey and approach this work with cultural humility.
- **Determine** how we each will take action personally and professionally. Our plans should start with where we are in our own journeys.

Summary of AGS Work at the Intersection of Structural Racism and Ageism

New Groups established to advance the Intersection of Structural Racism and Ageism (ISR&A)

- ISR&A Steering Group with representatives from the AGS Board and past AGS Board members and long-time leaders that will advise the Board on this project;
- AGS ISR&A Goals & Strategies Committee that is developing priorities and actionable strategies to

accomplish those priorities in service of the AGS vision of a healthcare system free of discrimination;

- AGS ISR&A Framework Writing Group that is developing a framework for understanding the intersection of structural racism and ageism; and
- *Journal of the American Geriatrics Society (JAGS) Diversity in Research Series*: We have identified three co-editors for a planned paper series that is focused on understanding the current baseline for inclusion in research (with a focus on race, ethnicity, and age).

AGS Research and Annual Scientific Meeting Program Committees, and JAGS Editorial Board

- Designing a ten-year approach for working towards our goal that by 2031, original research presented at our meeting or published in our journal reflects attention to diversity in study populations.

AGS Quality and Performance Measurement (QPMC) and Clinical Practice and Models of Care (CPMC) Committees

- AGS is often asked to review and comment on proposed quality measures and clinical practice guidelines/recommendations. Our QPMC developed a tool for assessing proposed quality measures through a health equity lens and our CPMC is developing a similar tool for reviewing clinical guidelines and recommendations.

AGS Products and Programs (Authors, Editors, Planning Committee Members)

As AGS products are due for updating, AGS is incorporating attention to bias and discrimination into the next editions. Work to date includes:

- Integration of attention to equity into our newly updated AGS Minimum Geriatrics Competencies for Medical Students;
- Attention to diversity and equity in our call for symposium proposals for the 2022 AGS Annual Scientific meeting and into the abstract submission site which is currently in development;
- A full update of the AGS Geriatrics Cultural Navigator by our Ethnogeriatrics Committee and creation of corresponding public education materials;
- Review of our *Geriatrics Review Syllabus* questions and *Geriatrics at Your Fingertips* to be sure that these

products account for patient complexity, health disparities, and patient demographics that are needed for clinical decision-making; and

- Attention to diversity in research in our review of the literature for our update of the AGS Beers Criteria® for Potentially Inappropriate Medications (due out in 2022).

AGS policy comments (multiple AGS committees and work groups)

In its policy work, AGS comments on a broad range of national policies with a focus on regulatory and legislative proposals that impact older adults and private sector standards (e.g., board certification in medicine). Recent comments that reflect our commitment to equity in healthcare include:

- American Board of Medical Specialties (ABMS) Draft Standards on Continuing Certification (July 2021)
- AGS/ADGAP Feedback on the Coalition for Physician Accountability's

Preliminary Recommendations on the Undergraduate Medical Education to Graduate Medical Education Transition (May 2021)

- Member Advocacy Opportunity on behalf of Direct Care Workforce (May 2021)
- Comment on HCBS Discussion Draft (April 2021)
- AGS Response to NIH request for feedback to Advance and Strengthen Racial Equity, Diversity, and Inclusion in the Biomedical Research Workforce and Advance Health Disparities and Health Equity Research (April 2021)
- AGS Priorities for New Administration: Letter to President Biden and Congressional Leaders (February 2021) ♦



Updated Competencies continued from page 1

the work of geriatrics health professionals, a greater understanding of frailty, and a greater focus nationally on ensuring that care is person-centered and driven by individual goals," explained AGS President Peter Hollmann, MD, AGSF. "With these competencies, the field of geriatrics has defined not just what all physicians should know as they embark on their careers but also how they should put that knowledge into practice."

The updated AGS Minimum Geriatrics Competencies for Graduating Medical Students are organized around the Geriatrics 5Ms, a framework developed in 2017 by Frank Molnar, MD, Allen Huang, MD, AGSF, and Mary Tinetti, MD, AGSF, around five key areas: Mind, Mobility, Medications, Multicomplexity, and what Matters most. Clinical educators in medical schools are rapidly adopting the 5Ms as a framework

for teaching medical students the skills, knowledge, and abilities they should have to provide high-quality clinical care for older adults. In the updated competencies set, each of the Ms contains new or modified competencies. Of particular note, multicomplexity, which describes the person who benefits most from geriatrics care, includes guidance on integrating a health equity lens into the practice of medicine.

"When we added a 27th competency, we believed it was critically important to highlight how important it is that physicians not only understand the impact that ageism and other forms of discrimination can have on the health of older adults but also take steps to overcome their own bias in addressing issues of health equity," AGS CEO Nancy E. Lundebjerg, MPA, said.

A workgroup of AGS leaders chaired by Rosanne Leipzig, MD, PhD,

Andrea W. Schwartz, MD, and Mandi Sehgal, MD, updated the 26 original competencies using a modified Delphi method to reach a group consensus based on expert and stakeholder input and a literature review. Having presented their work at the 2021 AGS Virtual Annual Scientific Meeting, the team is currently working on a paper describing their methodology and key qualitative findings from their research. The updated competencies are now available on the AGS' website for the Association of Directors of Geriatrics Academic Programs (ADGAP) at adgap.americangeriatrics.org.

