Dementia: The Disease of Our Generation

Scientists know that certain brain changes begin to occur about 15 years before memory loss and other symptoms of Alzheimer’s appear. The hope is to use neuroimaging and biomarkers to identify presymptomatic people who are destined to develop Alzheimer’s, so they can get treatments that could prevent or stop the disease before it causes more brain damage. But many critical knowledge gaps remain.

“The million-dollar question,” says Dr. Petersen, “is whether the different types of neuroimaging and cerebrospinal fluid biomarkers researchers now use to detect the earliest brain changes of Alzheimer’s—including amyloids in the brain—can predict who among cognitively normal people will develop Alzheimer’s and who will not.”

“If someone is clinically normal, but has amyloids, will he or she go on to develop Alzheimer’s disease? That’s what we can’t yet predict,” Petersen explains. “About 25% to 35% of people in their 80s will have amyloids even though they are clinically normal. Were the amyloids deposited years ago? Are some able to tolerate the amyloids while some are not? Why will some patients progress to Alzheimer’s while others will not?”

Early Alzheimer’s Diagnosis – Should We Do It?

• No early treatments are yet available
• It is expensive
• Screening measures are needed
• Early diagnosis has implications for patients—e.g., potential negative emotional and psychological impacts
• Patients want to know
• Early diagnosis allows patients and their families to make financial and life course plans

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The obvious motivation for and benefit of early diagnosis would be preventing progression of the disease, but currently that’s not possible. The four FDA-approved drugs for Alzheimer’s treat symptoms but have no impact on disease modification. And while the drugs are generally well tolerated, Dr. Petersen says they may have a finite period of effectiveness in patients. This raises complex questions about the best time to begin treatment.

Alzheimer’s: The Faces

Sandy Oltz first noticed a problem when she was assigned to teach a new computer program called EPIC to her colleagues at St. Cloud hospital where she worked as a surgical nurse. Always a quick learner, Sandy discovered herself unable to retain the steps and sequences of the new technology, let alone teach it to others.

“My boss asked me to take some time off work,” says Sandy. “I didn’t know what might be going on—was it a brain tumor? Depression? Strokes? No one was even thinking about Alzheimer’s because of my age.” Sandy was 45 years old.

Sandy’s eventual diagnosis of early Alzheimer’s (about a year later) resulted from a collaboration of doctors from St. Cloud and Mayo Clinic.

“I was actually relieved when the diagnosis came, because I thought I was going nuts,” she says. “I was putting bras in my son’s underwear drawers and towels in the fridge. Knowing what was wrong was better than not knowing.”

Sandy addressed attendees at the Summer Institute as a part of a panel titled Living With Alzheimer’s: The Patient Experience. The panel, moderated by Michelle Barclay, MA, vice president of program services at the Alzheimer’s Association of Minnesota and North Dakota, included three individuals living with Alzheimer’s and their spouses and partners.

Karen Starr, 72, was diagnosed with Alzheimer’s two years ago, shortly after she met her current partner, Chuck Hartell. Karen told Chuck about her diagnosis about three months into their relationship. “I told him I wouldn’t blame him if he left me,” she says. But Chuck stayed. Today he says that being a caregiver to Karen has been a gift, teaching him to slow down and live in the moment. Karen, now retired, helped found Chrysalis Women’s Center and worked for more than 20 years as a program officer at the Otto Bremer Foundation. Karen and Chuck enjoy reading, hiking, and camping as well as exploring meditation together.

For Dick Wagner, diagnosed with Alzheimer’s at age 62, giving up his work as a psychotherapist came as one of the greatest losses. Dick’s practice included therapy for couples, individuals, and groups. “I loved my work,” he says. “If I’d been able to continue I would have.” Dick and his wife Carol have developed many strategies for coping with Dick’s condition, including a prayer that they recite aloud together as often as needed throughout the day, especially when patience becomes strained or grief mounts.

All members of the panel acknowledged the sorrows that come with Alzheimer’s. Sandy’s husband, Rod, cried softly as he described the financial burdens of experimental drugs and living with one income. Carol shared sadness over how Alzheimer’s changes a marriage or partnership. “And there’s the fear that accompanies knowing the disease is progressive,” she says.

