In September 2004, the Donald W. Reynolds Foundation awarded four grants totaling $12 million to train academic health centers’ faculty in geriatrics, thus creating the Consortium for Faculty Development to Advance Geriatrics Education (FD-AGE). The Consortium membership includes Duke, Johns Hopkins, UCLA, and Mount Sinai. Over the last nine and a half years, each member school has used unique strategies to further the consortium’s common goal of developing clinician-educator faculty in geriatrics at academic medical centers in the US. The Duke Program’s PI is Harvey Jay Cohen, MD and its Project Director is Mitchell T. Heflin, MD. Sandro Pinheiro, PhD is the Education Director. Dr. Heflin led the publication of consortium results in a paper published in Academic Medicine in 2012.(1)

A major part of our program at Duke has focused on fostering the talents of our own faculty and fellows as clinician-educators. As detailed in an article in JAGS in 2008, Sandro Pinheiro, Ph.D. has led the Geriatrics Excellence in Teaching Series (GETS), which offers fellows and faculty from all disciplines practical instruction in teaching and education program design.(2) We are very proud of the work of Heidi White, MD and Gwendolen Buhr, MD in developing curricula in long term care for medical students, residents and fellows.(3) Katja Elbert-Avila, MD, with the help of Tony Galanos, MD, Toni Cutson, MD, James Tulsky, MD, Lynn O’Neill, MD and Jennifer Gentry, GNP, has spearheaded the development of a series of retreats on topics in Palliative care for fellows and faculty. The program has also provided funding for development of a Clinician-Educator Track for advanced

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Today I find myself immersed in a very exciting time in the field of geriatrics. In the era of Obamacare and ongoing health care transformations, a new spotlight is shining on the field of geriatrics. It is making the future of geriatrics in academic teaching centers and in community hospitals appear very bright. The number of hospitalized patients over the age of 65 is expected to grow in the coming years. Currently, more than 3,400 (per 10,000 population) of adults 65 years and older are discharged annually from nonfederal U.S. hospitals, and account for almost 44% of the national hospital bill. Their hospital stays account for almost 50% of the acute care bed days, and signals the growing presence of hospitalized older adults in the U.S. Due to ongoing national policy changes to provider payment, such as quality mandates, readmission penalties, and bundled payments, hospitals and health systems are turning to the geriatrics subspecialty to assist them with the increasing responsibility for providing high quality care to hospitalized older adults. As a result, the opportunities for geriatricians to impact the hospital care of older adults has suddenly grown! As an aspiring geriatrics hospitalist, I find the future to be very bright. However, a lot of work still needs to be done to continue improving the care of hospitalized older adults and to meet the responsibility of providing high quality care.

The Duke Division of Geriatrics has enthusiastically taken on these new responsibilities and has already launched several care model redesign initiatives within Duke Hospital to address some of the main challenges impacting the care of older adults. These care initiatives also represent innovative solutions in the clinical areas of peri-operative care and post-discharge care, and they are the following: 1) The Duke Peri-operative Optimization of Senior Health (POSH), which is a collaborative, multidisciplinary peri-operative care model to improve outcomes for older adults undergoing elective abdominal surgeries through targeted outpatient and inpatient peri-operative interventions; and 2) The Duke Health Optimization Program for Elders (HOPE), which is a multidisciplinary clinical demonstration project aimed at improving safe care transitions from hospital to skilled rehabilitation centers. Each of these care models are built on the “quality platform”, and are meant to enhance and revitalize quality care of hospitalized older adults while meeting national health care demands and quality metrics. Furthermore, the Duke Health System has actively engaged the Geriatrics Division to collaborate and lead health system and population based care changes in relation to new Medicare Healthcare Savings Plans and population based Accountable Care Organization care models. My involvement in these clinical initiatives has given me the practical experience that I need to expand my knowledge of local and national health care transformation agendas.