Moving forward, the AGS will continue to advocate that undergraduate medical education prepares graduating physicians to care for us all as we age. AGS is also developing educational tools to help educators to integrate attention to the new competencies into their programs. ♦

AGS MEMBERS SHARE THEIR STATE ADVOCACY STORIES

"Injustice anywhere is a threat to justice everywhere," Martin Luther King Jr. said in 1963, his words a guiding star for advocates for social justice and improvement at all levels of the U.S. government. As a national organization, the American Geriatrics Society is #AGSproud of the influence our members and staff have had and continue to have on the development and implementation of aging policy in Washington, DC. We are equally proud of the advocacy work our members are doing on the state level, where the decisions made have just as large, if not larger, effects on our day-to-day lives and the care we all receive as we age.

AGS News spoke to a few advocates about their entries into state government, their recent efforts to improve the quality of and access to care for older residents via state health policy, and their advice for other AGS members looking to get involved:

Patrick Coll, MD, AGSF, Connecticut

Past AGS Board Member Dr. Patrick Coll made his first foray into the state policy arena at the beginning of the COVID-19 pandemic, when his work as Medical Director for Senior Health at UConn Health made it apparent that skilled nursing facilities (SNFs) in his state were not getting the testing supplies they so desperately needed for infection control. At the request of a state official, Dr. Coll joined Connecticut's Nursing Home and Assisted Living Oversight Working Group (NHALOWG) as its medical representative in October 2020.



"I went into it knowing that these were going to be recommendations and a legislative process... and not everything would be adopted, but hopefully, some recommendations would be implemented," said Dr. Coll, who sat on NHALOWG's infectious disease protocol subcommittee alongside nursing home industry and union representatives. Along the way, he solicited input from colleagues in long-term care and was pleased to see some of their contributions adopted in legislation that passed in May 2021.

"Many citizens, myself included, feel their voice is not meaningful and not going to be heard—and it's not true," he said, reflecting on the experience and his previous involvement in the AGS' national advocacy. "I think that's something I learned through the AGS: you can make your voice heard... Legislators are interested in hearing from their constituents." Newly minted advocates can start small, by sending personalized emails or letters to their representatives.

Steven Counsell, MD, AGSF, Indiana

Former AGS President Dr. Steve Counsell has been involved in state-level advocacy efforts since he first moved to Indiana over two decades ago. His plan upon arrival: first, create a model of care for older adults dually eligible for Medicare and Medicaid at a safety-net hospital that would improve their quality of life and access to geriatrics-informed care while reducing potential hospital readmissions and long-term nursing home placement; then, work toward the model's replication across the state by making his voice heard in Indianapolis.



The professor of medicine at Indiana University is now involved in a state-wide initiative to redesign long-term services and supports and make home and community-based services (HCBS) more readily accessible for older adults who want to age in place. As medical director for Indiana's Division of Aging, he is working to facilitate the sharing of Medicare Advantage Dual Eligible Special Needs Plans' hospital and SNF admissions and discharge data with Area Agencies on Aging (AAA) that can help coordinate care for patients in the Medicaid HCBS waiver program.

Dr. Counsell credits the AGS' Health Care for Low-Income Seniors Special Interest Group, which he launched more than 15 years ago, for supporting his efforts to reform services for dually-eligible older adults, and he encourages other AGS members to get in touch with their local AAAs and State Units on Aging to offer their expertise. "There's a huge need and opportunity for geriatrics healthcare professionals to get involved in state policy and programming," he said.

Kathleen Unroe, MD, MHA, AGSF, Indiana

Since participating in the Health and Aging Policy Fellowship program in 2009-2010, former AGS Public Policy Committee chair Dr. Kathleen Unroe knew policy would be an important part of her career as a clinician-researcher passionate about improving nursing home care. As project director of OPTIMISTIC, the CMS demonstration project designed to reduce avoidable hospitalizations of long-stay SNF residents, she would help create a diverse stakeholder advisory board, and,



as a technical expert, she would sit on a state panel developing a value-based purchasing formula for Indiana's nursing homes.

During the COVID-19 pandemic, Dr. Unroe's healthcare start-up, Probari, has put its geriatrics and long-term care expertise to good use supporting the Indiana Department of Health's COVID mitigation efforts in SNFs and assisted living facilities. The company has provided assistance with everything from the coordination of all staff testing across the state to communication around the vaccine roll-out to training 1,800 National Guard members who served in Indiana SNFs during the public health emergency.

A clinician, researcher and educator at the Indiana University School of Medicine, Dr. Unroe has never been more grateful for the national network the AGS helped her build than she is now. "This year I called on many of [my colleagues]—sometimes at night or on the weekends—as I was doing my best to provide input and guidance on policy changes during the rapidly changing environment of the pandemic," she said.

Peter Reed, PhD, Nevada

Engaged in policy and advocacy work since his first job as senior director of programs at the Alzheimer's Association, joining Nevada's state task force on Alzheimer's Disease was a no-brainer for GWEP project director Dr. Peter Reed when he moved to the state in 2013. As a member with advanced training in public health, Dr. Reed has had the opportunity to advise the governor and the Nevada Department of



Health and Human Services on developing and monitoring the implementation of a biennial state plan to address Alzheimer's.

When the COVID-19 pandemic struck in 2020, the Director of the Sanford Center for Aging and professor of public health at the University of Nevada-Reno School of Medicine knew it would have a disproportionate impact on older adults and set out immediately to launch a state-wide campaign called Nevada CAN (COVID-19 Aging Network Rapid Response) with assistance from the state's Aging and Disability Services. In its first year, the program delivered 500,000 meals, coordinated 15,000 telehealth patient visits, and provided more than 300 hours of virtual social support, and Dr. Reed was invited to present on this work before the U.S. Senate Special Committee on Aging.

