

# AGS NEWS

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## PLAN YOUR #AGS23 ADVENTURE IN LONG BEACH, CA

A waterfront playground in the heart of Southern California, Long Beach has lots to do and see, from outdoor adventures and beach trips to cultural excursions, shopping, and nightlife. Whether you're looking to unwind from #AGS23 activities with colleagues or explore the area with your family, there's something for everyone within a short distance of the #AGS23 venue and local hotels!

### Get outdoors!

Temperatures average in May from the high 50s to mid-70s with typically fewer than 20 days of rainfall recorded each year, so it's always perfect to spend time outdoors in Long Beach. Start with **El Dorado Park and Nature Center**, a natural habitat oasis that provides a unique escape from the city and has activities everyone will enjoy. Nearly 100 acres provide a sanctuary for birds, trees, and other plant and animal wildlife as trails guide you through picturesque, wooded areas and around two lakes. Finish off your visit with a trip to the museum gallery, educational displays, and a small gift shop featuring local artists.



If you're more inclined to taking in the view than exploring it, consider renting swan boats on the **Rainbow Lagoon**. Get in some cardio exercise by pedaling—or “swanning” as it's known locally—before rewarding yourself with a stroll through **Shoreline Village**, a seaside collection of restaurants, activities, and shops, including a full time Lego operation.

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## AGS NEWS TALKS TO DR. JOSEPH NNODIM, MD, PHD, FACP, AGSF

Dr. Nnodim is a graduate of both the College of Medicine of the University of Lagos, Nigeria and the University of Wales, United Kingdom. After an internal medicine residency at the Saginaw Program of Michigan State University, he completed a geriatrics fellowship and a special program in advanced geriatrics at the University of Michigan. His areas of research include human gait properties and his clinical interests include balance and fall-risk assessment, mobility enhancement, and fall prevention. Dr. Nnodim—an AGS member since 2003—recently published his first book, *Toward Understanding the Nigeria-Biafra War and Lingering Questions* about the history of Nigeria during the colonial and immediate post-colonial eras.

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# AGS 360° WITH NANCY E. LUNDEBJERG, MPA



Yes, I took ChatGPT (<https://openai.com/blog/chatgpt/>) for a spin. The tagline for ChatGPT is that it optimizes language models in a way that makes it easy for someone like me to converse with, um, an artificial being. Over the course of two evenings, I did just that—talked with ChatGPT about one of my favorite topics—geriatrics! I learned that there are limitations (e.g., ChatGPT knows that geriatrics is not a noun but consistently used it as a noun meaning older people when I asked for poems about geriatrics). There are also possibilities. ChatGPT can generate a much simpler description of geriatric medicine than I can with my propensity for long sentences. In the sidebar, I'm sharing my favorite ChatGPT poem, written in the style of T.S. Eliot. Here at AGS, we'll be monitoring the potential of next generation search engines like the recently released Bing update (powered by same technology that powers ChatGPT) for their potential use across our portfolio of programs and products. AGS staff will also be following the work of three centers recently funded by the National Institute on Aging (NIA) that are focused on the intersection of artificial intelligence with geriatrics in order to better understand what this brave new world means for all of us as we age: [Johns Hopkins University](#), [University of Massachusetts Amherst](#), and [University of Pennsylvania](#).

Now, to transition to what I had planned to devote this column to, which is AGS public policy efforts and how we determine our priorities. From time to time, we field member requests asking us to take on new policy issues and make these a priority in our work. I thought it would be useful to lay out for members both the context of our policy work and the framework that we use to review new areas of focus.

**Me: Write me a poem about geriatric medicine in the style of T. S. Eliot.**

**ChatGPT:**

Geriatric medicine, a mystery,  
A labyrinth of care and cure.  
It offers hope, yet brings a hunt  
Of what we must endure.

In a world where age is but a number,  
And time, a thing of the past.  
Geriatric medicine stands steadfast,  
To heal and make it last.

**I'll start with the context.** AGS is a small society with limited resources and we are focused on policy at the federal level. Our top priorities (all of which

meet the litmus test for AGS being in a leadership role laid out in Table 1) are: Medicare payment, geriatrics health professions workforce, aging research funding, and quality measurement for older adults. We have a small but mighty in-house policy team (Alanna Goldstein and Anna Kim) that juggles both our work on our primary areas of focus and our work in other areas (e.g., AGS signed on to 35 letters in 2022, each of which required a staff level review and assessment). We also have external consultants at Arnold & Porter for our legislative and regulatory work (led by Kristine Blackwood and Paul Rudolf respectively). Finally,

**Table 1: AGS Framework for Considering New Policy Areas**

Question	Litmus Test	Example(s)
Where should we lead?	If AGS was not leading this, would it get done?	Coding and payment work Geriatrics Health Professions COVID-19 rationing framework Aducanumab/lecanemab
Where should we be engaged as a follower?	Can we have an impact on the work of others?	Nominating to TEPs (quality) Coalitions Legislative and Regulatory comments in response to RFIs
Where should we review and sign on to the work of others?	Is it an issue that aligns with AGS priorities?	Sign-on letters on a host of issues, including Social Security, immigration, Older Americans Act, paid family and medical leave.  Big topics where organizations with much larger budgets are working (the potential Medicare fee cut is a good example of this given that we are aligning our own letters with AMA's).
Since 2017, we have been asking ourselves this question...		
When do we have a responsibility to speak out?	Is this an issue where we have a moral or ethical responsibility to speak out?	<ul style="list-style-type: none"> <li>• Discriminatory Policies</li> <li>• Murder of George Floyd</li> <li>• Anti-Asian hate crimes</li> <li>• Incursions into the doctor patient relationship</li> </ul>

we have a host of passionate leaders with expertise on different issues whom we call for input on comment letters, policy statements, legislation, and other policy activities.

