A New Social Revolution
The Long-Term Care Re-think Tank

Robert L. Kane, MD, director of the Center on Aging, has devoted his career to changing the way our country views and delivers long-term care (LTC) for older adults. “We need to take a fresh look at this,” Kane says. “Essentially, LTC offers a compensatory service that responds to frailty. Policy debate around LTC centers on costs, but we’re paying for something we really don’t want—and getting something you don’t want, even at half price, is no bargain. LTC remains a necessary social service, but not something people get excited about. No one runs for office on a platform of improving LTC. That has to change.” Such change will require re-inventing and re-branding LTC.

Toward that end, last year Kane founded a group called The Long-Term Care Re-think Tank. Members come from a variety of backgrounds: family care providers, professionals, and students. The group’s underlying value statement for long-term care is that everyone has the right to age with dignity and choice. “We cannot simply do more of the same,” Kane says. “Rather, we should envision ways to deliver affordable LTC that allows recipients a livable life. Creating public support for improving LTC will require a new public discourse, one based on a positive model for LTC, one that people see as worth supporting.”

Creating an Appetite for Change
LTC is fundamentally the intersection of housing, personal care, and medical care. These three elements can be combined and coordinated in many ways. Kane says the goal should be an affordable system of care and support that allows people to get the help they need in a way that maximizes their autonomy and supports their individuality and independence. “The current LTC system is not what anyone would have designed,” he says. “It has grown in fits and starts with one eye on market opportunities, all in the context of heavy regulation. And we worry a great deal about how we will manage to pay for long-term care, but the elephant in the room is the fact that we’re already paying a lot of money for care few people really want. Even those who can buy care privately have great difficulty finding the care they want. Indeed, we are foisting on our parents care we would not want for ourselves. We continue to patch the roof on a house that is structurally compromised and woefully out of date.”

Kane notes that society is more likely to invest in care that has a positive social valence than one that simply provides necessary supportive care for people in need. “The public dialogue around LTC has to shift away from reliance on a sense of obligation to provide a socially necessary, but unattractive service, to one that offers something desirable,” he says. The goal for LTC should be to create an affordable system of care and support that allows people to get the help they need in a way that maximizes their autonomy and fits with their lifestyle. “To accomplish this,” Kane says, “will require bold steps rather than just incremental ones, and the ultimate challenge will be how to create an appetite for change.”

In this Issue

1 Re-thinking LTC
Perspectives on Retirement:
3 Grimley Evans
4 Henry Blackburn
7 The View From Here
7 Passion and Expertise—Distinguished Lectures
8 Role of Technology in Future of LTC—MAGEC Summer Institute
10 Family Caregiving in the New Normal
11 News, Notes, and Notable Achievements
12 Happenings
A New Social Revolution

LTC currently carries a strong negative image. “It needs to become a political issue,” Kane says. “When politicians campaign on a platform of improving LTC, we will have achieved a milestone.” What people describe wanting from long-term care includes words like ‘choice,’ ‘autonomy,’ ‘dignity,’ ‘respect,’ and ‘control.’ “They want to be able to take informed risks. Public discourse should focus on how to achieve these ends,” Kane says. “There is reason for optimism. The major social movements of our times—the women’s movement, civil rights, and gay marriage have come about when social forces argued that the current situation was unjust. So it is with LTC. We cannot continue down the current LTC path.”

Kane admits that making large scale change will inevitably generate opposition. “A lot of people and organizations have achieved a milestone.” What people describe wanting from LTC currently carries a strong negative image. “It needs to become a political issue,” Kane says. “When politicians campaign on a platform of improving LTC, we will have achieved a milestone.” What people describe wanting from long-term care includes words like ‘choice,’ ‘autonomy,’ ‘dignity,’ ‘respect,’ and ‘control.’ “They want to be able to take informed risks. Public discourse should focus on how to achieve these ends,” Kane says. “There is reason for optimism. The major social movements of our times—the women’s movement, civil rights, and gay marriage have come about when social forces argued that the current situation was unjust. So it is with LTC. We cannot continue down the current LTC path.”

This is a program for everyone. Few will escape either needing LTC or providing care for someone who does. Now is the time to get involved. Send a note to kanex001@umn.edu to sign up.

The Long-term Care Re-think Tank’s Tenets and Aims

The Background

• The population is aging; maintaining the status quo is unaffordable.
• The status quo is not what people want. We are in danger of inflicting on our parents care we would never want for ourselves.
• LTC was never planned; it evolved in response to financial and regulatory incentives. It responded to a need to supplement (but not supplant) family care.
• LTC consists of three basic building blocks: room and board, personal care services, and medical care (largely addressing chronic illness); it can be delivered in a variety of settings.
• Medical model settings minimize the potential to improve client quality of life and overall wellbeing.
• A great deal of innovation is occurring; technology will play a key role.
• Minnesota has been rated as a national leader in LTC rebalancing, but that should not be a basis for complacency. If we are to retain our edge, we need to think creatively.
• Minnesota leadership has been working actively to confront the issues around paying for LTC. We need to give equal attention to what we propose buying.

The Challenge

• How do we create the proper mix of incentives (payment and regulation) to encourage innovation and to create the sort of care people would want?
• What do we do with the extant infrastructure (i.e., institutions and current staffing)? How do we mobilize a workforce with a new mindset of LTC when many are highly invested in current models of LTC?