To AGS members who are considering entering the policy and advocacy realm for the first time, Dr. Reed said, "There's no magic to it...People tend to think about policy work as this special, vague activity, but it's really not... Identify the right venues," like a task force on an issue you're passionate about, "then meet people and let them know you care." ♦

Are you an advocate for the improved care of older adults in your state?

Share your stories with us at info.amger@americangeriatrics.org

You can also visit the AGS Advocacy Center at cqrccengage.com/geriatrics to get started on various initiatives.



The **AGS Geriatrics Evaluation & Management Tools (AGS GEMS)** include 21 concise, clinical templates which follow a History & Physical (H&P) format and are meant to provide guidance to clinicians and trainees who are caring for older adults. All tools have received 2021 updates, which have just been released and are now available on GeriatricsCareOnline.org.

As part of your member benefits, all AGS members have free access to GEMS. Navigate to your library on **GeriatricsCareOnline.org** and check out the tools today!

GeriatricsCareOnline.org
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FROM OUR PRESIDENT

PETER HOLLMANN, MD, AGSF

On July 13th, the Centers for Medicare and Medicaid Services (CMS) released the Medicare Physician Fee Schedule (MPFS) Proposed Rule, which outlines proposals for 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 2022 and developing our feedback. In the meantime, below are a few highlights of the CMS rule that might be of interest to you.

- Lowers the conversion factor (CF) to \$33.58 for Calendar Year (CY) 2022 from \$34.89. This is due in part to the expiration of the 3.75% increase to the CF provided for in CY 2021 by the Consolidated Appropriations Act. The AGS continues to advocate that Congress extend the 3.75% increase and reduce the proposed cuts for 2022.
- Proposes to refine its longstanding policies for split (or shared) E/M visits to better reflect the current practice of medicine, the evolving role of non-physician practitioners (NPPs) as members of the medical team, and to clarify conditions of payment that must be met to bill Medicare for these services in an expanded list of acceptable sites of care.
- Proposes to retain telehealth services added to the Medicare telehealth list as Category 3 services, which means they were allowed during the Public Health Emergency (PHE), until the end of CY 2023 in order to permit development of more evidence that could support permanent addition to the list.
- Proposes to make permanent the extended virtual check-in code (G2252) to support access to care for beneficiaries who may be reluctant to return to in-person visits. CMS has noted that it does not plan to continue to pay for audio-only E/M after the conclusion of the PHE.
- Removes geographic location requirements and allows patients in their homes access to telehealth services for diagnosis, evaluation, and treatment of mental health disorders regardless of the PHE.
- Proposes to accept the American Medical Association (AMA) RUC-recommended work values for the 10 codes in the Chronic Care Management (CCM) family of codes, which reflects increases for the already established codes in this set.
- For CY 2022, the AMA RUC resurveyed the CCM code family, including Complex Chronic Care Management (CCCM) and Principal Care Management (PCM), and added five new CPT codes. The AGS played a key role in the surveying of this code set.
- The CCM/CCCM/PCM code family now includes five sets of codes, each set with a base



code and an add-on code. The sets vary by the degree of complexity of care (that is, CCM, CCCM, or PCM), who furnishes the care (that is, clinical staff or the physician or NPP), and the time allocated for the services.

- CMS proposes to amend its regulations governing payment for services of a Physician Assistant (PA) to reflect a recent change in law, which removed a requirement to make payment only to the employer of a PA, effective January 1, 2022.

There are a multitude 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 (QPP) under Medicare.

Final comments on the 2022 MPFS Proposed Rule are due to CMS by September 13th and will be posted on the AGS website at <https://www.americangeriatrics.org/where-we-stand/payment-services-older-adult-care>. A Final Rule wherein CMS states their final policies will be issued in early November and take effect on January 1. ♦

Peter Hollmann MD

AGS/ADGAP MENTOR MATCH FOSTERS NEW CONNECTIONS, OPPORTUNITIES FOR GROWTH

Members of AGS and the Association of Directors of Geriatrics Academic Programs (ADGAP) are familiar with MyAGSOnline, our virtual member discussion forum, as a way to exchange ideas and resources, to discuss research, and to get answers to important clinical and educational questions. This robust network has grown over several years to be a true knowledge

and information exchange, and it has been vital in keeping our community connected in an increasingly virtual world.

Now, MyAGSOnline has become an even bigger member benefit with the addition of Mentor Match, a program designed to develop mentoring relationships based on your needs and availability.

BENEFITS FOR MENTEES	BENEFITS FOR MENTORS
<ul style="list-style-type: none"> • Get a fresh perspective from experienced professionals • Build your network and gain name recognition • Learn how to manage a mentoring relationship: establish and maintain the relationship on your own terms • Set your own agenda for meetings to get your specific questions answered • Make new contacts that might provide job leads or collaboration opportunities • Get insights on your CV, interview skills, contract negotiation, and more • Get the support you need to feel confident and uplifted as you navigate your career 	<ul style="list-style-type: none"> • Build leadership and teaching skills • Enhance your network and gain influence • Bring a new perspective to your work and discover new questions or ideas • Experience the rewarding fulfillment of assisting someone in their career and/or program development • Adjust your settings & availability around your schedule; get the flexibility other mentor programs don't offer <p>Mentors can set limits on their participation, including the number of mentees they can take on and turning off participation during selected date ranges. Mentors can also track their mentoring relationships through their personalized mentorship dashboard.</p>

Log on to **MyAGSOnline.AmericanGeriatrics.org** using your member account credentials to access the mentor program and join using the simple, three-step enrollment process. Start expanding your network today!