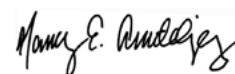
Because of our small size and given the wealth of expertise, we focus 90% of our effort on ensuring that federal policy is informed by the expertise of our members. Examples of our success with using this approach include the Affordable Care Act, which reflected inclusion of geriatrics as eligible for the primary care bonus, and reauthorization of the geriatrics workforce training programs. Another example would be our decades long effort to improve payment for the type of care that geriatrics health professionals provide ([Hard Work, Big Changes:](#)

[AGS Efforts to Improve Payment for Geriatrics Care](#)). From time to time, we ask AGS members living in states with Congressional leaders sitting on important committees to do grassroots outreach on an issue. Finally, we occasionally call on all members to take action in our Health in Aging Advocacy Center in support of bills that advance our priorities.

**What is our framework for considering new policy requests?** Table 1 provides our framework for considering member requests that we take something on as a new policy priority. Typically, we are able to work a new policy focus in as one where we should be engaged as a follower. Our work on environmental issues would

fall into that category – AGS Board member Diane Chau is representing us on the Medical Society Consortium on Climate and Health and we will sign on to letters that are focused on the intersection of the environment and older adult health.

Finally, we believe that influencing public policy for all of us as we age is best accomplished through partnerships, celebrating the work of others, and quietly doing the hard work that leads to those successes behind the scenes and without asking for applause. If you have a policy priority idea that you'd like us to consider, please don't hesitate to drop us a line at [info@americangeriatrics.org](mailto:info@americangeriatrics.org). ♦



## AGS/ADGAP BENCHMARKING SURVEY – TAKE PART AND FILL IT OUT TODAY

The AGS/ADGAP Benchmarking Survey launched in partnership with Phairify in February and is now available for geriatrician members to complete. It is the first in a series of surveys that will gather compensation, productivity, and practice characteristics across the numerous settings where geriatricians provide care. Once you complete the survey, you will have immediate and unlimited access to aggregated market intelligence. All geriatrician members received a personalized email with a unique link to activate your account and complete the 15-minute survey on geriatrics practice.

### About the Survey

This first survey collects three types of anonymous data:

1. Demographic data (e.g., year of birth, gender, ethnicity, board certifications).
2. The characteristics of ideal career opportunities you would be interested in learning more about, including professional function requirements, provision of locum tenens, maximum total compensation, and desired location.
3. Historic practice, compensation, and productivity data across multiple settings of care.

Your use of Phairify is free, secure, and anonymous; they do not collect, request, or use any personally identifiable or sensitive information.

**The more AGS geriatrician members complete this core survey, the more robust the data you will have to support your contract negotiations and manage your career choices, as well as support geriatrics academic programs budget negotiations. The core survey will set the stage for follow-up module surveys to explore specific areas based on practice type and/or setting(s) of care to determine different metrics across the spectrum of settings, including ambulatory, acute care, home care, and nursing home.**

We hope to receive responses to the core survey by **Friday, April 7** so we can share preliminary results at the AGS Annual Meeting, but the survey will not close on that date. Members will have the opportunity to access the Phairify platform at any time after submitting their survey to analyze data and/or participate in future follow up surveys and modules. If you have any questions about your account or the survey, please reach out to Anna Kim at [akim@americangeriatrics.org](mailto:akim@americangeriatrics.org). ♦

# FROM OUR PRESIDENT

MICHAEL HARPER, MD, AGSF

It feels like only a few months ago I was drafting my first column for this newsletter, in high anticipation for taking on my role as AGS President and preparing to attend the 2022 Annual Scientific Meeting. Since then, it's been a whirlwind pace across the AGS, with several major projects being implemented this year. You can read about some of the updates in the pages of this newsletter, but what you don't always see is the hard work that goes on behind the scenes – most of which is a collaboration between AGS staff and our members. For me, one of the great strengths of AGS is the way we partner with staff – drawing on our respective strengths and diverse perspectives to advance our vision for the future.

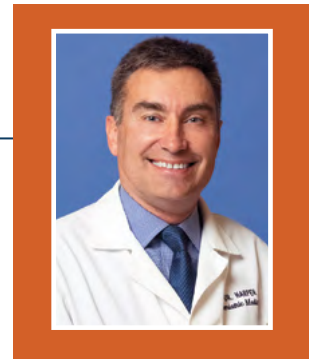
As I look ahead to transitioning from President to Board Chair at #AGS23, I am reminded of the early days of my career and the steps I took that brought me here. In 2005 I was a new Geriatrics Fellowship Program Director, and along with colleagues from around the country, volunteered to develop a symposium for fellowship directors at the 2006 Annual Scientific Meeting. That symposium was the precursor to what is now the annual AGS/ADGAP Fellowship Directors pre-conference. That first step was instrumental to my career as it helped me to build a national network of colleagues and friends.

