

WORKSHOP REPORT

Closing the Knowledge Gap: Toward the Creation of a Health Education Model for Professionals



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*An Affiliate of
Mount Sinai School
of Medicine*

*An Interdisciplinary Consensus Conference of the
International Longevity Center - USA
Thursday April 16th 2009*

With support from Pfizer, Inc.

Acknowledgements

The International Longevity Center-USA gratefully acknowledges Pfizer Inc. for sponsoring the consensus conference upon which this report is based. Dr. Everette Dennis at the ILC-USA served as moderator for the conference and was involved with the writing of the report. The project was managed by Heather Sutton, the ILC's director of development and corporate relations. James Nyberg served as rapporteur and drafted this action-oriented report. Finally, our gratitude to the panelists who generously brought their considerable knowledge and judgment to bear on this report.

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Health Education Model
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Workshop Participants

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Rapporteur: James Nyberg

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Preface

Sharing information is a hallmark of the digital era, a time when interactivity and social networking allows for easy access to information of all kinds, but it requires dedication and effort. That said, the flow of knowledge in medicine and other health fields often doesn't travel very far. Information published in peer reviewed journals may attract media attention with provocative or controversial findings, but that doesn't guarantee that this knowledge or the best practices of one discipline or field will be widely adopted by others with like minded interests. Certainly this is true in gerontology and geriatrics where the flow of new knowledge sometimes lurks behind disciplinary and professional barriers or is simply cut short by time and motivation.

For that reason, the International Longevity Center with the support of Pfizer, Inc. organized a Knowledge Gap Project in 2008 and 2009 to address this problem and find solutions. Through background research and a scientific consensus conference, reported here, we have engaged 10 experts from several fields to share their knowledge-transfer experience with us so that we could begin to pursue their important questions and circumstances that affect the transfer and dissemination of health care information for older people.

The conference yielded many important proposals, some involving policy, some more focused on practical applications. One that struck me as exceptional and powerful was the suggestion that the Center for

Medicare and Medicaid Services (CMS), the primary payer for health care and long term care, play a more active role in promoting an integrated approach to care—from shared knowledge across the various disciplines to better linkage between graduate education in medicine, nursing, social work and other fields. No organization is better poised for leadership in closing the knowledge gap.

We are indebted to several individuals at Pfizer, Inc. for being part of this effort and supporting its funding, allowing us complete independence in the process. Thanks to Joseph Feczko, M.D., Pfizer's chief medical officer and a member of our ILC Board of Directors and Jack Watters, M.D. who first believed in and championed this project.

Also our gratitude to Michael Hodin, Ph.D., also of Pfizer, whose longstanding interest in the ILC and its work is much appreciated. My thanks too to all those who took part in this project and especially to Everette E. Dennis, Ph.D, who conceived the project and chaired the conference, to Heather Sutton, MBA, of the ILC staff who managed this effort and to James Nyberg of the Rhode Island Association of Facilities and Services for the Aging (RIAFSA) who served as our rapporteur and authored this report.

Robert N. Butler, M.D
President and CEO
International Longevity Center

Overview

For decades, health care professionals who specialize in the care and treatment of older persons have generated knowledge both through clinical experience and in systematic research. Recognizing that the medical and health needs of older persons are different from those of other generations, notably the young and middle aged, these professionals draw on that knowledge to do their work serving their patients and clients. Concurrently generalists and other professionals are also engaged with persons from all age cohorts and are also accumulating and using new knowledge, based on experience and research as well.

Although there are academic and professional meetings as well as journals where knowledge is disseminated and shared, just how much geriatric-specific information goes to physicians, nurses, social workers and other health professionals not specifically trained in geriatrics and gerontology is not known. What research there is, as well as considerable impressionistic evidence, suggests that these busy healthcare professionals and workers

don't share much. There may be many reasons for this—sheer time itself, status issues and perceptions of professional hierarchies, lack of easy access to the requisite information and knowledge—and other barriers, real or perceived.