For me personally, the national healthcare transformation agendas and the local hospital initiatives have created the perfect arena for me to develop as a geriatric hospitalist researcher. In the same way that quality gaps have been identified in the clinical care of hospitalized older adults, there are also research gaps that exist. There is priority in expanding our knowledge in several areas of care of the hospitalized older adult, including high risk medication use in the inpatient setting, and deterioration of function during hospital stays. To that end, I have worked closely alongside my research mentor, Susan Hastings, MD, MHS (Associate Professor of Medicine in the Division of Geriatrics at the Duke University School of Medicine and Senior Fellow in the Duke Center for the Study of Aging and Human Development; Research Health Science Specialist in the HSR&D Center of Excellence, and Core Investigator in the Geriatrics Research Education and Clinical Center (GRECC) at the Durham VA Medical Center) to complete a project on the association between inpatient medication exposure and readmission

**FEATURED RESEARCHER:** Juliessa Pavon, MD – Medical Instructor, Geriatrics; Senior Fellow in the Duke Center for the Study of Aging and Human Development*

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EDITORIAL
Give The ACA A Chance*

By Erdman Palmore, PhD

The Affordable Care Act (ACA, often called “Obamacare”) has become a hot partisan issue and many seniors fear that it may hurt Medicare. They may be reassured that the law specifically protects guaranteed benefits: “Nothing in this act shall result in a reduction of guaranteed benefits” under Medicare.

Even the problems with the ACA website won’t affect Medicare users, because they will continue to use medicare.gov as their electronic portal. Furthermore, the ACA adds new benefits to Medicare at no extra cost to the beneficiaries. These new benefits include:

• An annual wellness visit to their physician
• Preventive screenings such as for diabetes and cancer
• Closing of the “doughnut hole” in the Part D prescription drug coverage.

But critics say that the hundreds of millions of dollars in reduced Medicare spending will make fewer doctors and hospitals available for seniors. At this point there is little evidence as to whether the ACA will result in net gains or losses for seniors.

Here are the facts about the financing of the ACA. The Congressional Budget Office estimated that Medicare spending will be reduced by $716 billion over 10 years. This will result mainly from reductions in the annual increases in Medicare reimbursement for Medicare Advantage, hospital costs, home health services, hospices, and skilled nursing services. Hospitals will have to absorb most of the reductions—about $200 billion. Medicare Advantage will be reduced by about $156 billion; home health will be reduced by $66 billion; skilled nursing services by $39 billion; and hospice by $17 billion.

Supporters of the ACA say that these reductions are necessary to assure the future financial health of Medicare Part A, the hospital insurance program. They also say that hospitals can offset reductions in payments by improving the quality and efficiency of their care. The law rewards hospitals that reduce their rate of hospital-acquired conditions, such as bedsores, and that improve the quality of their follow-up care to reduce readmissions.

Only time will tell whether the supporters or critics of the ACA are right. In the meantime, let’s do what we can to give it a chance.

* The opinions expressed are those of the author and do not necessarily reflect the policies of the Center on Aging. Some of this editorial is based on an article by Marsha Mercer, “Is Your Medicare Safe?” in the AARP Bulletin of January-February, 2014.

Whitfield Publishes Book on Minority Aging

Keith Whitfield, PhD, and Tamara Baker, PhD, have just published a book titled, Handbook of Minority Aging (NY: Springer Publishing Company). Whitfield is Professor of Psychology and Neuroscience as well as a Senior Fellow at our Center on Aging.
fellows, which to date has graduated twelve outstanding geriatrics educators, including our own Mamata Yanamadala, MD, Loren Wilkerson, MD, and Shelley McDonald, DO, PhD who will start on faculty in July 2014.

Another portion of the program focuses on faculty development in clinical education for physician faculty from other US academic medical centers through weeklong mini-fellowships here at Duke. Since 2004, we have hosted 35 mini-fellowship programs benefiting a total of over 220 visiting faculty scholars from other institutions around the US. These programs over the years have focused on education and curriculum design in the areas of Undergraduate Medical Education, Evidence-based Medicine in Geriatrics, Long-Term Care, Palliative Care, Geriatrics in the Medical Subspecialties, and Graduate Medical Education. Each program typically offers the visiting scholars a 5-day, 4-night experience during which they receive individual mentoring, guidance on curriculum development, and the opportunity to observe curriculum events here at Duke. Scholars return home to implement their project plans with an option to have Duke faculty visit their institution for a follow-up Education Consultation Visit. Reynolds faculty teams also offer consultation visits to the home institutions of participating scholars. Visits include faculty development sessions, lectures on geriatrics and meetings with key stakeholders. Over the course of the grant, geriatrics faculty have visited 16 different institutions, providing follow-up support for a total of 26 faculty scholars.