One of the true gifts of becoming a leader in my national organization is the relationships, personal and professional, that I've forged while participating in AGS activities. With every role I've taken on, I've been inspired by the team of dedicated volunteers who are working together to implement programs, advocate on behalf of geriatrics, and train the next generation. Personally, that first volunteer experience led to opportunities to edit

the Geriatrics Review Syllabus, serve on the Education Committee, chair the AGS/ADGAP Fellowship Directors Group, and to serve on the Board and as the President of the Society.

Nowhere is the teamwork of our staff and volunteer leaders more evident than at the AGS Annual Scientific Meeting. Case in point is our upcoming meeting in Long Beach, CA #AGS23. Our Annual Meeting Program Committee has selected symposia and workshops that capture the breadth of geriatrics practice. Many of our members reviewed abstract submissions, helping us to select the best of geriatrics research for our paper and poster sessions. At the meeting, symposia and workshop faculty and paper and poster presenters will make this content come alive. Upcoming opportunities to participate in the meeting include signing up for our mentoring program – whether you are a mentor or mentee, the goal of this program is that members can make meaningful connections with other members, hopefully establishing relationships that will support them throughout their careers. Some of you will join our extended communications network by signing up to be a social media correspondent, promoting sessions and sharing your experience at the meeting with the people you communicate with online. At the meeting, attendees will have a host of special interest groups and sections to attend, learn, and network with others with common interests.

So my final message to you—which is also a challenge!—is how can you get involved this year at the AGS? If you don't know where to start, visit <https://www.americangeriatrics.org/membership/get-involved> or check out the volunteer opportunities listed on <https://myagsonline.americangeriatrics.org/home>.



No matter where you are in your career, making new connections is always rewarding and getting involved with the AGS is a great way to do that. I look forward to meeting many new faces at #AGS23 and to learning about you and from you.

As I hand over the reins to Dr. Donna Fick, PhD, GCNS-BC, FGSA, FAAN, I am grateful to have served alongside a stellar group of colleagues this past year, and I thank them deeply for all their support and collaboration. I look forward to continuing on the Board as Board Chair and working with Dr. Fick and other leaders to improve the health and quality of life for all of us as we age. Dr. Fick is a Distinguished Professor in The Pennsylvania State University College of Nursing, the Elouise Ross Eberly Endowed Professor of Nursing, and Director of the Center for Geriatric Nursing Excellence. A member of the interdisciplinary panel for the Beers Criteria for Inappropriate Medication Use in Older Adults, she also serves as an expert faculty member and coach for the Creating an Age-Friendly Health System Initiative, among her other roles as a leader in the field. Dr. Fick is nationally and internationally recognized for her work on Delirium Superimposed on Dementia (DSD) and ultra-brief delirium detection at the bedside. I warmly welcome her into her new position as the new AGS President!

It has been a privilege to serve as your President and I look forward to seeing many of you at #AGS23 in Long Beach, CA in May 4-6 (preconference day: May 3). ♦

A handwritten signature in black ink, appearing to read 'Michael Harper', with a small diamond symbol at the end.

## Take in the art and architecture scene

What better way to get to know the city than through Long Beach's vibrant art and architecture? Your first stop should be the **Long Beach Museum of Art**, on Ocean Boulevard beside **Bluff Park**. Located within the historic Elizabeth Millbank Anderson House, its permanent collection and rotating exhibits feature more than 3,200 works of American and European Art. A second museum campus, **LBMA Downtown**, showcases resident artists.

Long Beach is home to dozens of larger than life-sized urban murals, most of which are located downtown near the city's art museums and notable architecture. **POW!WOW! Long Beach**, an international mural festival, helped beautify the city's urban spaces, and you can discover these creations and other public art installations on the **Art Council for Long Beach's public art map**, which will guide you on a walking tour past the highlights of the city's collection.

## Don't forget the beach!

Despite what its name may suggest, Long Beach isn't actually one, long beach. Instead, the city is home to several beaches, each with its own environment and vibe that are distinctly different from each other. **Mother's Beach**, a local favorite, is a shallow beach protected from the open ocean so best suited for children and the less adventurous at heart. The city's best-known beach, **Bayshore**, is popular with singles and couples and is located at the end of the **Second Street Shopping District**. The area offers up lots of different activities such as kayaking, swimming, and paddleboarding.

For a good all-round beach experience, try **Granada Beach**, located around Granada Avenue in Belmont Shore. Walkways are paved and usually filled with wandering crowds taking in the view alongside beach volleyball players and wind and kite surfers.

## Foodie adventures

No matter how you've spent your free time, you can't miss Long Beach's thriving restaurant scene - a foodie's paradise in SoCal.

Although the city is home to many tasty international cuisines, Cambodian should be at the top of your list. Long Beach has the largest population of Cambodians outside of Asia and there is a designated area called **Cambodia Town**. In and around this area you will find the best Khmer food in the country.