"Medicine is all about giving back, and this was a great way to reach out to others following a similar career path and to reassure them that they are not alone in this journey. I have to say I felt reenergized, motivated, and inspired as a mentor in the AGS/ADGAP Mentor Match Program."

— Priya Mendiratta, MD, MPH, AGSF
Mentor



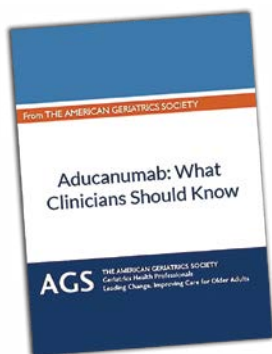
TELL A TRAINEE!

Students and residents can join AGS and access this program for free via e-membership. See AmericanGeriatrics.org for more information.

GERIATRICSCAREONLINE.ORG RELEASES EXCITING NEW RESOURCES & PRODUCT UPDATES IN 2021

For AGS members, **GeriatricsCareOnline.org** is a one-stop online resource for access to the AGS publications and products meeting all your needs as a clinician, researcher, educator, or residency program or fellowship director. To provide high-quality, trustworthy information and to ensure that all healthcare professionals have the latest research on caring for older adults, GeriatricsCareOnline.org regularly introduces new resources and updates existing ones. Browse the site today to make the most of the latest resource developments:

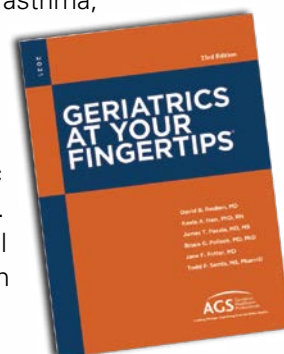
- **Aducanumab: What Clinicians Should Know** provides preliminary guidance for clinicians on informing patients and surrogates about the risks and benefits of aducanumab, an amyloid beta-directed antibody developed by Biogen and approved by the FDA in June under its accelerated approval pathway for use in treating patients with mild cognitive impairment or mild dementia due to Alzheimer's disease. "Aducanumab: What Clinicians Should Know" offers users guidelines for prescribing the new drug marketed as Aduhelm™; an outline of major differences between the FDA's approved usage of aducanumab and the conditions under which the treatment was studied in clinical trials; more information about aducanumab's FDA approval, clinical trials, and cost; and suggestions for further reading.



- The **AGS Quick Guide to Diabetes Management in Older Adults** provides a five-step framework for diabetes management. The guide was adapted from *Finding the Sweet Spot: an Interactive Workshop on Diabetes Management in Older Adults*, (Triantafylidis et al.) to help clinicians develop individualized goals for diabetes treatment, list safety and efficacy characteristics of antihyperglycemic agents, and implement geriatric prescribing and deprescribing principles for antihyperglycemic agents. The guide's framework builds off the AGS approach to multimorbidity and includes a case example.
- The **Geriatrics 5Ms Quick Guide** offers a framework for caring for older adults through the aging process and the end of life that aligns with the 4Ms of Age Friendly

Health Systems. The guide, adapted from Holliday et al., outlines five key concepts to help improve care for older adults in any setting: what Matters, Mind, Mobility, Medications, and Multicomplexity.

- The **AGS/ADGAP Burnout and Resiliency Toolkit**, developed by the AGS/ADGAP Education Committee's Faculty Development Subcommittee in response to the COVID-19 pandemic, is a compendium of articles and tools offering multiple audiences guidance on maintaining resiliency and avoiding burnout across multiple settings. The toolkit is organized by three topics: (1) identifying wellness burnout level; (2) personal level; and (3) program level.
- The **AGS Geriatrics Evaluation & Management Tools (AGS GEMS)** include 21 concise, clinical templates which follow a History & Physical (H&P) format and are meant to provide guidance to clinicians and trainees who are caring for older adults. All tools have now received 2021 updates.
- **Geriatrics at Your Fingertips® (GAYF)**, an AGS member favorite, is an annually updated reference that provides quick, easy access to the specific information clinicians need to make decisions about the care of older adults. This year's updates include a new section on preventive cardiology, new guidelines on asthma, osteoarthritis, and gout, and new material on telehealth and endovascular thrombectomy. The text and tables contain updated and newly recommended diagnostic tests and management strategies. Members can access their digital copy of GAYF via their library on GeriatricsCareOnline.org. ♦



Check out all these guides and tools on
GeriatricsCareOnline.org
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Meet the Older American of 2020

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, assembled by the Administration for Community Living (ACL). The report illustrates the shifting demographics of Americans age 65 and older, who represented 16 percent of the U.S. population (54.1 million) in 2019. See the highlights from the most recent report on [ACL.gov](https://acl.gov) below.

Health status and disability

In 2019, 22.3% of adults ages 65 to 74 described their health as "fair" or "poor," compared to 29.3% of adults ages 75 and over. About one in five older adults reported they could not function at all or had a lot of difficulty with seeing (22%), hearing (31%), mobility (40%), communication (8%), cognition (27%), and/or self-care (9%).

Employment

In 2020, 9.8 million (18%) older Americans were working or actively seeking work. This was a decrease from the 10.7 million older adults in the labor force in 2019, attributable to the COVID-19 pandemic.