Yet, despite revelations of pain, uncertainty, and loss, members of the panel repeatedly circled back to hope. “The way the message is delivered is crucial,” says Sandy, who thanks the Alzheimer’s Association and her physicians for communicating optimism and empowerment. “A friend who was diagnosed around the same time was told to go home and get her affairs in order, and not surprisingly, she spiraled downward rapidly until she started getting more positive care and advice.”

“Thank you! This panel challenged my perceptions; i.e., the panelists were not much older than me! And they shared stories of living with early Alzheimer’s—not dying with Alzheimer’s.”

– Summer Institute Attendee

To learn more about Alzheimer’s disease or to seek information and support if you or someone you care for is diagnosed with Alzheimer’s, visit the Alzheimer’s Association’s website at www.alz.org. For additional opportunities for raising awareness of Alzheimer’s and related resources in communities throughout Minnesota, visit ACT on Alzheimer’s at www.actonalz.org.
Minnesota-Based Collaborative Receives Odyssey Policy Award for Outstanding Leadership That Improves the Lives of Older Americans

ACT on Alzheimer’s, an innovative Minnesota-based collaborative working to help communities prepare for the multi-faceted impacts of Alzheimer’s disease, has been honored with the 2013 Age and Disability Odyssey Policy Award. The award recognizes a group that has demonstrated public policy leadership resulting in improved quality of life for elders, people with disabilities, and their communities.

ACT on Alzheimer’s Background
In 2009, to tackle the mounting Alzheimer’s crisis in Minnesota, the Minnesota Legislature charged the Minnesota Board on Aging to establish the Alzheimer’s Disease Working Group (ADWG) and make recommendations for policies and programs that would prepare Minnesota for the future. The ADWG developed a set of recommendations for the Legislature in January 2011 and a coalition formed to focus on implementing the recommendations. Originally called Prepare Minnesota for Alzheimer’s 2020 (PMA 2020), that coalition is now known as ACT on Alzheimer’s. The project has developed a curriculum on Alzheimer’s disease for health professionals that can be accessed at www.coa.umn.edu.

Five Clear Goals for Creating Dementia Capable Communities
Today, ACT on Alzheimer’s is a statewide, volunteer-driven organization fueled by the belief that by coming together community by community to create supportive environments for everyone touched by this disease, Minnesota will be prepared for Alzheimer’s. The collaboration has more than 150 participants, including some 50 nonprofit, governmental, and private organizations, and works toward five goals:

1. Identify and invest in promising approaches that reduce costs and improve care.
2. Increase early detection of Alzheimer’s disease and improve ongoing care and support.
3. Sustain caregivers by offering them information, resources, and in-person support.
4. Equip communities to be “dementia capable” to support residents who are touched by Alzheimer’s disease.
5. Raise awareness and reduce stigma by engaging communities.

Dementia Capable Community Toolkit
One way in which ACT is equipping communities to create supportive environments for people with dementia is through developing and distributing a “dementia capable community toolkit.” The toolkit outlines a clear four-step process that communities can use to strengthen themselves while improving overall services, supporting caregivers, and preparing health care professionals, clergy, service staff, and others involved in the support of those affected by Alzheimer’s.

“There is cutting-edge collaborative is doing phenomenal work,” says Pat Schommer, Associate Director of the Center on Aging. “In fact, it’s being presented at an international conference of the Alzheimer’s Association in Boston this summer as a model that can be replicated in other states and countries. Here we have a Minnesota-based project that’s leading the way for communities around the world. Their work is outstanding.”

ACT’s international impact will gain even more traction this fall. The organization has been selected to present its community toolkit work at the Alzheimer’s Europe Conference in Malta in October 2013. “Through an international peer review process, ACT on Alzheimer’s submission was one of only three U.S. abstracts accepted for presentation at this conference,” says Mary Ek, ACT on Alzheimer’s project manager. “We will learn a great deal from other countries working on dementia friendly and capable communities.” ACT will present on a panel with five other countries at the European conference.

To learn more about how you can get involved with ACT on Alzheimer’s or to download the community toolkit, visit www.actonalz.org.

Why Our Communities Must ACT on Alzheimer’s

- One in nine people age 65 and older has Alzheimer’s disease.
- Young onset Alzheimer’s, occurring in people under age 65, is on the rise.
- About one-third of people age 85 and older have Alzheimer’s disease.
- By 2025 the number of people age 65 and older with Alzheimer’s disease is estimated to increase 40%.
- Older African-Americans and Hispanics are proportionately more likely than older whites to have Alzheimer’s disease and other dementias.