At the same time, there is mounting evidence of mutual respect between and among these persons, bound together by a common concern for the health status of older persons, which is not necessarily on the agenda of everyone who works in the health care field. Interdisciplinary and multidisciplinary approaches in education are now more in vogue, so the climate for such interaction, learning, and knowledge sharing is perhaps improving, especially (and ironically) among younger professionals, who have more open and fluid attitudes in a non-hierarchical world where social networks of all kinds are valued and appreciated.

Everette E. Dennis

*Executive Director and COO,
International Longevity Center -USA*

Introduction

4 The lack of education and training in geriatrics for all health care providers has been an issue of great concern to the ILC. There is a well-documented shortage of academic geriatricians and related faculty in the nursing and social work fields, as well as practitioners who specialize in the unique needs of older people. Various reports, including the recent Institute of Medicine (IOM) report “Retooling for an Aging America: Building the Health Care Workforce” in 2008, highlighted how almost all health care providers treat older individuals at some point in their career, yet they lack the skills necessary to effectively care for older people. Moreover, as the field of geriatrics gains new knowledge and standards of practice through the work of its geriatric physicians, nurses, and social workers, the disconnect between those who possess such specialized information and those who provide the majority of care to older individuals grows.

In order to highlight and address this disconnect, the ILC hosted a consensus conference on “Closing the Knowledge Gap – Creating a Health Education Model for Professionals,” which brought together experts from various fields and disciplines to assess

the state of knowledge about the specific medical and health needs of older people, and discuss how to address the gap between the trained geriatric experts who possess such knowledge and those health care workers who routinely care for older individuals. Partial funding for the conference was generously provided by Pfizer, Inc.

As a solutions-oriented research and education center, the ILC was committed to avoid convening a ‘banquet of complaints,’ during which experts lament that front line workers “don’t know what we know.” Rather, the conference reviewed the reasons for the current disconnect in knowledge and practice, and spent the majority of the time exploring solutions that could bridge the knowledge gap and ensure that all health care workers, from primary care physicians to nurses aides, are better prepared to provide quality and effective care to older people. This report distills the thoughts, perspectives, and suggestions of the participants on a wide range of issues – clinical, policy, and social – and lays out a series of recommendations that outline how to close the knowledge gap on healthy aging.

FIGURE 1: GERIATRICS KNOWLEDGETRANSFER: *WHAT AMERICA NEEDS TO DO*



Innovation and Education in Geriatrics

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The field of geriatrics has grown remarkably in the last few decades. Much has been learned about the unique health-related issues and needs in the older individual, as well as effective treatments for numerous conditions. This is largely the work of expert geriatricians and gerontologists who have conducted the research and education necessary to advance the field. Although still limited in number, there are now full-fledged departments of geriatrics scattered throughout the United States. Foundations such as the John A. Hartford Foundation, the Donald W. Reynolds Foundation, the Brookdale Foundation, and Atlantic Philanthropies have made significant investments in the field, promoting geriatrics in medical schools, nursing programs, and schools of social work.

This relatively specialized information on how to better care for older people and promote healthy aging needs to be transmitted to the wider health care community and beyond. An important development in the field, noted at the outset of the workshop, has been the recent efforts to create a set of geriatric competencies for health care providers – basic knowledge and skills that need to be possessed and can be taught in an interdisciplinary way. These competencies are an effective tool to disseminate the progress that has been made in geriatrics and gerontology, and the ongoing work in this area is critical to promoting interest and knowledge in the field. An example of Minimum Geriatric Competencies is in Figure 2.

**FIGURE 2:
SAMPLE OF MINIMUM GERIATRIC COMPETENCIES**

Medication Management

- Explain the impact of age-related changes on drug selection and dose based on knowledge of age-related changes in renal and hepatic function, body composition, and Central Nervous System sensitivity.

Cognitive and Behavioral Disorders

- Compare and contrast among the clinical presentations of delirium, dementia, and depression.