The Attributes of a New Approach To LTC

• Can we harness the business concept of disruptive innovation, which suggests that cheaper, more convenient products may drive existing ones out of the market, even if the new products are of lower quality?
• Will society accept less formally trained care providers who are better supervised through technology?
• How can we offer a positive model of LTC that will make funders willing to spend money on it?
• How can LTC models channel the power of human connection and engage individuals to live with purpose and as vibrantly as they are able, or choose to live?
• Care is provided in livable environments (ambience depends on personal financial resources). A variety of housing options would be available; most would be small individualized living units.
• Clients live in the setting of their choosing; may need to move into more congregate settings but retain tenant status. They control access to their living quarters.
• Care given largely by aide level workers supervised by clinical professionals through smart phones or other information technology.
  • Check reliability and time spent (GPS).
  • Monitor conditions (clinical tracking forms).
  • Report changes in client status.
  • Caregivers are trained and competent to provide care in a way that minimizes discomfort and provides the greatest consideration and respect for the individual.
• Clients hire/select workers, but with some method of oversight from professionals.
• Primary care is proactive—track client’s status and intervene when there is early evidence of a change.
• Medical care, social care, and the client coordinate to develop and focus on shared goals.
• Personal care workers make ”clinical” observations and collect data.
• Coordinated care would address the potential for improvement in independence and quality of life.
• Care would emphasize nonpharmacologic interventions.
• Assistance with decision making.
• Clients are allowed to take informed risks.
• Payment reflects/rewards outcomes (quality of life and quality of care) as well as services provided.
• Payment and provision of subacute care (post-hospital) should be separate from LTC. Subacute care can be given in rehabilitative units or at home, but the same institution or operating unit should not deliver subacute care and LTC.
• Communities are engaged with and connected by regular, ongoing interaction with LTC clients to benefit both groups.
Perspectives on Retirement

This series explores the diversity of responses and levels of enthusiasm for retirement, especially by those who have invested extraordinary effort in and devotion to their careers. We’re interested in how recent retirees have adapted to this next stage in their lives. Each issue of Old News features interviews with retirees. We are trying to assemble a set of varied experiences, but ultimately we will go where the trail takes us. If you know of a story we can tell (including your own), please let us know. If you have not yet retired, but are thinking about it, share your thoughts with us as well.

Respect for Geriatric Medicine—Fighting the Good Fight
Sir John Grimley Evans

When Sir John Grimley Evans (Grimley to everyone who knows him) first got interested in the medicine of aging back in the 1960s, it was the lowest rung on the ladder of medical specialties, “just above venereal disease.” Since then, he has devoted his life to bringing geriatrics into national focus in Britain, while improving conditions and care for older people. Grimley is a professor emeritus of clinical geratology at Oxford University (an institution that insists on the term “geratology” for its accurate reflection of the Greek root). In addition to an impressive clinical and academic career, Grimley has worked with the Department of Health, the Medical Research Council, and the Royal College of Physicians, served as editor of Age and Aging, and contributed to two editions of the Oxford Textbook of Geriatric Medicine and other specialty publications. One of his happiest activities was as a founder of the European Academy of Medicine of Aging, “which continues to flourish but, sadly, no longer has a British presence on its board,” he says.

The Social Revolution

Born in 1936 into a poor family, Grimley is careful to point out that “the ‘sir’ bit is a knighthood, not an inherited baronetcy.” It was awarded to him in 1997 for his services to the medicine of older people. “Or so the queen said,” he says. “I would rather she had said ‘services to older people,’ but you do not argue with a lady brandishing a sword.”

Grimley’s first memories are of bombs dropping. “They missed me, but just barely. The postwar world in Britain was hard, but also a time of great hope and social revolution. They were building the welfare state and creating opportunities for the disadvantaged.”

A Detour Remembered Fondly

At Cambridge, Grimley studied natural sciences, including psychology. He went to Oxford for clinical training and fell into a research job with Donald Acheson, who later became chief medical officer in England and a prominent epidemiologist. “That inspired my interest in the new science of epidemiology of chronic disease. I wanted to combine that with clinical practice. I had always wanted to be a doctor and I didn’t want to give that up. But at the time, most epidemiologists were not working at the bedside. So I detoured into psychiatry.”

Grimley enjoyed working with the patients, “but the other psychiatrists—I did not get on with them at all,” he says. “Fortunately, the experience was positive because I met a charming young lady named Corinne, a clinical psychologist on the team. She’d been told all doctors were boneheads—so I had to convince her that wasn’t true. I succeeded, and when I left psychiatry, Corinne came with and married me.”

Aging is Not Governed by the Clock

In 1967, a research job in New Zealand changed the trajectory of Grimley’s career. “I would be studying the health of Polynesians who were moving from Tokelau Islands to New Zealand,” he says, “measuring basically everything about them.” Life on the island was tough. “Nothing really grew, the soil was just heaps of rubble. So they caught fish, but only a day’s worth at a time. It was taboo to leave fish on the island overnight, because the spirits of the deep would want to know who was killing their friends. Therefore, the islanders were very active and fit. Calorie output matched input. But when they moved to New Zealand, terrible things happened. They became obese, developed coronary heart disease, diabetes, high blood pressure, etc. I had been told aging was a biological clock ticking away, but here these people had aged ten years in one year! If you went by biological age and risk of death, then aging is a product of lifestyle and environment, not the clock. That stimulated my interest in the medicine of aging.”

Grimley’s older brother became an officer in the Royal Navy. “It would have been unthinkable to my parents that their children might be an officer in the services or be a doctor or even go to university. My parents could never have afforded Cambridge—out of the question. But state scholarships were available to anyone who passed the right exams.”