In 2011, the program was renewed to continue to provide faculty development programs and to enhance its offerings to particularly promising young educators through a longitudinal scholars program. Through the program, selected minifellowship participants receive ongoing mentoring from Duke faculty, attend the annual Reynolds All-grantees meeting in the fall of the year and attend a new minifellowship on Leadership and Scholarship, which focuses on enhancing leadership skills, project administration and production of scholarship. We have enrolled a total of four longitudinal scholars to date from North Carolina, Texas, and Ohio.

We are very proud of the program’s success and are deeply indebted to Michele Burgess, the program coordinator, who provides expert organizational guidance for the entire program.

References:


**FACTS ON AGING**

What Are Actinic Keratoses?*

My Mother often told me that “Lots of sunshine is good for you.” And she encouraged me to stay in the sun for hours (resulting in a lot of sunburn). As a result, I have a lot of actinic keratosis. These are the “sun spots” or lesions on the skin caused by over-exposure to ultra-violet rays. These lesions tend to harden and peel and then harden again. They are considered pre-cancerous because they may develop into skin cancers.

So my Mother’s views on sunshine are being replaced by warnings of the dangers of over-exposure to sunlight, especially for light-skinned people.

Actinic keratosis can be removed in various ways, such as surgery or medications that remove a layer of skin. But prevention by using sun blockers or covering up is “worth a pound of cure.”

However, a “moderate” amount of sunshine may be beneficial by creating Vitamin D in the skin. The problem for light-skinned people (including blondes and red-heads) is that any exposure over a half-hour or so may cause these keratoses. Furthermore, if you already have them, even a few minutes of exposure to the sun is likely to make them worse. It is probably safer to get your Vitamin D from enriched milk and/or pills.

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* Adapted from Palmore, Older Can Be Bolder (Amazon, 2011).
Brain imaging using radioactive dye can detect early evidence of Alzheimer’s disease that may predict future cognitive decline among adults with mild or no cognitive impairment, according to a 36-month follow-up study led by Duke Medicine.

“Our research found that healthy adults and those with mild memory loss who have a positive scan for these plaques have a much faster rate of decline on memory, language and reasoning over three years,” said lead author P. Murali Doraiswamy, M.D., Senior Fellow at the Center on the Study of Aging, Professor of Psychiatry, and Director of the Neurocognitive Disorders Program at Duke.

The current study, which enrolled 152 adults ages 50 and older, was designed to assess whether silent pathological changes in the brain associated with Alzheimer’s and detected with positron emission tomography (PET) can predict cognitive decline. Of the participants, 69 had normal cognitive function at the start of the study, 52 had been recently diagnosed with mild cognitive impairment, and 31 were diagnosed with Alzheimer’s disease.

Subjects completed cognitive tests and underwent PET scans of their brains. This type of imaging uses a radioactive tracer to look for chemical signs of disease in specific tissues.

The radioactive dye used, florbetapir (Amyvid), was approved by the U.S. Food and Drug Administration in 2012 for PET imaging of the brain to estimate beta-amyloid plaque density in patients being evaluated for cognitive impairment. It binds to the beta-amyloid plaques that characterize Alzheimer’s disease, helping to measure the extent to which plaques have formed in different brain regions. Using this information, the researchers rated the PET scans as positive or negative.

After 36 months, the researchers repeated the same cognitive exams to reassess participants. They found that those with mild or no cognitive impairment who had evidence of plaques at the trial’s start worsened to a greater degree on cognitive tests than those with negative scans.