If you're looking for food with origins closer to home, Long Beach is also well known for its breakfast. **Claire's at the Museum** with its view of Long Beach Harbor or **Fuego**, a Latin-infused restaurant and lounge at the Hotel Maya that features signature cocktails and its own spectacular view of the ocean, are both great options. Interested in the food more than the view? Try **The Breakfast Bar**, recently named one of the 15 best brunches in the entire US.

## Other sights worth checking out

**Queen Mary** ([QueenMary.com](http://QueenMary.com)) A historic ocean liner and WWII troopship and one of Long Beach's top tourist destinations.



**Aquarium of the Pacific** ([AquariumOfPacific.org](http://AquariumOfPacific.org)) California's largest aquarium with more than 11,000 animals and over 50 exhibits.

**Museum of Latin American Art** ([MOLAA.org](http://MOLAA.org)) Founded in 1996, a pioneering museum dedicated to modern and contemporary Latin American and Latinx art.

**Catalina Express** ([CatalinaExpress.com](http://CatalinaExpress.com)) to **Catalina Island** To venture further afield, a trip to Catalina can serve up snorkeling, unique shopping and dining options, and a scenic view of coastal California in almost no time. ♦

### The AGS Has Your Hotel Deals Covered—But Act Fast!

The official #AGS23 program will be held at the Long Beach Convention and Entertainment Center. The AGS has negotiated special rates at five area hotels on a first-come, first-served basis. Visit [AmericanGeriatrics.org/Annual\\_Meeting](http://AmericanGeriatrics.org/Annual_Meeting) to reserve your spot today!



### DIRECTORY

- **El Dorado Nature Center** - <https://www.longbeach.gov/park/park-and-facilities/parks-centers-pier/el-dorado-nature-center/>
- **Wheel Fun Rentals** (swan boats) <https://wheelfunrentals.com/ca/long-beach/rainbow-lagoon/>
- **Shoreline Village** - <https://shorelinevillage.com/>
- **Long Beach Museum of Art** - <https://www.lbma.org/>
- **Claire's at the Museum** - <https://www.lbma.org/claaires/>
- **POW!WOW! Long Beach** <https://www.longbeachwalls.com/>
- **Arts Council Public Art Map** <https://artslb.org/public-art-map/>
- **Cambodia Town** - <https://www.visitlongbeach.com/neighborhoods/eastside/cambodia-town/>
- **Fuego at the Hotel Maya** - <https://www.hotelmayalongbeach.com/fuego-restaurant/>
- **The Breakfast Bar** - <http://www.the-breakfast-bar.com/>

### Why did you decide to pursue a career in geriatrics?

I began my career after medical school in the basic sciences and made a transition to clinical medicine full-time much later - after I arrived in the United States. My decision to opt for geriatrics after I made the transition flowed from an interest in the aging process I had nurtured during my basic science career. In graduate school, I had studied fat cells from two different kinds of adipose tissue—brown and white—as they aged. Much later I researched the biology of aging in skeletal muscle.

Another determinant was my relationship with my parents and grandparents. I was very fond of them as I was growing up and even more so as they grew older. I believe the influence they had on me went well beyond the impact parents and grandparents ordinarily have on their offspring. In a very real way, they modeled for me the qualities and attributes I cherish

as well as the passions for reading and writing which I have embraced.

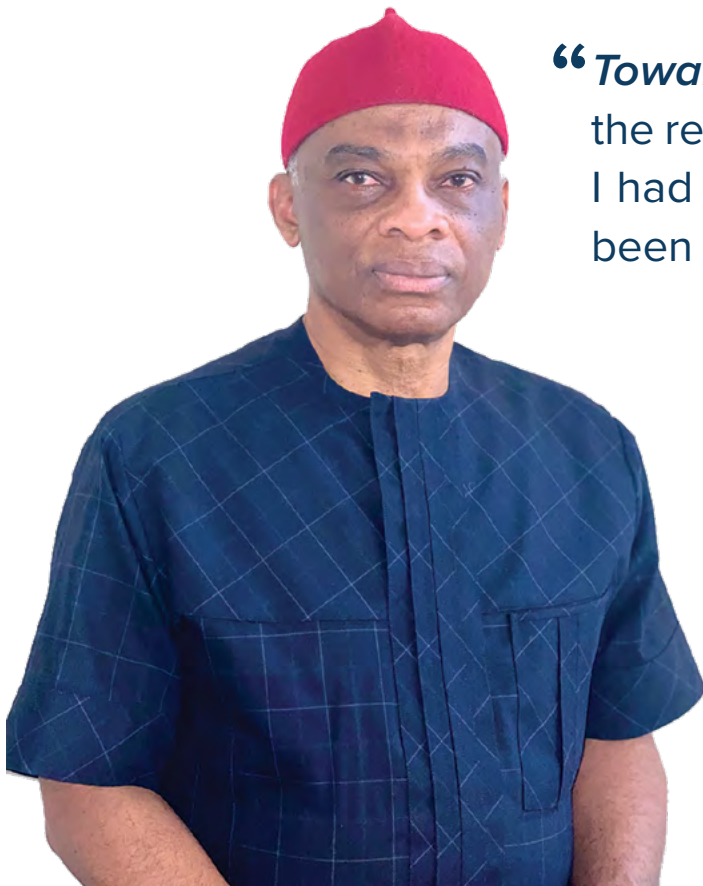
### How have your experiences studying medicine in Nigeria and the UK influenced your practice here in the US?