Race/Ethnicity

Racial and ethnic minority populations increased from 7.8 million in 2009 (20% of the older adult population) to 12.9 million in 2019 (34% of older adults). The population of racial and ethnic minorities in the U.S. is projected to increase by 115% between 2019 and 2040.

Income and Poverty Level

The median income of older persons in 2019 was \$36,921 for men and \$21,815 for females. In 2019, 4.9 million older adults (8.9%) lived below the federal poverty level.

Life Expectancy

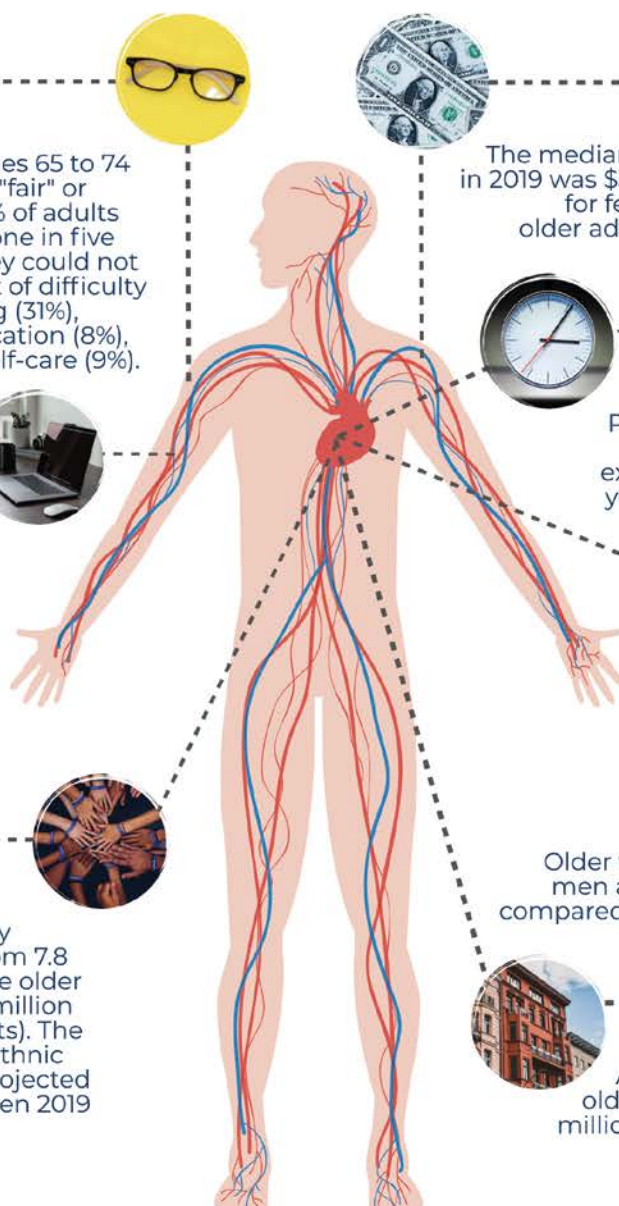
Persons reaching age 65 in 2019 had an average life expectancy of an added 19.6 years (20.8 years for women and 18.2 years for men).

Gender

Older women outnumber older men at 30 million older women compared to 24.1 million older men.

Living arrangements

About 27% (14.7 million) of older persons lived alone (9.7 million women, 5 million men).



and multiple conditions to manage, so those are the patients I gravitated to. And then, when I was given the opportunity to get some additional training in geriatrics, I came to recognize there's a whole world that I hadn't been exposed to during residency training—that it went all the way from basic science to population science. And even though I thought I knew about older adults, because I had been trained in internal medicine and I was a chief resident in internal medicine, there's just so much more to it. So, it was those early exposures that made me really excited about the field, and it's been my lifelong pursuit since then.

Q: You've been very engaged with the AGS and you have had multiple leadership roles. What advice do you have for other people who are considering getting engaged in their national professional organizations, and how has that engagement impacted your career?

A: I could say it's very important, because the opportunity to get involved with national organizations helps you to understand the whole landscape of what's going on in your field. Every academic institution and every hospital has its own ethos, and getting a chance to talk to people in different parts of the country and in different systems, you find out that what you thought was a truth is relative. So, it's important to get this chance to see that and to just network with other people who may be facing similar career challenges to you and knowing that you're not alone. National organizations are great opportunities to develop and hone your leadership skills, and to generate new ideas for things that you want to take back to your home institution. In fact, you can end up getting job opportunities as a result of being involved. Because of my involvement with AGS and other national organizations, I got a chance

to do some leadership things, get known, and ultimately get invited to serve on the National Advisory Council for the National Institute on Aging and then become the deputy director.

Q: You led the development of the third department of geriatrics in the U.S. at the University of Oklahoma College of Medicine. Can you tell us about the challenges you encountered during that process and how you overcame them as the department's first chair?

A: It presented lots of challenges. When we launched the department, it was me, a graduate of our geriatric medicine fellowship program, and one PhD educator. But we ultimately ended up with 50 full-time and adjunct faculty, and a required geriatric rotation for all 150 third-year medical students in Oklahoma City and Tulsa. It was a lot of building to get there. Of course, we were supported by the Donald W. Reynolds Foundation grant, but you had to get the grant. And then you had to get the faculty, and lots of people felt that you could not recruit into Tornado Alley. But we did it. Recruitment was the biggest challenge. I remember one time we were just about to seal the deal with a potential new faculty member, when an F5 tornado—the worst possible tornado—came through Oklahoma. After that, he and his wife said, "There's no way."