Self Care Capacity

- Develop a preliminary management plan for patients presenting with functional deficits, including adaptive interventions and involvement of interdisciplinary team members from appropriate disciplines, such as social work, nursing, rehabilitation, nutrition, and pharmacy.

Falls, Balance, Gait Disorders

- Ask all patients >65 y.o., or their caregivers, about falls in the last year, watch the patient rise from a chair and walk (or transfer), then record and interpret the findings.

Health Care Planning and Promotion (HCP)

- Accurately identify clinical situations where life expectancy, functional status, patient preference or goals of care should override standard recommendations for screening tests in older adults.

Palliative Care

- Present palliative care (including hospice) as a positive, active treatment option for a patient with advanced disease.

Hospital Care for Elders

- Identify potential hazards of hospitalization for all older patients (including immobility, delirium, medication side effects, malnutrition, pressure ulcers, procedures, peri and post operative periods, transient urinary incontinence, and hospital acquired infections) and identify potential prevention strategies.

Available at the Portal of On-Line Geriatric Education
www.pogoe.org/node/697

Published: Leipzig RM, Granville L, Simpson D, Brownell Anderson M, Sauvigne K, Soriano RP. Keeping granny safe on July 1: consensus on minimum geriatric competencies for graduating medical students. *Acad Med.* 2009;84:604–610

Barriers to Bridging the Knowledge Gap

The participants noted that the progress being made in geriatrics reinforces the need to effectively convey such knowledge to students, as well as those individuals working in the field. It was noted that the need to teach these students is huge, and there are efforts to teach them well, but there is a great deal of competition in terms of curriculum, resources, and time. Many students are more interested in children, or in the case of social work in particular, interested in social development issues. Aging issues often get subsumed under other categories. In addition, the current curriculum at many schools is jam-packed, with no time to add additional training topics, such as geriatrics. Lastly, given the low numbers of individuals who pursue the field, many schools have difficulty in justifying the investment in a geriatrics program, which then perpetuates the lack of training.

On a related note, the army of health care workers called personal care assistants, nurses aides, or certified nursing assistants (CNAs) who work most intensively with older people, are undertrained in general, and certainly undertrained in geriatric knowledge and skills. The curricula for training these individuals varies greatly state-by-state as there are no established national standards for such training. An example of the lack of focus on geriatrics can be found in a recent review of caregiver curricula by the ILC, which found little to no mention of why and how older people may react differently to prescription drugs nor how to identify possible side-effects and other harmful interactions in this population. This is despite the

fact that older people consume 40% of all medications and take four, five, or more medications at any given time. Moreover, these workers are often overlooked in terms of communicating geriatric knowledge from nurse supervisors and other health care professionals.

Underlying societal attitudes towards aging and older people, which can be ambivalent at best and ageist at worst, are also an impediment. This can deter physicians, nurses, and social workers from pursuing a career in the field. It certainly has stymied the development of academic geriatrics, which has been extensively noted. Geriatrics and the care of older people is simply not seen as interesting or effective, which those with experience in the field know is certainly not the case.

FIGURE 3: ATTITUDES TOWARD GERIATRICS

Medical students are frequently given the message through their mentors that medical care of geriatric patients is futile and that their prognoses are depressing. Stereotypes, fears and irrational prejudices about the aging process can harm the very people physicians are trying to help.

- Physicians are often negative toward their frail older patients and dismissive of their symptoms.
- Physicians may reinforce the misconceptions that age-related diseases such as arthritis, confusion, sexual dysfunction and incontinence are inevitable.
- Physicians frequently discriminate against people because they are old in ways that are similar to racism and sexism.
- Older people are generally categorized as senile, depressing, and hopeless. Epithets such as “crock” and “vegetable” are common and acceptable.