Thirty-five percent of plaque-positive participants who started with mild cognitive impairment progressed to Alzheimer’s, compared to 10 percent without plaque. In addition, plaque-positive participants with mild impairment were more than twice as likely to be started on cognitive-enhancing medication than those without plaque.

Conversely, those with negative scans experienced much less decline: 90 percent of participants with mild cognitive impairment but no plaque did not progress to Alzheimer’s. This finding supports the negative predictive value of using PET imaging to identify patients unlikely to decline, which has important implications for both clinical research and treatment.

“Having a negative scan could reassure people that they are not likely to be at risk for progression in the near future,” Doraiswamy said.

Doraiswamy cautioned that florbetapir is currently not approved to predict the development of dementia and is not used as a screening tool in cognitively normal people. Future longitudinal studies are needed to further clarify the prognostic role of beta-amyloid plaque PET imaging in a clinical setting.

“Even though our study suggests the test has predictive value in normal adults, we still need additional evidence,” Doraiswamy said. “We need longer-term studies to look at the consequences of silent brain plaque build-up, given that it affects 15 to 30 percent of normal older people.”

Doraiswamy added that the findings provide support for planned and ongoing multicenter clinical trials of asymptomatic older adults with plaque-positive scans. The research also has implications for other conditions where amyloid might play a role, such as traumatic brain injury (from sports or combat).
risk in hospitalized elders using health system data. In addition, I am currently working with Dr. Hastings on conducting an evaluation of an inpatient walking program for hospitalized older adults and examining the relationships between inpatient functional status (as measured by gait speed, 2 minute walk distance, and grip strength) and readmission. The purpose of these studies is to identify novel ways for leveraging our health system data to identify high risk individuals at risk for readmission, which is a costly outcome, and reducing readmissions is a current national health care priority.

My overall career goal is to promote the quality care of hospitalized older adults through innovative research that leads to better treatment, reduced risk, and reduced cost to older adults. Therefore, I am currently proposing a research study that focuses on improving the quality and safety of anticoagulant use in medically ill hospitalized older adults, and understanding the role of inpatient mobility in the prescribing of anticoagulants to older adults. This study will combine the use of health system data and the innovative use of accelerometers to measure inpatient mobility. In support of this proposal, I was recently awarded the 2014 Department of Medicine Chair’s Research Award.

The integration of geriatrics and hospital medicine at the clinical, educational, and investigational level at Duke University represents significant steps in taking on challenges in the care of hospitalized older adults, and has tremendous potential for improving geriatric care both in local and national hospital settings. With this health care transformation spotlight shining ever brightly on geriatrics, significant opportunities remain for collaboration, care coordination, and research to improve the care quality of hospitalized older adults. Indeed, this is an exciting time!

**FEATURED RESEARCHER: Juliessa Pavon, MD, continued**

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**Blazer Honored**

Dan Blazer MD, PhD, JP Gibbons Professor of Psychiatry and Behavioral Sciences was awarded the Distinguished Service Award from the American College of Psychiatrists in February, 2014. He also chairs an ongoing “Committee on the Public Health Dimensions of Cognitive Aging” at the Institute of Medicine, a report forthcoming in 2015.

**Matchar Honored**

In January, 2014, Bobbi Matchar of the Duke Family Support Program was presented with the Durham-Chapel Hill Jewish Family Services (JFS) Volunteer of the Year Award. As an active professional volunteer, Matchar has served on the JFS Advisory Board for six years. In 2012, she helped pioneer the first of what is now five completed eight-week education and support group programs for individuals with early stage dementias and their care partners. The eight-week groups meet at the Levin Jewish Community Center in Durham. This successful collaboration involves the Alzheimer’s Association, JFS, Duke Memory Disorders Clinic and the Duke Family Support Program. The original 2012 program was intended to address a largely unmet community need and it has spawned over 50 “veterans” and a growing early stage Alzheimer’s NC community. This new community has expanded ongoing options for education, social engagement and support, including Duke’s Nasher Museum gatherings.


July 08-10: Geriatrics-2014 International Conference. Chicago North Shore, IL. Contact: geriatrics-2014@omicsonline.net.