State Society on Aging of New York

SSA BULLETIN

SUMMER 2009

NOW THAT I AM ALMOST 64, WHO WILL MEET MY NEEDS WHEN I AM 84?

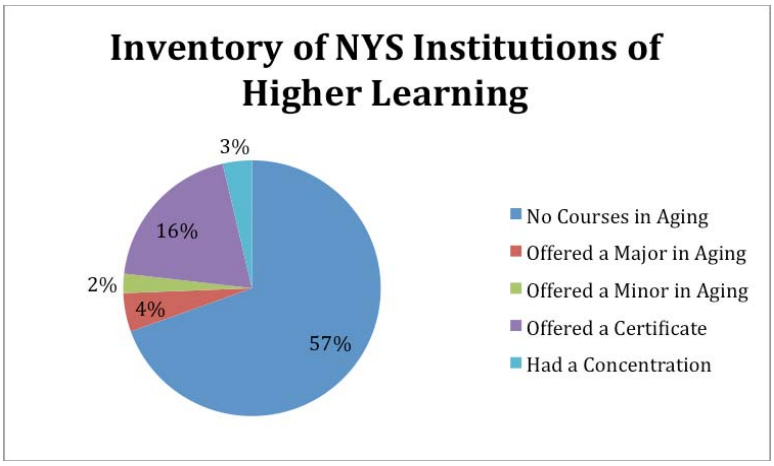
By
Deborah Heiser
Judith L. Howe
Robert Maiden
Beverly Horowitz
Pat Brownell

When you think of growing older, what comes to mind? Fun, family, golf, workforce issues...? Workforce issues? Yes, workforce issues. Believe it or not, we need to pay very close attention to them. Each day 8,000 baby boomers turn 60. In 2011, 78 million baby boomers will begin to turn 65. The Bureau of Labor Statistics (2005) estimates the demand for employment in aging will increase 26% over the next few years – particularly in health related jobs. All the while, those 85 years and older are the fastest growing segment in the U.S. population. This age group is expected to double in 2030 to 9.6 million and to double again by 2050.

Unfortunately, there is a down side to all of this longevity. There is a HUGE need for a trained workforce to serve the aging. According to Boxer and Collins (20007), 8 out of 10 older adults have at least one chronic illness and, of those, about 2/3 have multiple chronic conditions that require complex treatment and coordinated care. Maiden, Chireac, and Maiden (2002) found that 50% of people requiring in-home care are 85 but older-family members find it difficult to secure, manage, maintain, and pay for adequate in-home assistance. To meet the demand, we need 36,000 certified geriatricians; we only have 7,128 in the U.S. Despite the demand, and the increase in demand, the supply of in-home workers remains very low and is expected to remain low. Even those who are available receive very little training and are then asked to perform functions they are not adequately trained for (Maiden & Maiden, 2004). Only 5% of social workers are trained in aging issues and only 3% of advance practice nurses specialize in aging. "Besides being inadequately prepared in geriatrics, the current workforce is not large enough to meet older patients' needs and the scarcity of workers specializing in the care of older adults is even more pronounced" (Institute of Medicine, 2007, p. 5).

To determine what was going on in education**, Dr. John Krout**, a professor in New York State and a Past President of the State Society on Aging of New York, recommended taking a look at the New York State Institutions of Higher Learning. Based on this recommendation, an inventory of all schools within the state was conducted. The findings were astonishing!

Of 242 schools in higher learning:



- Note ***Only one school, now defunct, offered a PhD.

The State Society on Aging of New York (SSA) and The State Office on Aging of New York (NYSOFA) teamed up in 2007to create the Workforce Project charged with understanding training needs in the State of New York. The SSA and NYSOFA conducted a series of 8 Listening Sessions across the State. The notes taken during each of the Listening Sessions were compiled and a content analysis was conducted to systematically identify key words and phrases used at each Session to determine important structures and themes. The results are based on ratings provided by three independent coders who identified and tallied themes discussed at each of the Listening Sessions.
A total frequency and percent of discussion associated with each key topic was determined for each of the seven major discussion questions that framed the Listening Sessions.