Barriers between types of health care providers is another impediment. For example, a team-based approach to geriatric care is acknowledged to be an effective way to share knowledge and develop effective interventions, but such interventions are limited by both practice boundaries (e.g. “I do this, you do that”) and by payment systems. Indeed, health care payment systems, with Medicare being the obvious example, pay according to the service being provided, which limits collaboration and cooperation.

Indeed, the discussion highlighted Medicare, which provides health insurance for the older population, as a missed opportunity. As a payer of health care, it does little to promote effective and coordinated geriatric care. As one conference participant noted, “there is Medicare A, B, C, and D. But D does not care what B does and vice versa.” Moreover, even though it is the primary payer of graduate medical education for physicians, it does little to promote education and training in geriatrics.

Moreover, practicing physicians and other health care providers often do not have the time given the size of their patient loads to effectively treat frail older individuals. A participant observed in less than an eight-minute office visit precludes effective geriatric care, which in turn reduces the perceived need for such knowledge.

Approaches to Bridge the Knowledge Gap

One participant noted that there are two types of health care workers that go into geriatrics: those that receive specific training in the field to become geriatric providers and/or researchers, and those who, by simple virtue of health care demographics, provide a great deal of care to older patients. This latter group, which comprises the vast majority, does not receive any formal training in geriatrics. Given the growing number of old people coupled with ongoing increases in life expectancy, an effective way to transmit knowledge and best practices to these various health care professionals is critical and was the focus of discussions on bridging the knowledge gap.

The participants discussed a number of ideas and approaches to bridging the knowledge gap. The recommendations fall into three broad areas: Clinical; Policy; and Social.

CLINICAL APPROACHES

One initial area of agreement was to establish a set of core competencies that all health care providers should have in geriatrics. A prominent example of this effort is the Partnership for Health in Aging, which is a loose coalition of health care organizations focused on developing core geriatrics competencies. Given the lack of time that health care providers have, these competencies, with a focus on the critical knowledge about conditions as well as preventive measures and interventions, will be an essential tool. Their dissemination and application will be critical to promoting knowledge transfer and utilization in the health care community.

It was noted that specific factoids which demonstrate the difference in caring for a 75 year old versus a 45 year old can be an effective teaching tool, especially for physicians. For example, 60 percent of individuals age 80 and over with myocardial infarction (MI) present without chest pain. Such factoids, which can be conveyed as a ‘pop quiz’ help students, and even providers, recognize their own knowledge gap. The goal is to get people to ‘want to know,’ so that, as one geriatrician at the workshop noted, “when I am 80, I want to see a doctor who ‘gets this stuff.’” A brief handout or flyer that summarizes some of the more unique issues associated with presentation and treatment of illnesses in older people would be a useful teaching tool across the spectrum.

The discussion also reviewed ways to incorporate or integrate geriatrics into medical education and training. One approach was dubbed “stealth geriatrics” and refers to having excellent geriatricians and gerontologists serve as instructors, and by extension as role models to encourage students to explore the field. Another important intervention is community placement of students, whether they are medical students, nurses, or social workers. In the past, students used to be placed only in nursing homes, but now, in some schools, they rotate through placements in facilities and in community-settings. This mixture of experiences highlights the diversity of the aging population, and increases the enthusiasm of students in pursuing the field. The Chief Resident Immersion Training (CRIT) program was also highlighted as an example, in which

Chief Residents, who play a significant role in patient care and medical student and resident training, undergo a brief immersion in geriatrics. This has been an effective tool to stimulate interest in the field and disseminate key knowledge to providers.

A significant focus of the discussion was on the direct care workforce, such as nurses' aides. The development of national standards for education and training, with a strong geriatrics component, is important. The size of this workforce is significant, at least 3 million caregivers and growing, but underutilized. These individuals, particularly in home care, have hours of interaction with older individuals, as opposed to the aforementioned eight-minute office visit. The proper dissemination of geriatric knowledge to improve the skills and attitudes of these workers will play a pivotal and cost-effective role in improving care, since the services of these individuals are already being reimbursed by public programs such as Medicare and Medicaid. Another way to foster dissemination of geriatric knowledge in the field is to train the supervising nurses, who generally have more experience and education in the care of older people, to better communicate with aides in the field. The lack of training for nurses in the areas of communication and supervision undermines knowledge transfer. Another is to use the caregiving workforce as a delivery system for overall health education by better training them on knowledge dissemination.