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Lessons from the Demonstration Project for the Quality Assurance Program Initiative for Nursing Homes

With the passing of the Affordable Care Act (ACA) in 2010, the U.S. government required a compliance program to be instituted in each nursing home by the end of 2013. Once the regulation is in place, each home will be required to have a quality assurance and performance improvement (QAPI) program within a year. Stepping beyond quality assessment and assurance, QAPI regulations introduce performance improvement as the key ingredient—and unlike previous regulations about nursing home care, this one mandates that the Centers for Medicare & Medicaid Services (CMS) provide technical assistance to the nursing homes.

History of the Project

In response to the ACA, CMS contracted with the University of Minnesota (U of M) and its subcontractor, Stratis Health (an independent nonprofit quality improvement organization) to conduct a demonstration project. That project began in fall 2011 and will conclude in September 2013. The project’s aim was to develop and test materials, including a number of best practice examples, for CMS’s future national QAPI regulation rollout.

At the outset of the project, Dr. Rosalie Kane, QAPI demonstration project director and professor in the Division of Health Policy and Management at the U of M School of Public Health, summarized the pertinent questions: “It’s one thing to have a list of expectations, but what are the roadblocks? How useful are the various materials that have been created?”

The demonstration project included 17 nursing homes in four states (California, Massachusetts, Minnesota, and Florida). Participating homes represent a wide spectrum of facilities with regard to size, location (rural and urban), ownership (chain, nonprofit, and independent), and prior quality assurance experience.

QAPI Goals

“The goal of QAPI is that each home systematically identify for itself its most salient quality issues with input from a variety of sources, including staff, families, and residents,” explains QAPI demonstration project co-director, Dr. Robert Kane, professor in the Division of Health Policy and Management at the U of M School of Public Health. “Then, after identifying the issues, the home prioritizes them, develops its own plan to respond to them, and tests out solutions. If the solutions work, then the home would implement systematic changes to make improvements in perpetuity.”

Toward that end, facilities that participated in the demonstration project received tools and resources from the U of M to develop and manage their own QAPI programs, including early access to developing an online QAPI resource library of training modules, evidence, and best-practice case studies.

“Training consisted of developing educational modules around the five core elements of QAPI,” says Robert Kane. “We also provided individual technical assistance to each of the homes and convened three learning collaboratives in which we brought the homes together to share their experiences and to teach each other and us what works and what doesn’t in establishing a QAPI program.”

“Performance improvement is the new kid on the block; nursing homes are already required to have quality assurance. Performance improvement is a proactive effort to use data to understand and improve your own challenges.”

– Rosalie Kane

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Early Successes, Yet Challenges Remain

Robert Kane says that it’s clear as the demonstration project concludes that the homes using the tools developed by the U of M made more progress than those not using the tools. “They found it very helpful,” he says. “This is not necessarily at the top of their agenda every day, but they generally found it to be a positive experience. Of course, they got a lot of help—much more than will be realistic in a national implementation among 16,000 nursing homes. Nonetheless, they taught us a lot.” Notably, some of the demonstration homes are making sustainable system-level changes. “They’re using root-cause analysis to get at the crux of the issue instead of the old standard of simply increasing in-service training,” explains Pat Schommer, Associate Director of the Center on Aging.

The release of a draft regulation outlining the official requirements of a QAPI program is still forthcoming, and the regulation won’t take effect until at least a year after the draft. “But in the meantime,” says Robert Kane, “we’re gearing up for a national implementation of QAPI in collaboration with quality improvement organizations and major nursing home organizations across the country.”

“The unanswered question is how you marry the two elements of QAPI. Quality assurance is linked to regulation and may punish those who are not living up to quality. On the other hand, performance improvement is an internal process whereby homes identify their own needs for improvement and work toward positive change. Nursing homes are concerned that if they expose problems through the PI part, they can be punished through the QA part.”

– Robert Kane

A Step in the Right Direction

Robert Kane notes that we’re involved in a major effort to change the way quality is being managed in nursing homes. We’re moving from a mindset of quality assurance to one that is more balanced and that emphasizes performance improvement. We’re moving away from a punitive regulatory model to one that is more positive and emphasizes improvement. “It’s not the answer to the last crusade,” he says, “But it’s a step in the right direction.”

