The Glennan Center for Geriatrics and Gerontology

LEAD Virginia

October 16, 2009
History

- Created in 1996 to embody academic geriatrics at EVMS.
- Center of Excellence at EVMS focusing on prevention, intervention and research, education and thoughtful and compassionate care for older people.
Mission

To serve older adults by advancing the art of their health care through leadership in geriatric and gerontologic education and academia.

Credo

Harvesting Wisdom and Good Health
In 1990, Dr. John Franklin, Professor of Internal Medicine and Dr. Desmond Hayes, Professor Family and Community Medicine recognized the growth of the older population and their need for specialized care and created a required 2 week clerkship for all 4th year medical students.
The geriatric clerkship provided impetus within EVMS and the community to advance geriatric education and to create a division of geriatrics within the Department of Internal Medicine, which is now The Glennan Center for Geriatrics and Gerontology.
Dr. and Mrs. John Franklin

Founder of EVMS and The Glennan Center
History

- **July 1, 1996-** Glennan Center opens with 4 physician-faculty members, a post-doctoral fellow, a laboratory/research director, 3 ancillary staff, a colony of monkeys and the geriatric clerkship.

- **July 1, 2009-**
Faculty and Clinical Providers
8 Faculty
4 Physicians (3 FT, 1 PT), 1 Ph.D, and 3 Masters-level educated

- Rex Biedenbender, MD
- Yuping Deng, Ph.D.
- Madeline Dunstan, MS
- Christianne Fowler, GNP

- Marissa Galicia-Castillo, MD
- D. Michael Geller, MD
- Sharon Reed, MD
- Robin Wallace, PA-C
Additional Staff-7

- **Office Administrator (1)**
- **Financial Analyst (1)**
- **Medical Assistant (1)**
- **Clinical Research Coordinators (3)**
- **Clinical Research Associate with the Driver Research and Evaluation Laboratory (1).**
Endowments

8 named endowments

- John Franklin Chair of Geriatrics by John and Lillian Norfleet
- The Glennan Center Endowment by Mrs. Virginia Ferguson
- The Lillian and Gideon Welles Grime Endowment for Geriatrics and Gerontology by Rosemary Jordan
- The Rosemary, Fenton and Garnett Jordan Professorship in Geriatrics
Endowments

- Sue Faulkner Scribner Distinguished Professorship
- The Milton Donn Family library endowment
- The Douglas C. Powers, M.D. Endowed Research Professorship by Mrs. Douglas Powers
- The Jack V. and Clare S. Cook Award for Excellence for research from the estate of Clare S. Cook
Education

- **Geriatric Clerkship** - 2 weeks – 4th year - 9 clerkships per year.

- **Senior Electives** - 3 students - 4 week rotations in either Palliative Care of Geriatrics Skilled Nursing Care.

- **Geriatric-Internal Medicine** - 3 week rotation for 3rd year med students.

- **Introduction to the Patient** - 1 afternoon, small groups of 6 students, and fellows serving as Small Group leaders.

- **SAGE - Student Association of Geriatric Enthusiasts** - Student club meets monthly during the school year.

- **MPA program** - 4-6 week block rotations - 8 per year, new one week intensive LTC rotation (PAGE), and 10 geriatric lectures.
Resident Education

- **Geriatric Medicine Fellowship** - one year program, one fellow currently enrolled, 13 completed the program, 8 successfully completed the exam in geriatrics. All graduates Internal Medicine Boarded.

- **Geri-Med Combined Residency Program** - 1 enrolled (PGY-2).