Basic medical education in Nigeria in my time, was a 5-year program comprising 2 years of basic sciences and 3 years of clinical sciences. Then followed one year of housemanship, a rotating internship which preceded residency training. During the clinical training years, thorough history-taking and physical examination at patient encounters were emphasized. The approach to the patient we learned was very highly socially contextualized. Also, as a rule, medications were referred to by their pharmacological names. Trade names were never used.

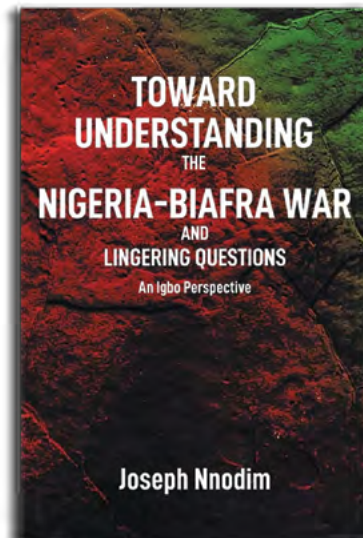
There were three professional examinations, each of which was very grueling. They had an oral component

("viva voce") and involved external examiners usually from UK medical schools, since the vast majority of the faculty received their formation in that country. One of them who made a very formidable impression on me was a neurologist. Before joining the faculty of my medical school, he had practiced in London, with offices on Harley Street. At every opportunity, he would make allusions to Sir Arthur Conan Doyle and encourage us to treat the diagnostic process as an exercise in crime-detection - painstakingly collecting evidence and using it to find "whodunit". My years in the United Kingdom were devoted to bench research and I was steeped in the scientific method during that time. I had the opportunity to attend two meetings every year and at each one, I gave a platform presentation.

Emerging successfully from medical training in the College of Medicine of the University of Lagos



**“*Toward Understanding* was inspired by the realization that a literally seismic event I had lived through in my childhood had been very inadequately documented.”**



gave me very reassuring confidence that the skills I had acquired were of the highest standard. Here in the United States, I have continued to rely on the findings of good history-taking and physical examination as the fundamental elements of sound medical decision-making. My training for patients and their ailments to be considered in their social contexts resonates very much with the growing awareness of the role of social determinants in health and disease. My thought process has remained scientific - the need for valid evidence to underpin a diagnosis or intervention. When, as is sometimes the case, such evidence eludes, the same thought process enables the formulation of a place-holding working hypothesis while the search for evidence continues. To the extent that there is a convention against the use of trade names for medications here in the US, it is rather facultative. I have continued to adhere to my training but I do not demand that others do so.

**What inspired you to write your book, *Toward Understanding the Nigeria-Biafra War and Lingering Questions*?**

As explained in its opening pages, *Toward Understanding* was inspired by the realization that a literally seismic event I had lived through in my childhood had been very inadequately documented. The available accounts were either disingenuously selective or outright false. The colonial experience of the peoples of the lower Niger had culminated in the creation of a state without sufficient consideration of the affinities and disaffinities among the constituents. In under one decade of independence, the experiment went

very badly wrong. After repeated victimization, one group tried to disengage from the union. The rest refused and set upon it in a very brutal war during which a holocaust happened. Through a deliberate policy of weaponized starvation, at least one million Igbo children died. Hardly any mention is made of it. There appears to be a conspiracy of silence predicated on the delusion that the civil war was in the past and should be forgotten. It is not even taught in schools at any level. In *Toward Understanding*, I make the case that the failure to come to terms with the past has seriously undermined the present and will foredoom the future.

**Does your work as a geriatrician overlap at all with your interest in history and writing? How do you make time in your schedule to research and write?**

My work as a geriatrician does indeed overlap with my interest in history and writing. I have always thought that if I hadn't become a medical doctor or scientist, I would have become a historian. The geriatrician or any other medical doctor can relate to the methods of historical analysis. The historian collects evidence about events in the past, evaluates it, and then formulates an explanatory narrative about what exactly took place as well as how and why they happened the way they did. As a geriatrician, I have to collect and deal with a lot of "history" during a patient encounter - history of present illness, past medical and surgical history, family history, socio-functional history. I then use the information, along with findings from physical examination and investigations for medical decision-making, which is the explanatory narrative.

In a typical week, I may have the good fortune of seeing one or two patients who share the names of historical personages and, time permitting, I have taken the opportunity to ask questions and have sometimes been rewarded by incredibly interesting personal stories.

Finding the time to write as well as work full-time as faculty has been very challenging. However, I seem to have a rather unconventional fragmentary writing style which is somehow suited to my circumstances. It involves laying out all the planned chapters of the entire book project, with their headings, at the outset. When the work of my "day job" is done and if any interesting book-related thoughts had occurred to me that day, I would spend an additional half an hour or thereabouts in my study writing them down under the relevant chapter heading/s before going to bed. With *Toward Understanding*, this went on for over one year. Then during my vacations, when I had extended periods of time available, I did bursts of writing. Our librarians at the University of Michigan were very helpful with my research. They were able to obtain for me the numerous titles I needed to consult. I also purchased works, especially biographies, that were still in print.