“More Useful Than I Used To Be”

Words of Wisdom from the U of M’s Oldest Professor

Professor John Fraser Hart, who recently celebrated his 89th birthday, says the world has changed so profoundly since he taught his first class that the differences can’t be summed up. The WWII Navy sailor has been teaching geography at the University of Minnesota since 1967.

“Each year I have a new group of students, and I teach them,” says Hart. “It’s all fun, I enjoy doing it, and my job is to make it as fun for them as possible.” Not surprisingly, Hart acknowledges that the most exciting years on campus were in the late ‘60s. “You had political activism, students rebelling, Vietnam—it’s been a long time since students have barricaded Morrill Hall.”

What hasn’t changed is the privilege Hart feels for the opportunity to share his knowledge. “I am just an old-fashioned country geographer who likes to make and use maps,” he says. Hart also likes to tell stories in the darkened classroom as he clicks through his collection of Kodachrome slides—50,000 total—all of which Hart took himself.

“I try to understand what I see as I ramble through rural areas, and I supplement my observations with census data and maps that are based on these data,” says Hart.

“I enjoy sharing what I have learned, both in the classroom and through scholarly publications, which to me are inseparable aspects of the research process.” Toward that end, Hart has published 17 books.

Most of Hart’s work has centered on aspects of rural landscapes in the Midwest and in the South. He still travels, and he still takes slides, but not as much as he used to. And he takes teaching one year at a time. “I would like to think I have learned something each year, each month, each day, and that I’m continuing to grow, doing better than I did 40 years ago,” he says.

But what of the critics who claim that the trend toward delayed retirement and an aging professoriate is limiting opportunities for younger teachers while straining university budgets? “In my department I don’t see that,” says Hart. “In fact, within the last two years, two faculty members died and two left. The department is shorthanded, so maybe I’m more useful than I used to be.”
Caring for the Elderly – In Whose Hands?

Challenges and Opportunities for Expanding this Workforce in an Aging America

Consider this phenomenal fact: two-thirds of people worldwide who have reached the age of 65 are still alive today.

This reality and its staggering implications set the stage for the Center on Aging’s distinguished lecture presented in April by Robyn Stone, DrPH, Executive Director and Senior Vice President for Applied Research at LeadingAge in Washington, DC. “It’s so frustrating that the aging workforce isn’t on the top of our priority list,” says Dr. Stone. “The top of the list is technology–telemedicine, alarms, sensors, electronic medical records, etc. But behind technology are people.”

Increasingly, long-term care facilities are becoming post-acute units, while the workforce is largely made up of individuals with associate degrees. “It’s a problem of numbers, but even more so, a question of whether we will have a competent workforce to meet the need as the elderly sector grows over the next 20–25 years. It’s a train wreck waiting to happen,” says Dr. Stone.

Sizing Up the Challenges

Obstacles to developing an adequate supply of qualified long-term care providers are many. Dr. Stone highlighted the following significant hurdles to be overcome:

• Difficulty in recruiting
• Rapid turnover
• High vacancy rates
• Aging of professional and direct care staff (current average age is 46)
• Inadequate preparedness of potential candidates for long-term care (LTC) given current and future realities
• Poor image and the lack of financial incentives exacerbate recruitment and retention problems

According to Dr. Stone, the problem of providing an adequate workforce for the mushrooming demand for LTC defies the simple concept of supply and demand. “The labor pool of caregivers is actually shrinking,” she says. “The negative stereotype of LTC doesn’t draw people.”

Heading Off the Train Wreck

According to Dr. Stone, the obvious solution for the numbers problem is to expand the supply of qualified professional caregivers. Toward that end, Stone emphasizes the need to create more competitive positions with wage and benefit redesigns. “We’re going to need to improve working conditions and the quality of job positions,” she says, “and make larger and smarter investments in formal and continuing education of the LTC workforce.” Additional priorities should include developing new models of LTC service and moderating the demand for LTC personnel.

Dr. Stone underscores the need for more and better training for LTC professionals. “The expanding LTC population requires a highly trained, competent workforce across all settings,” she says. “And we know geriatric training is linked to quality, as are interdisciplinary team approaches.”