Sir John Grimley Evans
The Road to Respect—for Geriatrics

Back in London, Grimley was soon recruited by Dr. Ted Jarvis to set up a modern geriatrics facility in Newcastle-upon-Tyne. They developed a comprehensive service integrating acute care, rehabilitation, long-stay, and a range of community outreach facilities including home assessment visits and day hospitals. In 1973, Grimley was appointed to Newcastle University’s newly established chair in geriatrics. “Gratifyingly, a subsequent independent study showed Newcastle producing the highest proportion of British medical graduates actively seeking careers in geriatric medicine,” he says.

By 1985, Oxford had taken note of that success, and offered Grimley a chair in geriatric medicine (or, as it is known at Oxford, geratology). “My ambition was always to change the world and make it a better place,” he says. “Mostly, though, I was beavering away behind the scenes like a civil servant. But I think I did have some important influence through the Royal College of Physicians in making geriatric medicine a respectable specialty. I had to work very hard on that.”

Grimley says it was more than ageism casting a shadow over geriatrics. “It was the way geriatrics came into the system. The Americans coined the word around 1900, but never took it up. They developed a comprehensive service integrating acute care, rehabilitation, long-stay, and a range of community outreach facilities including home assessment visits and day hospitals. In 1973, Grimley was appointed to Newcastle University’s newly established chair in geriatrics. “Gratifyingly, a subsequent independent study showed Newcastle producing the highest proportion of British medical graduates actively seeking careers in geriatric medicine,” he says.

By 1985, Oxford had taken note of that success, and offered Grimley a chair in geriatric medicine (or, as it is known at Oxford, geratology). “My ambition was always to change the world and make it a better place,” he says. “Mostly, though, I was beavering away behind the scenes like a civil servant. But I think I did have some important influence through the Royal College of Physicians in making geriatric medicine a respectable specialty. I had to work very hard on that.”

Grimley says it was more than ageism casting a shadow over geriatrics. “It was the way geriatrics came into the system. The Americans coined the word around 1900, but never took it up. They developed a comprehensive service integrating acute care, rehabilitation, long-stay, and a range of community outreach facilities including home assessment visits and day hospitals. In 1973, Grimley was appointed to Newcastle University’s newly established chair in geriatrics. “Gratifyingly, a subsequent independent study showed Newcastle producing the highest proportion of British medical graduates actively seeking careers in geriatric medicine,” he says.

Second Honeymoon

In retirement, married people will see much more of each other than in their working years. “That turned out to be very pleasant in my case, but it isn’t always,” Grimley says. “For us, having lunch together is a novelty, because it only happened after I retired. And the novelty has not worn off yet.”

Grimley and Corinne have three children. “Our older boy designs chips for mobile phones, the younger is a freelance journalist, and our daughter is a doctor.” Grimley says it’s no surprise his daughter was born when he was more senior. Other people had to wait for children after they retired, but Grimley didn’t want to stop working too soon. “I expect that is sometimes the case,” he says. “But I was saved by the fact that I had retired.”

As for what lies ahead, Grimley sees no prospect of getting bored. “That’s a real horror of retirement—boredom. The key to not getting bored is to do things that require a bit of effort. You get a little block and you have to find a way around it.”

If You Love Your Work, Why Leave It?

Henry Blackburn

Henry Blackburn’s contributions to the field of cardiovascular epidemiology span six decades and much of the globe. But he doesn’t like to toot his own horn. “That nauseates me,” he says, “the idea of people talking about their own contributions.” Instead of talking about the past, Blackburn, who turned 90 in March, keeps active in the present. Since retiring in 1995, he has, among other things, written four volumes of memoirs, raised substantial funds to chronicle the history of cardiovascular disease epidemiology, and undertaken major writing projects on prevention in public health. His office in the West Bank Office Building overflows with books he has authored and framed photographs of him with his international colleagues in field surveys and shaking hands with some of the country’s most prominent entertainers and politicians, including Woody Allen and Hubert H. Humphrey.

Continued
A Trajectory of Service

Blackburn was born in Miami Beach in 1925, where his father was a Methodist missionary. “That affected my trajectory,” he says. After one year at Florida Southern College, Blackburn joined the Navy. “They provided my medical training, which I paid for later in various ways.” He was called to active duty in 1943. “I got my B.S. at the University of Miami and was sent to Key West Naval Hospital to man the VD clinic while awaiting assignment to medical school,” he recalls. After four years of medical school at Tulane and playing jazz in New Orleans, Blackburn interned at Northwestern Memorial in Chicago before honoring his promise to his father of missionary work. He spent the summer of 1949 in Oriente Province, Cuba, near where Castro would later hide in the mountains. There, he established five Methodist mission clinics and experienced mass diseases requiring a public health approach. He also met Nelly Trocme, daughter of French pastor and pacifist Andre Trocme, who would become his “French wife.” Eventually, Nelly accompanied Blackburn to Austria, where he served as U.S. Public Health Service (PHS) officer for the Displaced Persons Act from 1950 to 1953.

Many Contexts, Same Message

In his travels and studies, Blackburn kept encountering a compelling message—that health was related to lifestyle and environment, largely beyond the reach of clinical medicine. This was a novel idea at the time. “I remember vividly in medical school the visit of a missionary who had worked in the Congo for 25 years without ever seeing a heart attack or a case of appendicitis or tonsillitis,” Blackburn says. “That really stuck with me. In Cuba, I saw how poverty, hardship, oppression, and even superstition caused disease and suffering.” Blackburn recalls taking antibiotics into Cuba. “We did three-day tours on horseback with a devoted local doctor, and one night we were called to see a woman with advanced typhoid—she had an enlarged spleen, bloody diarrhea, very ill—and we gave her the ‘miracle’ drug specific to her typhoid, instructed her family on nourishment, and said we’d be back in 24 hours. We weren’t out of that house for even a half hour before a shaman was called. He cancelled our orders, gave the woman castor oil, and she died before we got back.”