We also had to convince the other faculty at University of Oklahoma of our validity. There was quite honestly a lot of jealousy over the funds that we'd gotten. I got comments like, "Well, I guess if we can get a big grant, we can have a department, too." And there was a desire to control our funds, but fortunately we had significant support from the Dean and the Provost, and a mandate from the Reynolds Grant that we use the funds in a certain fashion.

The final barrier was the medical students themselves. A requirement of the Reynolds grant was the development of a required geriatrics rotation for all third-year medical students. As we were launching the rotation, the medical students went to the Dean complaining, "Dr. Bernard is going to make us give patients bed pans, and deal with bed sores and we just don't think this is right." We had to talk them through what a geriatrics rotation would really be about. And after the first couple of years, there was uniform agreement in the end-of-rotation evaluations that students found it a valuable rotation, enhancing their abilities as physicians. Unfortunately, very few were inspired to become geriatricians because they felt the field was too complex. But they acknowledged value to having the rotation.

Q: After your time at Oklahoma, you joined the NIA as the agency's Deputy Director. Can you talk about what prompted that decision and what you're proudest of achieving as deputy director?

A: I basically got tapped on the shoulder by a couple of colleagues who took me out to dinner and talked to me for a long period of time about how I should think about making the transition. Because I was quite happy in Oklahoma, I wasn't thinking about leaving. But the point that they made was that the position of Deputy Director at the National Institute on Aging provided an opportunity to have a broader impact. In Oklahoma, you had a local impact, maybe a regional impact since it was the tertiary care hospital for the region, but not much beyond that. And at the National Institute on Aging, you help to drive the research agenda for the nation. That was a good point that they made, and so I did go ahead and apply, fortunately got the position, and have had the opportunity to have a broad influence.

“ On the individual level, we need to recognize that the natural process that we have for handling information is to sort and categorize. It leads to biases in the way you perceive others - for instance, who would be a successful physician or scientist, or who would be a good member of your team to help in providing care or doing research. We call it implicit bias. ”

One of the things I'm most excited about is the Inclusion Across the Lifespan Policy that's now in place at the National Institutes of Health. Our group did the heavy lifting in terms of the NIH portfolio analysis that demonstrated that even for phase three clinical trials, the last step prior to general dissemination of study findings, in diseases that were common in older adults, you didn't have representation of older adults as you would expect (<https://pubmed.ncbi.nlm.nih.gov/30693958/>). Thus, when we were mandated by Congress to look at age policy, that analysis informed NIH's approach. We led the development of the congressionally mandated workshop, Inclusion Across the Lifespan, and contributed to the development of the new policy (<https://grants.nih.gov/policy/inclusion/lifespan.htm>). And then when we heard concerns from the aging research community that non-aging research scientists do not know how to meaningfully include older adults, we led the development of Inclusion Across the Lifespan II, providing additional insights and tools for meaningful inclusion of older adults, children, and others across the lifespan (<https://www.nia.nih.gov/Inclusion-Across-Lifespan-2020>). So, I'm excited to have had that opportunity.

Q: What recent developments in aging research do you think have the most potential to influence the day-to-day work of clinicians, in the more near future?

A: There are a couple of things that come to mind right way. First, developments in the field of geroscience. There is a lot of interesting animal research that suggests that you can modify the aging process by caloric restriction and by various drugs. This is now being applied to humans in proof-of-concept type studies. The theory is that if you can slow the aging process you can delay the development of chronic illnesses and have healthier lifespans – as appears to be the case in animal models. If the drugs prove fruitful, I am doubtful they will be restricted for use solely by geriatricians. However, I think there will be an important role for geriatricians to play in providing advice and consultation regarding the appropriate deployment of the drugs. And then, with the recent approval of aducanumab for Alzheimer's disease, and potentially more amyloid-focused drugs in the relatively near future, I think geriatricians are likely to be deluged with requests from patients to determine whether they are appropriate candidates for these drugs, if that has not already begun. I think that those are two developments that could have a big impact on clinical practice.

Q: The COVID-19 pandemic has had a disproportionate impact on older adults and communities of color, and the pandemic has highlighted health inequities impacting these populations. If you had to identify three main determinants of health in these populations, that would

merit more attention from researchers and additional federal dollars, what would they be?

A: They are known issues: access to care, such as providers and hospitals, and access to reliable and trusted health information. The myths that are out there still in communities of color about the COVID virus itself and the vaccines are very concerning. I'm happy to say that NIH has been working hard to offset those challenges through CEAL, the Community Engagement Alliance (<https://covid19community.nih.gov/>). But we need to do more. We need to have permanent collaborations to facilitate access, rather than swooping in and swooping out. We hope to build on the CEAL initiative and other similar efforts to build those lasting collaborations. And I think we need to pay a lot more attention to comorbidities and how they can influence health status. That is going back to the issue of inclusion; so frequently, if people have multiple chronic illnesses, they get excluded from studies – and that translates into exclusion of many older adults and under-represented racial and ethnic minority populations. We need to get to the point that those people are not only allowed but encouraged to participate in studies, so that the data that we gather is truly applicable to all.

Q: As NIH's chief officer for scientific workforce diversity and co-chair of the Women of Color Committee of the Working Group on Women

in Biomedical careers, what do you believe needs to change about biomedical research to make it a more diverse, inclusive, and equitable enterprise for all?