My work as a geriatrician has exposed me to a segment of the population who, as young adults, lived through a very significant time in history of the US, marked by conflict abroad and profound social change at home. Their experiences intersected in some degree with those of my childhood and some reference is made to them in *Toward Understanding*. Someday, a fuller story will be told—in another book. ♦

What were the most-downloaded geriatrics research updates in 2022? The *Journal of the American Geriatrics Society (JAGS)* has the answer! Check out their list of top research highlights below, and get the full studies by visiting the DOI link.

**1. Periodontal health, cognitive decline, and dementia: A systematic review and meta-analysis of longitudinal studies** (Asher *et al*)

<https://doi.org/10.1111/jgs.17978>

Emerging evidence indicates that poor periodontal health adversely impacts cognition. In this study, researchers reviewed the available longitudinal evidence concerning the effect of poor periodontal health on cognitive decline and dementia by searching literature across five electronic databases for relevant studies published through April 2022. Longitudinal studies having periodontal health as exposure and cognitive decline and/or dementia as outcomes were considered. Researchers concluded that poor periodontal health and tooth loss appear to increase the risk of both cognitive decline and dementia. However, the available evidence is too limited to draw firm conclusions, so further studies involving standardized periodontal and cognitive health assessment are needed to address reverse causality.

**2. Optimism, lifestyle, and longevity in a racially diverse cohort of women** (Koga *et al*)

<http://dx.doi.org/10.1111/jgs.17897>

Many research studies have suggested optimism is associated with healthy aging and exceptional longevity; however, most of these studies focused on non-Hispanic White populations. Researchers in this study examined associations of optimism to longevity across racial and ethnic groups and looked at whether healthy lifestyle is a possible mediating pathway by asking participants to complete a validated measure of optimism. The study concluded that higher optimism was associated with longer lifespan and a greater likelihood of achieving exceptional longevity overall across racial and ethnic groups.

**3. Time to benefit for stroke reduction after blood pressure treatment in older adults: A meta-analysis** (Ho *et al*)

<http://dx.doi.org/10.1111/jgs.17684>

Hypertension treatment in older adults can decrease mortality, cardiovascular events, including heart failure, cognitive impairment, and stroke risk, but also may lead to harms such as syncope and falls. Current guidelines recommend

preventive interventions for immediate harms and delayed benefits to patients whose life expectancy exceeds the intervention's time to benefit (TTB). Researchers for this study evaluated nine trials of participants to estimate a meta-analyzed TTB for stroke prevention after initiation of more intensive hypertension treatment. The results determined that 1.7 years were required to prevent 1 stroke for each 200 persons receiving more intensive hypertension treatment. Despite the heterogeneity across studies, researchers suggested the TTB estimates from individual studies may be more relevant for clinical decision-making.

**4. Associations of sleep timing and time in bed with dementia and cognitive decline among Chinese older adults: A cohort study** (Liu *et al*)

<http://dx.doi.org/10.1111/jgs.18042>

This population-based cohort study using data from 1982 participants aged  $\geq 60$  years set out to determine longitudinal associations of sleep timing and time in bed (TIB) with dementia and cognitive decline in older adults free of dementia and living in rural communities in western Shandong, China. During the mean follow-up of 3.7 years, dementia was diagnosed in 97 participants (68 of whom were diagnosed with Alzheimer disease). Researchers determined that long TIB and early sleep timing are associated with an increased risk of dementia; the associations with greater cognitive decline are evident only among men aged 60–74 years and older.

**5. The ethics of euthanasia in dementia: A qualitative content analysis of case summaries**

(Groenewoud *et al*)

<http://dx.doi.org/10.1111/jgs.17707>

Since the last major study of euthanasia in cases of dementia, 40 new cases have been published, prompting researchers to analyze all 111 Dutch case summaries between 2012 and 2020, selected from the total of 1117 cases published by the Regional Euthanasia Review Committees (RTE). The initial analytical framework consists of six due care criteria and five ethical principles by raising seven reoccurring ethical questions focusing on the cognitive ability of patients to make voluntary requests, determinants of “unbearable



suffering” in the present versus future, and what defines a “reasonable” alternative. Beyond these questions, however, the study highlighted serious challenges for the future, such as narrowing the gap between perceived and real nursing home quality; making efforts to better personalize information to cognitively incompetent patients and their relatives about end of life options since many patients with dementia may not understand all of the euthanasia procedure; and involving patients' own physician as long as possible in a euthanasia request.