A Serendipitous Connection

When Blackburn returned from Cuba to get specialty training at the University of Minnesota, he met a man whose ideas on lifestyle and nutrition were breaking new ground. “I got introduced to Ancel Keys, who was looking at cultural differences and dietary differences in Italy, South Africa, Japan, and Finland, with the idea that diet had something to do with risk of heart attack in a population. The day I finished my residency, Ancel offered me a job as a research associate, and I jumped at it.”

The job paid $4000 a year. Even in 1956, that was woefully inadequate to support a family—Blackburn and Nelly had three kids. To supplement, Blackburn went into clinical practice and became medical director of an insurance company. “I held three jobs. That’s what you had to do in those days.” Finally, in 1960,

A Certain Age

At a certain age, one would like to know that he or she has matured in judgment and behavior, yet remains playful as in childhood, idealistic as in youth, sound as in his prime.

One would like to know that he has done one thing well, a few other things useful, and, after all, has done little harm.

One wants to find satisfaction rather than pride in what he has done.

One wants to have been actively involved, the more the better, with the central issues of his time, not just an observer from the fringes.

At a certain age, one wants to be understood and accepted as he is; perceived neither as much smaller nor much larger than he truly is.

One wants to forget if not forgive his enemies and accept if not embrace his adversaries, but lose not another night’s sleep over any of them.

And one wants to acknowledge gratefully, before it’s too late, those who made his way smoother or his voyage richer.

At a certain age one wants to say what needs to be said and no longer worry whether all the world agrees.

One wants on occasion, however, to say or do things that make people smile.

At a certain age, one needs to do mainly what one loves to do rather than mainly what others want him to do.

At a certain age, one wants to hold and admire and amuse and inspire his grandchildren and see them light up at his presence.

Finally, at a certain age, one should allow a little pleasure in hearing nice things said about him, but neither need nor seek to hear them.

Ancel got a grant that covered Blackburn’s salary for full-time work in his Laboratory of Physiological Hygiene, housed in Memorial Stadium. “It was a very exciting place, at the beginning of this romantic period in the origins of cardiovascular disease epidemiology,” Blackburn says. “Paul Dudley White was the most popular cardiologist in America, a consultant for Dwight Eisenhower’s 1955 heart attack, and Ancel Keys exposed Paul Dudley White to the concept that medicine is more than individual susceptibility and environment.”
Blackburn’s early work with Keys focused on methods. “We needed guidelines about inferring cause from statistical associations,” he says. “Ancel would sometimes antagonize people with his bluntness, and then he’d get attacked. At a Geneva meeting, he was challenged by a curmudgeonly statistician about diet and heart disease associations—and the series of exchanges that followed led to the guidelines used in the famous 1964 Surgeon General’s report on smoking and lung cancer.”

In 1958, Keys and Blackburn pioneered the Seven Countries Study, examining the relationship between habitual diet in traditional societies and heart attack. The 12,000 participants have been followed for 50 years. Then, in the late 1970s, Blackburn proposed population-wide strategies of surveillance and preventive interventions in whole communities, culminating in the Minnesota Heart Survey, conducted since 1979, and the Minnesota Heart Health Program, a six-community demonstration begun in 1980.

When Keys retired in 1972, Blackburn was on sabbatical in Geneva. “The idea was, maybe with Ancel’s retirement, the University could just get rid of this one-man research department. So, for the first time in my life, I became political. I called the associate dean and the head of medicine and the head of cardiology, and I said, ‘If any of you three guys think I have any potential in running this thing, I would like to do it.’” Within a year, Blackburn took a $200,000 departmental budget and built it into a $15 million full-fledged academic division in the School of Public Health.

After 18 years as division head, 1972 – 1883 for the Laboratory of Physiological Hygiene, and then 1983 – 1990 for the Division of Epidemiology when the two programs combined, Blackburn stepped down at age 65, remaining on the faculty for an additional five years before retiring in 1995. He continues as emeritus faculty. “I like the idea of a staggered retirement,” he says. “You can more readily make a healthy transition.”

Creativity First

Since retiring, Blackburn has prioritized creative work. “You have to discipline yourself not to sit on review boards and committees,” he says. “I continue to write in my field—for example, a recent article in the International Journal of Epidemiology on Ancel’s work on body mass index, and another on Leonard Schuman’s and Stoney Stallone’s contributions to the 1964 Surgeon General’s report on smoking.” Thus, Blackburn has become a historian. “And we’ve built an archive on the history of prevention research in Minnesota,” he says, gesturing to a fat blue binder on his desk. “This contains 30 cabinets worth of papers.” He has also helped create a popular website of oral histories, biographies, essays, abstracts of early studies, and a wide array of media, including films of early fieldwork, all about prevention of heart attack and stroke.

Soon, Blackburn will turn these archives over to the University. “I’ve greatly enjoyed my foray into history. It’s nice to have a new community at my stage of life.”