- **Resident Geriatric Rotation** for Portsmouth Naval, Internal Medicine, Family Medicine and Combined FM/IM residents (average 30 residents annually).
Conferences

Geriatric Sit Down Rounds

- One hour program on the 2nd Tuesday of each month at noon in Hofheimer Hall.
- Presentation by either Glennan Center residents or Family Medicine Residents.
- Geriatric case study allows audience to enhance knowledge of geriatric medicine, current modalities of evaluation and care management and appreciation of resources for older adults.
- Open to community partners affiliated with agencies and organizations providing services to senior adults.
Conferences
Weekly Didactics

- Each Tuesday at 8 am and 9:15 am (except second Tuesday), faculty and trainees gather for various didactics and lectures.
- Conferences designed to fulfill accreditation requirements for the geriatric fellowship.
Clinical Care

- 4 clinical programs at EVMS
- 8 facility/community based
EVMS

- Driver Research and Evaluation-Dr. Geller, Glennan Center Research Coordinators and Associate Director of Education

- Memory Assessment Clinic-Dr. Biedenbender, and consultants from Hampton Roads Behavioral Health

- Memory Consultation Clinic-Dr. Reed, Glennan Center Research Coordinators and Associate Director of Education

- Primary Care and Acute Care Geriatric Clinic-Dr. Sharon Reed and Robin Wallace, PA-C
Facility and Community

- Berger-Goldrich Home at Beth Sholom Village (SNF and LTC)
- Chesapeake Place (Assisted living-memory)
- Harbor’s Edge (Continuing Care Retirement Community)
- Lake Taylor Transitional Care Hospital
- The Memory Center (Assisted living)
- Oakwood Nursing and Rehabilitation Center
- Odyssey Health Care (Hospice)
- Sentara Norfolk General Hospital (Palliative Care Consultation Service)
Clinical Research
6 active studies, 6 recently completed enrollment

Active and Open: Annual Fluzone, Diabetes (Johnson & Johnson for better glycemic control in LTC), Rivastigmine (Novartis, Excelon® patch in ALF and LTC facilities), and Pandemic Influenza (Sanofi-Pasteur), H1N1 Influenza (Sanofi-Pasteur), Fluzone with JVRS-100 adjuvant (Juvaris).

Active and Closed: EPIX 202, EPIX 203, West Nile (Acambis), Rotavirus, Zostavax and Focus.
Other Research, Grants and Contracts

Faculty and staff engaged in scholarly activities, research, contributing to the literature.

Received career development awards, GACA, Hartford, AMDA, MAPS, and other scholarships-AMDA Futures, the National Highway Traffic and Safety Administration, Alzheimer’s research award from national and state organizations, NIH, VDMV, AARP.
Other Service and Education

- Intramural and extramural activities
- Leadership roles in professional organizations at the local, state and national levels.
- Volunteers to advocate and work towards improving our community.
- Pursuing additional credentials, degrees, certifications and other educational ventures.
- All designed to further knowledge, skills and abilities to develop and improve capacity for meeting the challenges of education, research and clinical care.
RETOOLING FOR AN
AGING AMERICA:
BUILDING THE HEALTH CARE
WORKFORCE

The number of older adults in the United States will almost double between 2005 and 2030, and the nation is not prepared to meet their social and health care needs. The baby boom generation starts to turn 65 in 2011, which will create multiple challenges for the health care system. For one, the majority of older adults suffer from at least one chronic condition and rely on health care services far more than other segments of the population. Additionally, this generation of older adults will be the most diverse the nation has ever seen: with more education, increased longevity, more widely dispersed families, and more racial and ethnic diversity, making their needs much different than previous generations. Another problem is the dramatic shortage of all types of health care workers, especially those in long-term care settings. Finally, the overall health care workforce is inadequately trained to care for older adults.

In 2007, the Institute of Medicine (IOM) chartered the ad hoc Committee on the Future Health Care Workforce for Older Americans to determine the health care needs of Americans over 65 years of age and to assess these needs through an analysis of the forces that shape the health care workforce, including education and training, models of care, and public and private programs. The committee concluded that the definition of the health care workforce must be expanded to include everyone involved in a patient’s care: health care professionals, direct-care workers, informal caregivers (usually family and friends), and patients themselves. All of these individuals must have the essential data, knowledge, and tools to provide high-quality health care. The committee proposes a concurrent three-pronged approach:

- Enhance the geriatric competence of the entire workforce
- Increase the recruitment and retention of geriatric specialists and caregivers
- Improve the way care is delivered

ENHANCING GERIATRIC COMPETENCE

In general, the health care workforce receives very little geriatric training and is not prepared to deliver the best possible care to older patients. Since virtually all health professionals care for older adults to some degree, geriatric competence needs to be improved through significant enhancements in edu-

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What is *Old*? Who is *Old*?