A: I think that there need to be multiple interventions. There are things that need to be done at the individual level and there are things that need to be done on the institutional level. On the individual level, we need to recognize that the natural process that we have for handling information is to sort and categorize. It leads to biases in the way you perceive others - for instance, who would be a successful physician or scientist, or who would be a good member of your team to help in providing care or doing research. We call it implicit bias. So, interventions to mediate that are important, making people aware of it, providing training, making sure that you have clear and objective criteria that are well articulated, and that you do not rush decision making - as that tends to cause reversion to implicit bias in selections. At the institutional level, it's important to be transparent about data, to hold people accountable for being inclusive in searches and selections, to make sure there is broad outreach, that you evaluate the impact of things that you might be doing, and that diversity is linked to the values of the organization, with leadership making it clear its expectations and support of diversity.

Q: Is there anything different about this moment in time that gives you hope that we will together achieve meaningful change as we work collectively on diversity, equity, and inclusion?

A: I think absolutely, with the COVID pandemic, where we've seen disproportionate deaths of people in under-represented groups, and with the videotaped murder of George Floyd, we are at a tipping point. It is like the Civil Rights era, when

GETTING TO KNOW DR. BERNARD

Q: Name one thing on your bucket list.

A: I'd like to go on a cruise around the world if there's not another COVID pandemic.

Q: What is one interesting thing about you that few people know?

A: Well, the people who worked with me in Oklahoma knew about it, because I had the broken boards in my office. But I'm a former Taekwondo practitioner, just short of my black belt. And I kept the boards there just to remind them, "Don't mess with me."

Q: What do you like to do to relax?

A: You must make time because you can't work non-stop. I like to do crossword puzzles, watch schlocky television programs, and read schlocky novels. I am a member of a woman's book club focused on serious study of the history of this nation and the current political paradigm. However, for every serious book I read, I read a romance or light rom-com. And I like to explore the restaurant world. I'm loving living in Bethesda, Maryland. There are so many nice restaurants in the DC-Maryland-Virginia area.

Q: What's your favorite part of your usual weekend routine?

A: Sleeping in. During the week, I'm usually up at 5 a.m. During the weekend I get to sleep a little bit later, until 7 a.m.

peaceful protestors were televised with fire hoses and dogs turned on them. People then, and I think now, are saying, "This is not who we are." Every place you turn people are trying to make changes to improve things, and I think that is wonderful. President Biden has issued numerous executive orders focusing on diversity, equity, and inclusion. The wind is at our back, pushing us to make our ecosystem more diverse, equitable, and inclusive. I think it is a very exciting, unique time, and we need to take advantage of the opportunities.

Q: What advice do you have for young women physician-scientists of color working to establish their careers in the field?

A: I would say, "Put your head down and do your work. Don't worry about what's going on around you." That's

what my mother used to tell me. I would also say, "Don't expect to be a wonder woman." My mother's generation did everything. They were involved with the church, the Girl Scouts, cooked dinner, worked full-time, and died at an early age. I would recommend that you get help with meals, childcare—whatever you need. Take advantage of your support network. And finally I'd say, "Remember that life is long." You don't have to do everything right away. There are some things that can be deferred to a later time.

Another bit of advice is to take advantage of ties through the AGS. They have a formal mentoring system in place. Through the program I have met several early career women with whom I still have a relationship. But even without a formal mentoring program, established people often are

flattered for others to make outreach to them. That is what I did early in my career, yielding some wonderful collaborative research opportunities. I think it is also important that people recognize that there is no single mentor who has all the answers. So, you need a mentoring network. If you're a researcher, there may be mentors for you locally who can help direct your research. But there should be other research mentors that you can turn to, who will help with other viewpoints. And other professional mentors at your institution and elsewhere can help with career perspectives. It is then up to you to put it all together and see what really works for you.

Q: Anything else we didn't cover?

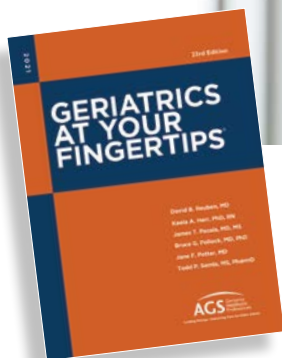
A: I would like to say that my role, Chief Officer for Scientific Workforce Diversity, is representative of NIH's dedication to assuring that we take advantage of the full talent in our country to maintain our creativity and innovation in biomedicine. The UNITE initiative has been launched to accelerate achieving true diversity, equity, and inclusion. I am impressed with the fervor and dedication of Francis Collins, NIH Director to the UNITE mission. And every single Institute and Center director is fully on board. This is a unique time and a great opportunity. I would be happy to chat with any AGS members who would like to know more. ♦

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WHY I'M AN AGS MEMBER

Blythe S. Winchester, MD, MPH, CMD, AGSF

Director of Geriatrics Services, Cherokee Indian Hospital
Certified Medical Director, Tsali Care Center
Chief Clinical Consultant, Geriatrics and Palliative Care, Indian Health Service

I've known that I wanted to be a doctor since I was young. I was a sickly child, often in and out of the hospital, and I became fascinated with science and being able to heal people. When I look back on it, I think that because I'm an Indigenous person and a member of the Eastern Band of Cherokee Indians, I was searching for the healing aspect that was a part of my culture.

We didn't get a lot of exposure to geriatrics in med school until I did a family medicine residency. I did a geriatrics elective, and I fell in love with everything about it. I discovered that geriatricians are awesome—they're interesting, and they have great personalities. These people are advocates who fight for the underdog.