Beyond the Office Walls

“I don’t need to climb any more mountains,” Blackburn says. As a field epidemiologist, Blackburn was away from home more than 90 days each year. “You could say I’ve lost my taste for travel. But I do immensely enjoy playing jazz. It’s not often an academic can move people to dance and smile.” Blackburn plays saxophone and clarinet. He is in a jazz quartet and plays with other local groups with frequent gigs at the Eagles Hall in south Minneapolis and Aster Café. “I make a CD every couple of years with young colleagues here, and for my 90th birthday bash we had musicians from the age of 20 to 90.” Blackburn and his wife, Stacy (he divorced and remarried) run a jazz series every winter at the Longboat Key Education Center in Florida. “We invite musicians from around the world. Stacy emcees. She says I can put together a band within a half an hour of arriving in any airport in the world.”

This summer, Blackburn plans to create a personal website. “For my music,” he says, “and thousands photographs, hours of family movies. My tech-savvy nephew is going to help put it together. I’ve got a whole bunch of ‘papa’s stories’ I’ve made up for my children and grandchildren, recordings of me reading stories in dialect, travelogues coming out of my ears. Some are fairly interesting.”

Family is important to Blackburn, whose life has included “two 30-year marriages” and three children. Blackburn’s eldest son, John, who was, like his father, an avid jazz musician, died of a brain tumor at age 28. “Now I have two lovely daughters,” he says. “One is an Associated Press journalist in Seattle and the other is a veterinarian who lives ten minutes away.” Blackburn also has three grandchildren. “One granddaughter just graduated from Grinnell in political science, the other is on a Fulbright in geology in New Zealand, about to enter Columbia graduate school specializing in paleo climatology, and my grandson is working in construction in Alaska. He’s an adventurer.”

The only negative part of retirement as Blackburn sees it is the rapidity with which things are forgotten. “There is little institutional memory. It’s disturbing. And of course there is some loss of control of your fate. As an emeritus, your appointment is annually renewed. University Parking sends you a note every year saying if you don’t immediately get the dean’s approval, you’ll lose your parking space.”

Despite these indignities, Blackburn can’t imagine giving it all up. “If you love your work, why leave it? Goodness gracious, I can’t understand why people would. Just keep at it in a reduced form. Change your focus every few years. Give more than you take. It’s a great relief to not be caught in the daily grind, not to need to seek or have power, to focus on your creativity in ideas and action.”
The View From Here

Model Retirement

The past several issues of Old News have featured inspiring stories of people who have retired, for the most part successfully. We must bear in mind, however, that these people are outliers. They are accomplished professionals with adequate incomes. Normal retirements are typically much more stressful. Many people look forward to stopping their work, which is often simply a means of acquiring an income. Many reach retirement age with minimal savings. A recent estimate from the Kaiser Family Foundation suggests that as many as 45% of those aged 65+ are officially in poverty. They are hardly well positioned to enjoy retirement or withstand the first blow of a serious illness.

This finding makes the plans for the upcoming White House Conference on Aging (WHCOA) all the more disappointing. The conference, scheduled for July, will be barely a shadow of its former self, relegated to a single day rather than the week-long occasion it once was. Past conferences were meaningful opportunities for taking stock of important issues and proposing solutions to respond to upcoming challenges. Thanks to demographic and economic trends, we certainly have plenty of the latter.

Listening to presentations over a day is hardly the same as coming together in person with sleeves rolled up for a week of active problem solving. This year’s four topics of focus include healthy aging, improved health and social services, elder justice, and income security. These are good areas to focus on, but not to simply summarize what has been done. Each of these topics demands our attention, not only to recent accomplishments but also and more importantly to the gaps, challenges, and opportunities for doing better. Demographic and economic forces will not allow us to stay the course. Innovation and creativity are needed. We need to raise public consciousness about these issues and suggest reasonable ways to meet the challenge of the next decades.

Following the central mandate from Washington, DC, the Board on Aging has been gathering community input and feedback through listening sessions, but this year’s vastly truncated WHCOA format allows no opportunity to evaluate all that has been heard or to prepare thoughtful responses and proposals. At a time when we need creative thinking and innovative ideas, we are still at the stage of tabulating opinions. This is a tragic lost opportunity created in large measure by unwillingness to fund the conference as in past years. How can we afford to simply give lip service to what is one of the major social challenges of the next decades? We need active, impassioned, thoughtful public dialogue if we are going to generate the support we need to make the changes we want to get a system that is fair and effective. All four of the focus areas command attention. All four need creative ideas. We can afford neither to continue down the road we have taken, nor to deviate from our commitment to improving the lives of older people in need of care and resources.

Each of us should take every opportunity to tell people about the problems that older adults face and to suggest ways to solve them. It would be wonderful if someday soon most Americans could describe their retirement years in terms similar to those used on these pages. In the meantime, we need to work on ways to better address the challenges of long-term care. (See the story on the Long-term Care Re-think Tank in this issue.) If WHCOA won’t do it, each of us needs to become a spokesperson to raise public awareness about the needs and the opportunities to improve the lives of older people.

Passion and Expertise

Three Spring Distinguished Lectures Co-Sponsored by the Center on Aging

The Center on Aging co-sponsored three exciting and well attended Distinguished Lectures this spring, given by renowned scholars who brought great passion and deep knowledge to their topics.