## 6. Glycemic treatment deintensification practices in nursing home residents with type 2 diabetes

(Lederle et al)

<http://dx.doi.org/10.1111/jgs.17735>

Although clinical guidelines recommend less aggressive glycemic treatment for frail older adults and nursing home residents, 17% of surveyed VA nursing home (NH) residents met the criteria for overtreatment and an additional 23% met the criteria for potential overtreatment. Only 27% of overtreated and 19% of potentially overtreated residents had their glucose-lowering medications appropriately deintensified, indicating that deintensification is uncommon. The authors concluded that many NH residents who are being overtreated are unlikely to benefit from tight glycemic control and should be considered for treatment deintensification, especially if they receive insulin and other medications that increase their already heightened risk of hypoglycemia even after HbA1c results suggest overtreatment. In addition to hypoglycemia risk, cognitive and functional impairment should be taken into consideration when identifying patients who would benefit most from treatment deintensification.

## 7. Can we improve delirium prevention and treatment in the emergency department?

**A systematic review** (Lee et al)

<http://dx.doi.org/10.1111/jgs.17740>

This study evaluated interventions to prevent or shorten the duration of incident delirium in older adults presenting to the emergency department (ED). Researchers reviewed 10 studies that evaluated interventions for the prevention and/or treatment of delirium and excluded non-ED studies. Only four of the studies demonstrated a significant impact, leading researchers to conclude that few interventions initiated in the ED were found to consistently reduce the incidence or duration of delirium. However, researchers suggested delirium prevention and treatment trials in the ED are still rare and should be prioritized for future research.

## 8. Complexities of care: Common components of models of care in geriatrics

(McNabney et al)

<http://dx.doi.org/10.1111/jgs.17811>

As people age, they are more likely to have an increasing number of medical diagnoses and medications, as well as healthcare providers who care for those conditions. Health professionals caring for older adults understand that medical issues are not the sole factors in the phenomenon of this “care complexity.” Socioeconomic, cognitive, functional, and organizational factors also play a significant role. Care complexity affects family caregivers, providers, and healthcare systems and therefore society at large. The AGS created a work group to identify the most common components of existing healthcare models that address care complexity in older adults. This article, a product of that work group, defines care complexity in older adults, reviews healthcare models and those most common components within them, and identifies potential gaps that require attention to reduce the burden of care complexity in older adults.

## 9. Delirium after COVID-19 vaccination in nursing home residents: A case series

(Mak et al)

<http://dx.doi.org/10.1111/jgs.17814>

Older adults in nursing homes (NH) are particularly vulnerable to severe illness and death due to COVID-19 infection. This case series found that vaccination is associated with reduced risk of infection, and vaccinated individuals who develop COVID-19 infection are less likely to experience severe symptoms or death. The rate of adverse events after vaccination has been minimal to none. However, there have been reports of delirium in older adults after COVID-19 vaccination. Researchers in this case series describe the frequency of delirium and its severity among NH residents after COVID-19 vaccination.

## 10. Should we still believe in advance care planning?

(Alexander K. Smith MD, MS, MPH)

<http://dx.doi.org/10.1111/jgs.17727>

This article features editorial comments on a previous study by Lee and colleagues, which found that older adults with a higher perceived risk of dementia are more likely to have engaged in advance care planning than those with no perceived risk. The author argues for advance care planning to be treated as a process rather than a one-time event, despite the limitations of advance directives outlined in the original study. ♦

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## AGS MENTORSHIP CREATING CONNECTIONS AT #AGS23 AND BEYOND



The abundant learning, collaborating, and networking that occurs at the AGS Annual Scientific Meeting remain a meeting highlight for attendees year after year—and #AGS23 will be no different! Whether you plan to attend #AGS23 in person or remotely, be sure to set aside ample time for networking and mentorship.

AGS is proud to offer two fantastic programs to serve your mentorship needs: the in-person mentorship program at #AGS23 and a longitudinal mentorship that takes place virtually.

### The In-Person Mentorship Program at #AGS23

A long-time annual meeting favorite, the AGS Annual Meeting Mentor Program is facilitated by the AGS Junior Faculty Special Interest Group, which organizes the matching of mentors and mentees based on the profile information participants submit.

“The results are always incredible,” said Greg Oullette, MD, who has spearheaded the matching process for in-person meetings. “We have stories of folks who met through this program years ago, who remain in touch and look forward to meeting up again at AGS each year.”

After the SIG completes mentor and mentee matches, participants are sent their match results via e-mail ahead of the meeting. Mentees, who are primarily responsible for managing the relationship, are given their mentors’ contact information and encouraged to reach out to their matched mentor and plan a time to get together during the conference.

Dr. Oullette gave us some insider advice for mentees: “Don’t spend precious time asking them things you can Google. Dive deeper into the conversation, so that the experiences they share with you can help you apply solutions to your own experiences.”

To participate in the #AGS23 mentorship program, register for the annual meeting at Meeting.AmericanGeriatrics.org. Be sure to check off your interest in the program during your registration, and then keep an eye on your email for next steps.

### Mentorship Anytime, Anywhere: Join Virtual Mentor Match

In 2021, AGS rolled out the virtual Mentor Match program that was built into MyAGSONline, our exclusive digital membership community. Match participants have the opportunity to develop connections based on their

specific needs, whether that’s a long-term or situational mentoring relationship across disciplines and career stages.

Mentors and mentees can sign up for the program via a simple, 2-step process: add a picture and short bio to your profile, and then fill out an enrollment form to define the type of mentorship desired.