Major strategies cited by Dr. Stone for achieving a highly trained workforce include:

• Establish teaching nursing homes
• Tie surveys to demonstrated staff competencies
• Increase clinical and educational placements
• Train the workforce to do the work
• Redesign technology to retrain quality
• Encourage retired physicians, nurses, and administrators to volunteer as mentors
• Employ retired CNAs to train family caregivers
• Recognize that family caregivers can become providers

“At the end of the day, we need to educate people,” she says. “Technology can complement the workforce, but only if we have a qualified workforce to use the technology.”
News, Notes, and Notable Achievements

Scholarship Awarded to Students in Aging Studies

Each year, the Center on Aging honors exceptional students in the field of aging studies with the Shelley Joseph-Kordell Scholarship. This year’s awardees are Jessica Finlay, a graduate student in the Department of Geography in the College of Liberal Arts, and Rusudan Kilaberia, a PhD student in social work with a minor in gerontology.

The Kordell scholarship is awarded to U of M graduate or professional students who demonstrate a commitment to working in the field of aging and bettering the lives of seniors. The scholarship honors the legacy of Joseph-Kordell, who was a pioneer in the field of geriatric care management up until her tragic death in 2003.

Kordell scholarship winner, Jessica Finlay
Kordell scholarship winner, Rusudan Kilaberia

Ms. Finlay is passionately engaged in work with older adults through both research and community volunteerism. “I’m dedicated to developing a better understanding of the relationship between neighborhood environment and senior health and wellbeing,” she says. Ms. Finlay hopes to expand the concept of aging in place, which supports responsive neighborhood environments that accommodate a broader diversity of citizen goals, values, and abilities. “My long-term goal is to develop concrete research findings that urban planners and governments can consult and utilize when re-developing cities and neighborhoods with aging populations in mind,” she says.

Ms. Kilaberia's commitment to the field of aging stems from positive life experiences with older adults. Since September 2013 she has been involved in the Late Life Supportive Care project titled LifeCourse with the Allina Center for Healthcare Innovation in Minneapolis. Additionally, she currently resides at the Augustana Apartments in Minneapolis, a Continuing Care Retirement Community. “I moved to this facility in January 2012 as part of a service learning opportunity,” she says, “and I decided to continue living here.” Ms. Kilaberia provides social support to Augustana residents and program and logistical support to the facility. “I have become aware firsthand of the realities many older adults face with regard to transitioning between care levels, daily activities, and life satisfaction.” Ms. Kilaberia’s goals include completion of her dissertation work on end-of-life care teams.

Special Recognition

Doug Olson, who received his PhD in Health Services Research, Policy, and Administration from the University of Minnesota, was honored with the 2013 Distinguished Alumni Award from the College of Business at the University of Wisconsin-Eau Claire at their annual banquet in April. Dr. Olson is an associate professor of health care administration and director of the Center for Health Administration and Aging Services Excellence (CHAASE) program at UW-Eau Claire.

In addition, Dr. Olson and two colleagues, Dr. Jennifer Johns-Artisensi and Ms. LaNette Flunker, received the Business and Health Administration Association’s 2013 MBAA International McGraw-Hill/Irwin Distinguished Paper Award for their paper, “Developing Effective Preceptors for Future Health and Aging.” Dr. Johns-Artisensi is the associate director of CHAASE and coordinates their regional geriatric education center, which is a member of the MAGEC Consortium.

United Way Project

With support from the Greater Twin Cities United Way, the Center on Aging is developing opportunities for students interested in aging to work on aging-related projects with a United Way funded agency. Under this arrangement, students will have the opportunity to gain experience while agencies will receive support on specific projects. The Center on Aging will receive a list of potential agency-based projects with which we will match interested students. Each participating student will receive a stipend. The goal is to give students real-life experience in aging work and hopefully to interest them in a career in nonprofit service.

MGS Award

Dawn Simonson, Executive Director of the Metropolitan Area Agency on Aging (MAAAA), received the Dutch Kastenbaum Gerontologist of the Year Award at the Minnesota Gerontological Society’s annual meeting in April. The award recognizes individuals who have contributed to the lives of older persons throughout Minnesota. Through Dawn’s leadership the MAAA is involved in many new initiatives or promising practices for older persons, specifically chronic disease self-management, care transitions across acute and long-term care settings, and efforts to help communities prepare for an older population. In addition, her work ensures that core programs of caregiver support, meals, transportation, and long-term care options consultation meet the needs of older adults to help them maintain independence in the community.