Vincent Mor, PhD, from Brown University, gave a panoramic view of the evolution of long-term care in his lecture, “Three Decades of Long-term Care Research” on April 13. Mor observed that over the last 30 years, four big lessons have emerged: 1) Policy matters from DRGs to other intended and unintended documentation of reductions in restraint use, to recent reductions in hospitalizations and signs of less functional decline, big and small trends in outcomes appear real and may be as large as we observe in some drugs. 3) Consumer demand matters: declining beds/1000 and rising HCBS spending and utilization reflect social values and preferences, not just a response to policy elites, but it is slow just like in medicine; what are the implications for consumer-driven care? 4) What has research and data given us? Observational data is critical to evaluate policy (could be more valuable if more readily available and real time) BUT clinical trials are essential to knowing what interventions improve care. He noted that his future directions will focus on efforts to build InnoVAtive Network for Nursing HOmE research (IVANHOE) and described the trials now underway.
David Barton Smith, PhD, from Temple University, described the role of Medicare in hospital desegregation in “Civil Rights, Medicare, and the Secret Struggle to Transform Health Care” on May 7. Smith recalled how in March of 1966, the federal government entered into the highest stakes gamble in domestic program history, as it implemented the Medicare program, by enforcing Title VI of the 1964 Civil Rights Act. Title VI prohibits federal funding of racially segregated and discriminatory organizations. As many as half the nation’s 8,000 hospitals in the new Medicare program were transformed, largely in secret and almost overnight, from racially and economically segregated private institutions (many of which excluded blacks completely) into highly integrated systems. After the implementation of Medicare, disparities in health care use by race and income largely disappeared and disparities in health narrowed. Dr. Smith’s lecture explored why and how this happened, the side effects that persist, and the lessons this experience offers to current efforts to assure equity in access to health care and health.

Mary Naylor, PhD, RN, from Pennsylvania School of Nursing, traced a remarkable course of research on chronic care in “Transitional Care Model: A Journey from Evidence to Impact” on May 22. Dr. Naylor, along with a multidisciplinary team of colleagues, designed the Transitional Care Model (TCM) to address the negative effects associated with common breakdowns in care when older adults transition from hospitals to their homes or other care settings. The TCM focuses on achieving longer-term positive outcomes by preparing patients and family caregivers to more effectively manage common changes in health associated with multiple chronic conditions. The TCM emphasizes coordination and continuity of care, prevention and avoidance of complications, and close clinical treatment and management. This is all accomplished with the active engagement of patients and their family caregivers and collaboration with hospital and community-based providers. With the support of numerous foundations, the TCM has been successfully translated into diverse health systems and community-based organizations. The approach has been extended beyond just care transitions to form the basis for chronic care. Multiple NIH-funded clinical trials have consistently demonstrated the positive impact of the TCM on older adults’ outcomes while reducing total costs of healthcare.

MAGEC Summer Institute Tackles the Role of Technology in the Future of Long-term Care

“Good technology should create new opportunities to do a job that people want done.” Tim O'Reilly

“The population that could benefit from technology the most is the population least capable of using it,” observed keynote speaker Majd Alwan, PhD, at the May 28th MAGEC Summer Institute, Using Technology to Improve the Care of Older Adults. “We have to acknowledge that technology is not going to be a replacement for in-person health, especially for those far down the path of cognitive decline.”

As fate would have it, Dr. Alwan was punting a bit in his presentation rather than showing the short video he had ready, because the media technology in the lecture hall was not working. “This is a metaphor for the problem with technology,” noted Robert Kane, MD, Director of the Center on Aging. “Whenever you have technology, you need somebody to fix it and someone to run it. It’s not labor saving, it’s employment generating. How will this work in long-term care?”

Despite these hurdles, the use of technology in caring for older people is growing fast, and certain technologies can support better function for older adults while maximizing health care effectiveness. Summer Institute attendees participated in an interactive day exploring various technologies and their implications for aging care, including activity and health monitoring, telehealth, monitoring and intervention, environmental design, robotics, care coordination, and assistive devices for mobility, among others. Two nationally renowned experts in technology and aging presented keynote addresses, Dr. Alwan and George Demiris, PhD, FACMI, along with presentations by an array of local experts.
Alwan emphasized the importance of proper implementation of technology for best results. “If we don’t want to rely on technologists or the IT team to make the technology work and to troubleshoot, then we need to invest time and effort in the thorough planning of the implementation and even the selection of each technology. And we need to engage clinicians as well as the technical team on the customization of chosen products.” He described two schools of thought. “Some technology companies bring their knowledge of best practices in a certain setting and they design their product with very little room for customization, whereas others build products that are very customizable for different environments. The latter approach is more usable and sustainable, but it takes longer and costs more to implement.”

“Evaluating technologies is difficult,” said Kane, “because you cannot predict what the impact is going to be. You can’t know until it is extensively developed and widely used.”

Questions of Quality of Care and Cost
Balancing the use of technology with need for interaction and relationships is a challenge. In response to an audience member observing, “Most people I know already feel some alienation due to doctors and nurses staring into computers,” Alwan pointed to the need for training in how to use technology with appropriate regard for human interaction in health care. “We need to stress the importance of bedside manners, how to use technology as an aid, as a tool, and not as the full focus. I have to admit, sometimes it’s really hard in this information age. You’re trying to sift through a lot of information, but at the same time you have limited face time with patients, and reimbursement is based on that limited time. If we changed the payment model and the operational model, we could change that.”

Other attendees raised issues of cost, asking: “Providers think it looks great, but who will pay? Has funding for technology mostly been grant based? If the technology pays for itself, what is the obstacle to payers getting on board?” “The most significant impediment to getting providers on board,” Alwan said, “is that these technologies can accrue savings, but those savings accrue to private insurance and Medicare, and most often the investment is on the part of the care provider, so that is misalignment.”

The Need for Patient-and Community-Centric Technology
Dr. Demiris stressed that for technology to be harnessed most effectively, we will have to shift from institution-centric to patient-centric and community-centric services and assessment. He described smart homes, environmental systems, and wearable systems all designed to enhance safety and function for older adults. “Ultimately, patient and consumer empowerment will be key,” he said.