- **Chronological aging**
  - Time since birth

- **Biological aging**
  - Age-related changes in structure/function
  - 60 years old, but look 30
  - 30 years old, but look 60
Stratify the Aging Population

- **Near-Aged**  55-64
- **Young Old**  65-74
- **(Middle) Old**  75-84
  sometime called Old Old
- **Old Old**  85+
  sometimes called Oldest Old
Life expectancy: 
**average vs. maximum**

- **usual aging:**
  - aging with disease
  - relates to average life expectancy

- **normal aging:**
  - aging process without disease/trauma
  - relates to maximum life expectancy
“a lot of living after 65”
life expectancy in 2005

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<th>Females</th>
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<td>@ 75</td>
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Table 26. CDC. Health, United States, 2008. used 2005 data
http://www.cdc.gov/nchs/hus.htm
STRULDBRUGS:
“Immortals”
with a red spot on forehead

- Guilliver’s Travels
- live forever
- but progressive senescence
- progressive cognitive loss/dementia
- “…despised and hated by all…”

Aging Pyramid & support of older people

- 1900: classic aging pyramid
- 2030: “squaring” of aging pyramid
  - less younger people to support older people

Due to: baby boomers-1946-64

http://www.cdc.gov/nccdphp/aag/aag_agp.htm
Projected distribution of the population age 65 and older, by race and Hispanic origin, 2000 and 2050

2000

- Non-Hispanic white: 84%
- Hispanic: 6%
- Non-Hispanic black: 8%
- Non-Hispanic Asian and Pacific Islander: 2%
- Non-Hispanic American Indian and Alaska Native: 0.4%

2050

- Non-Hispanic white: 64%
- Hispanic: 16%
- Non-Hispanic Asian and Pacific Islander: 7%
- Non-Hispanic American Indian and Alaska Native: 0.6%
- Non-Hispanic black: 12%

Note: Data are middle-series projections of the population. Hispanics may be of any race.
Reference Population: These data refer to the resident population.
Source: U.S. Census Bureau, Population Projections.

Modified from http://www.agingstats.gov/chartbook2000/4
Sources of income for older people

Concern: For 60% of people 65+: SS is the vast majority (65-83%) of total income

Note: A married couple is age 65 and over if the husband is age 65 and over or the husband is younger than age 55 and the wife is age 65 and over. The definition of “other” includes, but is not limited to, unemployment compensation, worker’s compensation, alimony, child support, and personal contributions. Quintile limits are $11,519 for the lowest quintile, $18,622 for the second quintile, $28,911 for the third quintile, $50,064 for the fourth quintile, and open-ended for the highest quintile.

Reference population: These data refer to the civilian noninstitutionalized population.

Gender @ age 80+ worldwide: many more older women than men

Figure III
Proportion of women among persons aged 40-59, 60+, 80+ and 100+ years: world, 2007

9 States have > 14% of their pop 65+

i.e., at least 1 out 7 people 65+

USA 12.6% or 1 out of 8 people 65+

High % total population 65+ due to:

↑ migration young,
↓ fertility rates &/or
↓ mortality,

Fig. 4 & Data from Fig. 6. AoA A Profile of Older Americans: 2008 based on 2007 data.
http://www.aoa.gov/AoAroot/Aging_Statistics/Profile/2008/index.aspx  Word link
Great state variability in per capita health care spending, 2004

Virginia is in the lowest 10
Geriatrician Shortage

Nationally: 20,000 needed; 7,100 actual
- Only ~350 in training per year

Virginia: 500 needed; 146 actual
- ~10 geriatric fellowships/yr

Greatest barrier:
- financial disincentives: Medicare reimbursement
  - e.g., 21% cut to MD’s required by current law in 2010, unless Congress prevents cuts, as it has in the past

Need to modify Medicare payment system

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Thank you!

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