The growing use of electronic medical records presents an opportunity to trigger certain information and interventions related to older people. If this software could be "geriatricized" as one participant observed, it would enhance efforts to increase knowledge and awareness among providers. The system could trigger certain information related to geriatric care, such as medication-related issues, or what certain symptoms could mean. This would

improve care and also help avoid unnecessary and costly tests, if the system guides the provider toward a lower-cost intervention.

POLICY APPROACHES

Another issue that was explored involved the need for practitioners to have a better understanding of systems of care, not just knowledge about geriatric care. The current health and long term care system is fragmented and difficult for providers and consumers to navigate. A comprehensive approach that includes physical, psychosocial, and environmental needs is important to caring for a frail, at-risk older person. For example, a basic eight minute office visit is not effective for an in-depth assessment nor for a discussion about various programs and services that may be available. In addition, physicians often do not know how to refer to a geriatric social worker to help address a patient's psychosocial needs.

One possibility is that the Centers for Medicare and Medicaid Services (CMS) which is the primary payer of health care and long term care via Medicare and Medicaid respectively, be more involved in promoting a more integrated approach to care. The perspective that Medicare is just a payer of care is no longer practical. New approaches in reimbursement, such as a mechanism for a team-based effort, or a geriatric medical home, need to be explored.

Indeed, the concept of a medical home, in which an individual has a primary care physician who is responsible for coordinating care from a wide range of health care professionals, is gaining prominence. This concept should be 'geriatricized' under Medicare to facilitate communication and coordination between providers and ultimately promote more seamless care for older individuals. On a related note, the need for greater communication

and collaboration among various agencies, including the Administration on Aging (AoA), the Agency for Health Quality and Research (AHQR), and the National Institute on Aging (NIA), to promote geriatric care was also emphasized during the discussion.

On a related note, the participants noted that each profession tends to seek to expand its scope of practice, but that this precludes more integrated approaches. An internal initiative among professional groups and disciplines to review scopes of practice and identify cross-over areas will facilitate more collaboration and perhaps revitalize a team-based approach to care. Many of the foundations that are involved in geriatrics education for physicians, nurses, social workers, and others could facilitate this change.

Another promising development in the policy arena involves legislation in the U.S. Congress “The Retooling the Healthcare Workforce for an Aging America Act,” which includes several provisions to promote academic geriatrics across various disciplines and at various career stages (medicine, nursing, social work, and other allied health professionals), as well as expanding training in geriatrics for nurses, direct care workers, and family caregivers. The enactment of this legislation will be an important step in helping close the knowledge gap.

SOCIAL APPROACHES

It was noted that the need for a form of social marketing to promote health across the life span and combat stereotypes and misperceptions about aging will not only benefit society, but will help promote geriatric care, as individuals and health care providers are more informed. A breakthrough event or individual, especially in this era of spontaneous awareness through various media platforms such as YouTube (e.g. Susan Boyle’s skyrocket to

fame based on her appearances on Britain’s “You Got Talent” show) would be instrumental and possibly lead to a successful public health campaign. The key is to identify a potential individual or event to help bring about a societal transformation and push up the level of knowledge about aging and the embrace of older people in our society.

A related need is to raise awareness of the life-course perspective, that many diseases of old age have their genesis throughout an individual’s life. A proper understanding of health throughout life, by health care providers and individuals, will mitigate the perception that geriatrics is just about caring for older people. Indeed, geriatric care is intertwined with all aspects of health care. For example, a television show or other popular medium on how caring for children can relate to their health status later in life will help raise awareness of geriatrics, both in society and by extension in health care. The linkage of geriatrics to health throughout life is critical.