That, plus the fact that geriatricians were so humanitarian, prompted my decision to specialize in geriatrics, despite the resident faculty member who tried dissuading me by suggesting that I'd "get plenty of geriatrics in primary care practice." Also, while I was in med school, my dad's father developed severe vascular dementia and went to live in a memory care unit. My mother's mother had severe Alzheimer's disease; both mom and dad cared for her at home until her death. The care they gave her was excellent, and I wanted both to model that and learn to help others deal with the challenges and rewards of that process.

In my tribal community, where I'm Chief Clinical Consultant for Geriatrics and Palliative Care for the Indian Health Service, there's an urgent need for geriatricians. In fact, geriatricians are rare in Indian Country—I know of only one other who, like myself, is a tribal person.

I joined AGS in 2010, even before I became a geriatrician. I'd worked with a geriatrician in the VA, who told me about AGS after I mentioned how I wanted to learn from and talk to other geriatricians. I'm in a rural area, so it's not like I have an academic setting with a million people I can talk to. He said that AGS is something I needed to join because it's multi-disciplinary,



In my tribal community, where I'm Chief Clinical Consultant for Geriatrics and Palliative Care for the Indian Health Service, there's an urgent need for geriatricians.

and it's for clinicians who also have an interest in leadership and research. I think my first AGS Annual Meeting was in 2010, and I immediately fell in love with everything about it. I value all the knowledge that I gather and appreciate the networking at AGS meetings. I see former fellows and mentors—it's a special time to reset and learn a ton of information.

I rely on so much that AGS membership offers. *Geriatrics at Your Fingertips* is an amazing resource that I've used frequently. There's JAGS to stay current with research. I use MyAGSOnline, the online member portal, and I've signed up for the virtual mentor match because I want to help mentees get the most out of their membership.

Thanks to my AGS membership, I've served three terms on the



Ethnogeriatrics Committee—it's been a huge benefit to network, to meet regularly, and to hear about people who have a passion for geriatrics, as well as for inclusion and addressing diversity and what can be done on a bigger scale. So many of these geriatricians serve in academic settings and other places where they're doing amazing things. It helps me to hear about how others are working on programming and policy change. ♦



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How to Be the Best Caregiver You Can Be

Many of us know an older person with a serious illness or an ongoing health problem. In fact, half of all adult Americans have at least one chronic condition for which they need help from a caregiver, family member, or friend.

If you've wondered how to show an older person that you care or how you can help them, here are some tips on how to be the best "care coach" or "care champion" you can be.

1 Build Confidence

Help the person you're caring for strengthen their confidence that they can get through their treatment. Support them in believing that they'll benefit by undergoing the treatment or rehabilitation, as difficult as it can be at times.

2 Start with small steps

For example, encourage someone dealing with chemotherapy to take just a few sips of water or soup so they get needed fluids, even when nausea or lack of appetite makes it difficult. If they have had a stroke or other mobility problem, help them take just a few steps, with the ultimate goal of getting to the bathroom.

3 Provide repeated encouragement

Tell them that they can eat some soup or take that short walk to the bathroom, and continue to reinforce the idea. Your encouragement should be realistic and repetitive.

4 Remember their successes

Even when they feel that it's impossible to eat any soup or take any steps today, remind them gently that they did it yesterday and can do it again today.

5 Exercise compassion

When the person you're caring for is going through chemotherapy or other difficult treatment, sometimes the best way to help is to just sit and talk with them during their treatment—that helps take their mind off the process. Or take them out for a milkshake when that's all they can eat. For someone who has had a stroke, help them manage their fear of falling by supporting them when they get up from a wheelchair.

6 Avoid useless gestures

Try not to say things like "let me know if I can do anything" or "call me if there is anything I can do." When someone is sick, they're unlikely to ask for help. Take the initiative to provide concrete help.



7 Don't hesitate to act

Never be afraid to just DO or SAY something. Don't avoid getting in touch with someone to let them know you've heard about their illness. Don't hesitate because you're afraid you're intruding on the person's privacy. If you heard about their illness, it is no secret. Never fear calling or sending an email or a card. Show you care in any and every way. You'll know by their response if it helps. Social support is critical to building their confidence and helping them get through their treatment or cope with an ongoing illness.

8 Offer words of encouragement

Think of things that may have helped you through difficult situations in the past and share them. This may be something as simple as sharing a favorite quote from a book that helped you put things in perspective or gave you hope in difficult times. Such words of encouragement can help the person you're caring for cope with their own challenges in treatment. You can also share your experiences about things that have helped you be resilient and bounce back during challenging times.

9 Check in often to show you care

Check in repeatedly with the person you're caring for. Educate yourself about their illness and the course of treatment they face. Then call, email, or visit with them at times you know will be most difficult for them.

For example, with cancer treatment, the day of treatment may not be as hard as the days after, when the symptoms really hit. Find out their treatment schedule and check in with them then.

10 Take care of yourself

When you become a care coach, the first and most important step is for you to take care of yourself. You can't possibly give support to someone else unless you're strong yourself. Set limits if you need to and make sure to do the things that keep you happy and healthy.

11 Ask questions about care procedures you are not comfortable doing

You may have to provide hands-on care that you are not comfortable doing, such as giving someone an injection or taking care of a wound. Do not be afraid to ask questions of healthcare providers, even if you have been instructed previously on the procedure. Make sure you feel comfortable and confident so that this type of care does not cause you anxiety or stress.

This tip sheet is inspired by Barbara Resnick, PhD, RN, an advanced nurse practitioner, educator, and researcher with an interest in physical activity and functional performance, restorative care nursing programs, and innovations in long-term care. This is based on her personal experiences as both a caregiver and a care recipient.