After submitting this information, mentees search the Mentor Directory for individual profiles to learn about and request a mentor, who then can accept or decline the mentorship. Both Mentors and Mentees can sign up here: <https://myagsonline.americangeriatrics.org/mentorship/inpersonmentorshipprogram>

To participate in the virtual AGS Mentor Match, visit [MyAGSONline.AmericanGeriatrics.org/Mentorship](https://myagsonline.americangeriatrics.org/Mentorship). Be sure you are logged into your membership account, and then follow the instructions at the top of the webpage to enroll.



# WE NEED YOU! BECOME AN AGS/AGING LEARNING COLLABORATIVE CHAMPION AND SPREAD THE WORD ABOUT MULTIPLE CHRONIC CONDITIONS (MCC) RESEARCH

The AGS/AGING LEARNING Collaborative is in full swing as the first domains of the Multiple Chronic Conditions (MCC) Research Core Curriculum were launched in January 2023. As we continue to release new domains and resources on the site, we are also turning our attention outwards to disseminating the MCC Curriculum and encouraging its use. We are thrilled to announce the first MCC Research Champion workshop is being held at the 2023 AGS Annual Scientific Meeting on Friday, May 5 from 7:00–8:30 am. This workshop will provide a broad overview of the curriculum resources and the importance of being a Champion. Participants will work together to discuss potential strategies to disseminate the curriculum, teach about people living with MCC and better prepare the next generation of investigators.

The AGS/AGING LEARNING Collaborative is also developing resources and tools specifically to help MCC Research Champions leverage their unique knowledge, skills and enthusiasm to encourage research that is inclusive of people living with MCCs, ultimately realizing the goal of translating these principles into the delivery of higher quality health care across the lifespan. Champions will be equipped with the Champion Facilitator Guide containing tips and tools on how to teach to the curriculum and promote the importance of inclusion of people living with MCCs in research.

MCC Champions are encouraged to report their outreach efforts, so that we can track dissemination and spread of the program. Champions who successfully report activity throughout the year will earn an MCC Champion Badge and earn the MCC Champion title that they can then include on their academic CVs.

Mid to senior level faculty and investigators who want to hear more about the MCC curriculum and process of becoming a Champion are encouraged to [register for the AGS Annual Meeting and attend the MCC Research Champion Workshop](#). There is no cost to attend the workshop and breakfast will be provided.

Remember, the AGS/AGING LEARNING Collaborative website at <https://mccresearch.agscocare.org> contains a variety of resources to help support clinical and translational research on the prevention and management of MCCs across the lifespan. Register today for a free subscription and access to all of the Collaborative resources including self-directed Online Educational Modules, teaching slides, webinars, podcasts, the online community, and the AGS Mentoring Program. As mentioned above, new resources are added regularly to the site. ♦



AGS CoCare is a suite of programs helping embed geriatrics expertise in broader care for older adults. Our programs provide institutions with a variety of resources to help support the implementation of its specific program model, through access to our tools, resources, training and technical assistance.



**AGS CoCare®: Ortho** is a Geriatrics-Orthopedics Co-Management model in which geriatrics professionals, or specially trained geriatrics co-managers work with orthopedic surgeons to coordinate and improve the perioperative care of older adults with hip fractures.

VISIT US AT [ORTHO.AGSCOCARE.ORG](https://ortho.agscocare.org)



**AGS CoCare®: HELP**, formerly known as the Hospital Elder Life Program, is a well-studied, effective and innovative model of hospital care designed to prevent both delirium and functional decline.

VISIT US AT [HELP.AGSCOCARE.ORG](https://help.agscocare.org)



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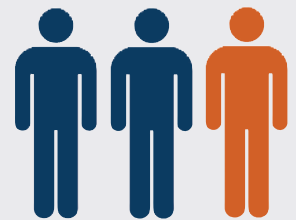


## Tips for Preventing Serious Falls

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

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

### Did you know?



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

### Tell your healthcare provider if you have had a fall

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

### Review your medications

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



## Make a falls prevention plan with your healthcare provider

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

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

## Exercise to prevent falls

**Exercise has been shown to decrease falls.** Healthcare professionals recommend that older adults exercise at least three times a week. Find an exercise that you enjoy that promotes strength and balance - such as walking or a group Tai Chi class. If you prefer to exercise indoors, chair stands (repeated rising from a chair without using your arms) can be done alone and are beneficial.

## Make your home safe from falls

- Keep cords away from areas where you walk
- Remove loose carpets and rugs or tack down the carpets and only use rugs with nonskid backing
- Add lights in dimly lit areas and at the top and bottom of stairs
- Use nightlights in bedrooms, halls, and bathrooms
- Clean up clutter, especially near staircases
- Put hand rails on both sides of any steps or stairs in or outside of your home
- Add "grab bars" near the toilet and bath tub, and no-slip decals or a rubber mat in the tub or shower
- Wear firm shoes with a back and a good grip on the bottom
- Avoid loose slippers or socks

## What to Do if You Fall

### Get Immediate Medical Attention

Even if you do not have an obvious injury, if you have any loss of consciousness or any sign of confusion after falling, seek immediate medical attention.

### Notify Your Primary Healthcare Provider

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



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