“Technology is a huge marketing force,” said Dr. Kane in his closing remarks. “There is great excitement about it, but we have to ask whether the technologies are responding to a need or creating a demand. In some cases, people don’t recognize a need until they get the technology, and then they can’t live without it. We have to ask if we are developing technologies for today or tomorrow. Today the care system is fragmented, slow, etc. What we want tomorrow is technology that is integrated, time sensitive, and geared toward providers all aiming for the same goal.”

About the Keynote Speakers

Majd Alwan, PhD, is Senior Vice President and Executive Director at LeadingAge Center for Aging Services Technologies (CAST) in Washington, DC. Prior to joining CAST, he served as an assistant professor and the director of the Robotics and Eldercare Technologies Program at the University of Virginia’s Medical Automation Research Center. Dr. Alwan’s research interests include passive functional and health assessment, biomedical instrumentation, medical automation, and eldercare and assistive technologies.

George Demiris, PhD, FACMI, is the Alumni Endowed Professor in Nursing at the School of Nursing and Professor of Biomedical Health Informatics at the School of Medicine, University of Washington. He is the Director of the Clinical Informatics and the Patient Centered Technologies Program. He also directs the National Institute for Nursing Research (NINR) and funded T32 Training Program in Aging and Informatics at the University of Washington. His research interests include the design and evaluation of home-based technologies for older adults and patients with chronic conditions and disabilities, smart homes and ambient assisted living applications, and the use of telehealth in home care and hospice. He is a Fellow of the American College of Medical Informatics, a Fellow of the Gerontological Society of America, and a member of the Washington State Academy of the Sciences.
Family Caregiving in the New Normal

A New Book edited by Joseph Gaugler and Robert Kane

Family caregiving is central to the long-term care system of the United States. Family caregivers, mostly unpaid, provide the majority of assistance to older Americans in need. According to numbers from the Pew Research Center and the California HealthCare Foundation, the portion of adults who are family caregivers jumped from 30% in 2010 to 39% in 2012. Almost two-thirds of these are caring for a parent or in-law. And now family caregiving is about to face a perfect storm as a host of influences—demographic, political, and economic—converge to complicate family caregiving in drastic ways. Demographic forecasts show that the numbers of caregivers per older adults needing care will be much lower than today. We simply cannot expect to do things as we do today; nor should we want to.

Family Caregiving in the New Normal, published in May by Academic Press, discusses how extreme economic changes over the past few years have precipitated a new conversation on how family care for older adults will evolve in the future and lays out a roadmap for stakeholders who will be tasked with finding solutions. The editors are Joseph Gaugler, PhD, professor in the School of Nursing and Center on Aging at the University of Minnesota, and Robert Kane, MD, who holds an endowed chair in long-term care and aging at the University of Minnesota School of Public Health and directs the Center on Aging.

“We combine stories of people's personal experiences of caregiving with analyses of what we know about caregiving and how the next several decades are likely to change how family care is provided,” says Gaugler. The book incorporates the best thinking of renowned experts on a range of elements that affect how family caregiving will be organized and addressed in subsequent decades. The demographic elements include sociodemographic trends such as divorce, increased participation of women in the workforce, geographic mobility, fewer children in post-baby boom families, chronic illness trends, economic stressors, and the current policy environment. These factors will affect policies and practices.

One future strategy relies on technology-based solutions that examine existing models, personal health records, and mobile applications, big data issues, decision-making support, person-centered approaches, crowd-sourced caregiving such as blogs and personal websites that have galvanized caregivers, and new methods to combine paid and unpaid forms of care.

“We also wanted to identify how and why the personal dimensions of caregiving can highlight the chasms between science, policy, practice, and the day-to-day needs of family caregivers,” say the editors, who stress that the personal and the political are inextricably intertwined in the context of family caregiving. Ultimately, they seek to provide a roadmap for policymakers, clinicians, decisionmakers, and caregivers who will face an increasingly complex caregiving environment.

“Looking forward to the next several decades,” write the editors, “caregiving may be facing the perfect storm. The collision of demography and economics catalyzed by a polarized political atmosphere may place greater pressures on caregivers. Due to the aging of the baby boom cohort, fewer adult children to provide family care, and a reduction of community-based long-term care services available to supplement family care, families may be expected to provide more help to disabled elderly relatives than ever before. Although this impending challenge is formidable, Family Caregiving in the New Normal outlines some possible solutions and other emerging forces that may help sustain family caregivers in the future.”

Ultimately, the editors note that the disruptive changes of the past several decades are both good and bad news. “The bad news,” they write, “is that caregiving is still caregiving, and there may be pressures to get more of it from fewer caregivers. The increasing prevalence and duration of chronic illness among older persons may exacerbate the pressures of caregiving for families. The good news, though, is the increasing recognition of the roles that families play in the provision of such care. Technologies are now available to potentially enhance care coordination, and more information than ever is available to assist families throughout the course of a relative's need for help.”

Family Caregiving in the New Normal seeks to ask this key question: “With the many disruptive and converging social, political, economic, and technological trends, how can we best support family caregivers as they provide help to their older relative now and in the future?”