Action Steps

The following are some key action steps distilled from the workshop discussions in order to begin closing the geriatric knowledge gap. This gap presents an opportunity for both private funders and public entities to leverage existing knowledge and resources to improve care for the older population now and in the future.

1. A coordinated and comprehensive effort to develop and disseminate core competencies in geriatrics for all health care providers. A public-private initiative to integrate these competencies across the health care provider spectrum will provide the necessary size and scope to unify the current efforts and mainstream this important development.
2. The establishment of a system to replicate best practices in expanding and enhancing geriatrics education and training in all health care education programs, including:
 - a. Promoting effective use of geriatric instructors to inspire the next generation;
 - b. Publicizing successful efforts such as the Chief Resident Immersion Training program; and
 - c. Incorporating successful community rotations programs so students experience the full range of geriatric needs
3. The harnessing of the large direct care workforce to promote geriatric care and to transmit knowledge about health and aging by incorporating geriatric principles into national training standards for this vital workforce.
4. Advancement of federal policies and initiatives to promote geriatric knowledge and utilization of systems of care.
 - a. Revamp payment systems to promote cross-discipline collaborations, such as establishing geriatric medical homes.
 - b. Foster interagency coordination (e.g. CMS, NIA, AHRQ) to strengthen the connection between research, practice, and payment systems.
5. Collaboration between professional groups and societies to review their respective scopes of practice to identify ways to better coordinate care.
6. Enactment of the Retooling the Healthcare Workforce for an Aging America Act, which contains a variety of initiatives to promote geriatrics education and training for students and current health care professionals.

Conclusion

With greater access to information of all kinds, it is natural that those concerned with older persons would want to benefit from the understandings that come from different kinds of knowledge from those who embrace what social scientists call “different ways of knowing.” In the aging and longevity field, geriatric physicians, nurses and social workers for example, have different disciplinary perspectives—and often different takes on the same issue or problem. Some are more attentive to one phenomenon, while others are focused on a different concern. In a postindustrial society, this is as it should be, for knowledge itself is the dominant feature.

Scholars concerned with this have posited theories about knowledge transfer between public and private domains where information, once a rare commodity held by an empowered class, is now transmitted to and shared with the public. Knowledge transfer is valued and methods for accomplishing it are many. At the same time, there is considerable scholarship on the so-called knowledge gap hypothesis that divides the information rich and the information poor. Here the disparities between the most and least knowledgeable are linked to educational attainment and socio-economic status. Thus there may be limited motivation for a high status professional like a geriatric physician with specialized knowledge to share much with a less well educated home care worker, for example, though this may be changing.

Add to this the notion of diffusion of innovations wherein the nature of change itself can be enhanced or blocked, depending on various factors and motivations of people who foster new ideas, methods and procedures. The diffusion of innovations theory actually offers a research-based explanation for process by

which individuals learn about and ultimately adopt new ideas and practices. Much of the interface of those who pay attention to these three arenas—knowledge transfer, knowledge gaps and dissemination or diffusion of innovations has been severely challenged by the digital age, which has expanded access to information on the Internet and World Wide Web in extraordinary ways. At the same time, social networking media and other interactive media, such as search engines, have made information transfer, access and utilization much easier.

While the complexities of the digital age suggest many methods for bridging the knowledge gap, which is happening continuously, there are many important if conventional means of doing this including mentoring, work shadowing, guided experience, work simulations, establishing communities of practice and others. The goal of this workshop was to download what a roomful of experts know about geriatric care and to craft guidelines and action steps recommended for bridging the geriatric knowledge gap, including conventional and nonconventional means. Some interventions may be targeted, focused on better integrating geriatrics into education and training, while other interventions require a re-thinking of our systems of care and professional practice boundaries, or even a societal change in perspectives towards older people. Since everyone has a vested interest in closing the geriatric knowledge gap, health care professionals, health care payers, and of course health care consumers, such efforts should be a priority. The ILC will continue to highlight this issue and advance the recommendations that were developed during this workshop, and looks forward to working with colleagues and partners on this important endeavor.