Fesler Lampert Chair Announced

The Center on Aging has named Dawn Lowe as the 2013-2014 Fesler-Lampert Chair in Aging Studies. Lowe, an associate professor in the programs in physical therapy and rehabilitation science with a PhD in exercise science, has dedicated her research career to the biology of aging. Her plans for the year are to broaden the aging research conducted in her laboratory and to join forces with the Powell Center to co-sponsor events on the theme of estrogen, mature women’s health, and musculoskeletal health. Lowe and this year’s Fesler-Lampert chair, Niloufar Hadidi, will be recognized at a reception this fall. For more information about the Chair, established in 1999 through the generosity of David and Elizabeth Fesler, visit www.coa.umn.edu/Research/index.htm.
The View from Here

The Once and Future Nursing Home

We are experiencing a climate change—and it is not just global warming. Long-term care is heating up too as the population ages and economic fears escalate. Today’s situation has changed radically from that of a decade ago ... or has it? Nursing homes now serve at least two distinct groups: short stay admissions devoted to rehabilitation and recuperation and long-stayers—largely people with dementia. The former are more lucrative. The question, raised several decades ago by those founding subacute care businesses, remains today: Can the same organization and staff be skillful and effective at both lines of business?

The goals and emphases of these types of care differ. Subacute care aims at positively affecting a person’s recovery trajectory. At least some of the limitations associated with hospital care (e.g., double beds, schedules) are tolerated (not to say they should be) in the name of improving function. Subacute care involves managing complex conditions that are still unstable. Medical care and clinical attention from nursing are critical.

Long-term care is a different matter. It is more stable. Quality of life issues are more salient. The living environment plays a strong role. Witness the excitement over small home designs. At the same time, beliefs are changing about how this long-term care should best be delivered. Community-based care is gaining ascendancy. The weight of opinion is now shifting to declaring community care the first choice and nursing homes as a fallback.

Of course, some people will be difficult to manage in the community but probably fewer than is currently believed. Promising examples of innovative care for people with dementia, even quite advanced, point to the art of the possible.

One intriguing idea, recently resurrected, centers on the question of what would happen if we changed the way nursing homes were paid for long-term care and stopped the outdated practice (based on hospital care) of paying for room and board. In one step we would eliminate the distinction between institutional and community care. Facilities would need to compete on amenities as well as basic care. Such a step would raise questions about coordinating living and caring, but we have already addressed these questions in several settings.

Eliminating room and board charges would also leave the subacute industry freer to develop a more effective product, perhaps one that borrows more heavily from rehabilitation. The growing interest in bundling payments between hospitals and subacute care would support such a step.

Nurses and therapists would presumably perform different roles in the long-term and subacute worlds. Whereas the latter are aimed at active rehabilitation, the former seek to maintain function and encourage independence. Success would be defined not simply as the absence of adverse events (e.g., pressure sores, medication errors, and hospitalizations), but as the enhancement of quality of life. Indeed, quality of life would then receive as much attention as quality of care does now.

The aging of the population strongly suggests that old approaches will not work. We cannot simply multiply the status quo by a larger population figure and hope to get an affordable answer. We need to be prepared to think about delivering care in radically new ways. Ironically, we are talking about raising the education requirements for various jobs just when we need to innovate with using less expensive personnel but within a framework of accountability. Information technology may help by providing both proactive guidance and retrospective assessments. Such new thinking will revive long-standing concerns about the trade-offs between risk and autonomy, and about who can do what to whom.

There may be room for new answers in a shifting climate.
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.

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Happenings

MGS and MAGEC Webinar

Getting the Long-term Care We Want
Wednesday, July 24, Noon - 1:00 pm

Join us as we discuss long-term care in a special two-part MGS/MAGEC webinar (offering two units for CEU credits):

Webinar Part I
Geriatric Education Module on Long-term Care
View on your own before attending the Webinar

Webinar Part II
“Getting the Long-term Care We Want”
By Robert L. Kane, MD, University of Minnesota,
School of Public Health

Register Now!

www.mngero.org
There is no cost to attend this webinar, but registration is required to receive the login information.

The University of Minnesota’s Center on Aging is a University-wide center for research and education focused on aging. Our mission is to foster basic and applied gerontology research and education that will inform public policy, prepare students at the undergraduate and graduate level for work within an aging society and provide information and outreach to help address the health and well-being of older adults.