Family Caregiving in the New Normal edited by Joseph Gaugler, PhD, and Robert Kane, MD

• Provides a concise “roadmap” of the demographic, economic, health trends, and policy challenges facing family caregivers
• Presents potential solutions to caregiving so that scientists, policymakers, and clinical providers can best meet the needs of families and communities in the upcoming decades
• Includes in-depth, diverse stories of caregivers of persons with different diseases who share perspectives
• Covers person-centered care approaches to family caregiving that summarize effective community-based services of psychosocial intervention models
• Examines how existing efficacious models can more effectively reach and serve individual families
News, Notes, and Notable Achievements

Fesler-Lampert Chair in Aging Studies Announced
Ling Li, DVM, PhD, has been selected as the 2015-2016 Fesler-Lampert Chair in Aging Studies. Dr. Li is an established researcher in Alzheimer’s disease and holds the VFW Endowed Chair in Pharmacotherapy for the Elderly in the College of Pharmacy at the University of Minnesota. She has a strong commitment to promote research and education on aging and age-related conditions such as obesity, inflammation, and atherosclerosis. Her goals for the year are 1) to promote research and education on aging and Alzheimer’s disease by organizing a symposium on aging and Alzheimer’s disease research and education, and 2) to conduct a pilot study to generate necessary preliminary data for the resubmission of an NIH R01 grant to develop a new HDL mimetic peptide for treating Alzheimer’s disease.

A reception to recognize Li, along with this year’s chair, Benjamin Capistrant, will be held this fall. For more information about the Fesler-Lampert Chair, established in 1999 through the generosity of David and Elizabeth Fesler, visit www.coa.umn.edu/Research.

Kordell Scholarship Awarded
Each year, the Center on Aging honors exceptional students with the Shelley Joseph-Kordell Scholarship; this year’s recipient is Tai Gilbert, DNP, MSN, RN, PHN. The Kordell scholarship is awarded to U of M graduate students who are planning careers in aging and to professional students who demonstrate experience and a commitment to work with older adults. The scholarship honors the legacy of Joseph-Kordell, a pioneer in the field of geriatric care management until her tragic death in 2003.

Dr. Gilbert is a PhD candidate in the School of Nursing. Her dissertation will examine the physical and psychosocial impact of an aerobic exercise program for family caregivers of individuals with Alzheimer’s disease. One of Gilbert’s career goals is to expand access to healthy aging, particularly for those with a familial risk of developing Alzheimer’s disease. Her research and experiences as a student and caregiver will help build a research trajectory for developing healthy lifestyle-based interventions aimed at maintaining years of quality life for families and communities affected by Alzheimer’s.

Cognitive Status Examination Videos Available Online
MAGEC has supported the production of several short instructional videos on administering cognitive status examinations, now available on the ACT on Alzheimer’s website and YouTube page. “These videos are attracting a significant number of views with no marketing,” says Mary Ek of ACT. Videos range in length from under a minute to around 20 minutes. Specific topics include an introduction to cognitive screening administration and scoring and demonstrations using videos with patients of how to administer and score the three major measures: Mini-Cog, Montreal Cognitive Assessment (MoCA), and St. Louis University Mental Status (SLUMS), as well as techniques for delivering a diagnosis, care coordination, legal planning, and medication management.

The links to the training videos can be found at www.actonalz.org/node/513.

Graduate School Funds New Aging Studies Interdisciplinary Graduate Group
The Center on Aging and School of Nursing have received funding from the University of Minnesota’s Graduate School to support the development of a new interdisciplinary faculty and graduate student group focused on applied aging studies. Members will bring diverse perspectives and backgrounds: social, behavioral, environmental, health, economic, design, technology, humanities, and administrative. The group will provide a platform for graduate students and faculty with an interest in aging studies to network and collaborate. Activities will include a journal club, methods presentations, career development workshops, and guest lectures. We will sponsor an interdisciplinary research team competition and a research showcase. Feedback on aging-related manuscripts and grant proposals will also be provided.

This is a great opportunity for students with an interest in aging to meet colleagues and develop or hone relevant skills. All faculty and graduate students are invited to participate. Planning will take place over the summer with a kick-off event in September.

If you would like more information or want to be involved, please contact the Center on Aging at coa@umn.edu.
The purpose of Old News is to provide timely information about events, education, and research in aging to the professional and public constituencies of the University’s Center on Aging and the Minnesota Area Geriatric Education Center.

Letters, opinions, and news items may be sent to:
Editor, Old News, Center on Aging
D351 Mayo (MMC 197)
420 Delaware Street SE
Minneapolis, MN 55455
Tel: 612-624-1185
Fax: 612-624-8448
Email: coa@umn.edu
Website: www.coa.umn.edu

The University of Minnesota is committed to the policy that all persons shall have equal access to programs, facilities, and employment without regard to race, color, creed, religion, national origin, sex, age, marital status, disability, public assistance status, veteran status, or sexual orientation.

Happenings

**Minnesota Gerontological Society/MAGEC webinars**

“Recommendations from Minnesota for the 2015 White House Conference on Aging”
Thursday, July 9, 2015, noon – 1 p.m.
with Kari Benson, MPA, Planning Coordinator, Minnesota Board on Aging, and Rajean Moone, PhD, Executive Director, Minnesota Leadership Council on Aging

“Hoarding Disorder: A Panel Discussion”
Thursday, August 27, 2015, noon – 1 p.m.
Panelists include Janet Yeats (The Hoarding Project), Nate Berg (Bio Hazard Cleaning), Stephanie Rasley (Professional Organizer), and Kevin Benshoof (Fire Department)

**Minnesota Network of Hospice & Palliative Care**

“Speaking of Being Mortal”
Friday, September 18, 2015, 6:30 – 8 p.m., St. Paul RiverCentre Ballroom
A life-changing conversation with Dr. Atul Gawande, author and surgeon, as he explores what really matters in end-of-life care.