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Appendix

CONSENSUS CONFERENCE:

“Closing the Knowledge Gap— Creating a Health Education Model for Professionals.”

Thursday, April 16th 2009

9:30am-12:00pm

**The International Longevity Center
60 East 86th St. New York, NY 10028**

(Call 212-517-1307 with any questions)

AGENDA

Purpose: To assess the state of new knowledge about the specific medical and health needs of older people, often confounded by a paucity of trained geriatric physicians, nurses, social workers and other health care professionals. In the face of those personnel shortages, the need to close the knowledge gap on healthy aging with other health professionals is urgent.

Schedule:

- 9:30am All participants meet in the 2nd floor conference room.
- 9:40am Welcome by Dr. Butler.
- 10:00am Group discussion led by Dr. Butler and Dr. Everette Dennis, Executive Director and COO of the ILC (see guiding questions below). Input and perspectives from all participants are encouraged.
- 11:30am Lunch is served; discussion continues.
- 11:45am Final thoughts and consensus points; wrap up by Dr. Dennis.
- 12:00pm Session concludes.

The International Longevity Center-USA Board of Directors

Lloyd Frank, Chair

Lloyd Frank is of counsel at the law firm Troutman Sanders LLP in New York, NY.

Edward M. Berube is CEO and President of FUTURITY FIRST Insurance Group.

Cory A. Booker is the Mayor of Newark, New Jersey.

Robert N. Butler, M.D., President and CEO of the International Longevity Center-USA, is a world leader in gerontology and geriatrics. As the first director of the National Institute on Aging, Dr. Butler helped educate the nation about the dangers of Alzheimer's disease and worked to make research a priority.

John J. Creedon is the former President & Chief Executive Officer of Metropolitan Life Insurance Co.

Everette E. Dennis, Ph.D. the ILC's chief operating officer and executive director (ex-officio) was founding president of the American Academy in Berlin and founding executive director of the Media Studies Center at Columbia University.

Susan W. Dryfoos - Vice Chair

Ms. Dryfoos is an award-winning independent filmmaker and author. She formerly served as the Director of The New York Times History Productions..

Joe Feczko, M.D. is president for worldwide development at Pfizer. He brings together all aspects of clinical development in both Pfizer Global Research and Development and PPG Industries into a single functioning role.

Robert W. Fogel is the Charles R. Walgreen Distinguished Service Professor of American Institutions, and Director of the Center for Population Economics, Graduate School of Business, at the University of Chicago.

Paul M. Gilbert is co-founder of MedAvante, a pharmaceutical services organization.

Annie Glenn has had a life-long interest in programs for children, the elderly and handicapped. She is a member of the Advisory Board for the National First Ladies' Library.

Senator John Glenn is the first popularly elected Senator from Ohio to win four consecutive terms. Before retiring at the end of the 105th Congress, he was the Ranking Minority Member of both the Governmental Affairs Committee and the Subcommittee on Airland Forces in the Senate Armed Services Committee.

Lawrence K. Grossman is Founder and Co-Chair of the Digital Promise Project, a public interest initiative focused on the development and use of the advanced information technologies. He is former president of NBC News and PBS.

Andrew D. Heineman, a retired attorney from Proskauer Rose LLP, is a board member of The Mount Sinai Medical Center and Williams College.

Karen K. C. Hsu is a civic leader in education, conservation and natural history. She currently serves as Trustee of The Nature Conservatory New York State Board.

Linda P. Lambert, Oklahoma City, is President of LASSO Corp., an investment corporation specializing in oil and gas development and Petree Valley Farms.

Naomi Levine is senior advisor to NYU president John Sexton and Chair and executive director, NYU George H. Heyman, Jr. Center for Philanthropy and Fundraising .

William C. Martin was the co-founder of Raging Bull, a leading online financial community.

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