The 6 Questions asked at each of the 8 Listening Sessions were:

Question 1:
Do you see a need for more education about aging staff in your organization?

Question 2:
On what topic would you like to see more education?

Question 3:
How should training / educational opportunities be presented?

Question 4:
What credentialing and certification should be considered?

Question 5:
Should gerontology be infused into college curricula? Across disciplines?

Question 6:
What is the ability of organizations to support education/training for employees

The Top 10 Key Findings were:

RANK	%	KEY THEME
1	71%	Understanding needs to start with school children - it should be incorporated into grade school curriculum
2	42%	Need the funding for advanced education
3	38%	Payment for and scholarships / pay increase
4	25%	No incentives
5	24%	Online Training with good modules
6	21%	Time off for education/training
7	20%	More training needed for aides, which needs to be at the level of their comprehension
8	18%	There is a disconnect between employers and academic institutions
9	17%	Work-site training and mentoring
10	17%	Face-to-face training

The findings from the Listening Sessions, as described in the Content Analysis show that a variety of issues were brought up. Some were brought up only once, and some several times. The organizations collaborated again at the SSA's Annual Conference in 2008 to discuss the findings and "next steps" with 120 conference participants. The participants completed questionnaires. Notes were taken and were reviewed for key themes with regard to the four workforce training and education questions posed to the group. The results are broken down by question:

Question 1:
What do you think are good next steps we can take?
The overarching theme for this question was education. Forty seven percent (47%) of the responses and notes highlighted the need for education from k-12. Additionally, they recommended educating college students earlier in their undergraduate education, and employing online education. Other responses with suggested sensitivity training for gay/lesbian issues in training aides, elder abuse training, expanding nursing programs, fully funding GECs, emphasizing Geriatrics as a career, exposing teachers to SSA and Teach for America, and grassroots efforts.

Question 2:
Of the top 10 key issues identified, what do you see as the most important to focus on?
There were three distinct themes for this question. Thirty nine percent (39%) of the responses advocated education, 39% training, and 22% financial aide and incentives. With regard to education, the responses were: education for k-12 and all curriculum, college students receiving education earlier in their undergrad education, and online education. Training responses were: aid training, caregiver training, and work-site training and mentoring. Financial aide and incentives were not broken down further.

Question 3:
How can we – area agencies, academics, practitioners, and government – work together to move workforce education and training issues forward?
There were two distinct themes for this question with 42% of the responses advocating financial solutions (financial aide and incentives, support the Boxer Bill, and fully fund GECs) and 31% supporting increased education (education – k-12 and all curriculum, online education, and pilot curriculum programs for secondary education.

Question 4:
Can you think of any other incentives for promoting education and training in aging?
Nearly 67% responded that there was a need for community service for high school students; approximately 33% responded that there is a need for increased payments and reimbursement for medical and social services.
Recommendations coming out of the Next Steps, SSA conference, mirrored the listening sessions. They focused on education (k-12 in particular, and online training). Responses for education were addressed in questions 1-3, and for two of the three questions, was a top response.

NowWhat?
We must now move toward addressing the issues brought up by New Yorkers as key workforce issues.
To read the full report published in 2008 by NYSOFA, please go to the State Office of Aging of New York Website: http://www.aging.ny.gov/ReportsAndData/WorkforceEducation/Introduction.cfm

Abuse and Agism in the Workplace

By

Mebane Powell, MSW

When you hear the term abuse, what pops into your mind? I bet that if I could talk to you directly, you would most likely think of abuse as something that occurs at home between partners, against children and against the elderly. Similarly, if I were to ask you do we live in an ageist society, I would wager that most of you would say yes. However, I would wager that few of you reading this thought about abuse and ageism as occurring in the workplace. I recently participated on a panel at the United Nations NonGovernmental Organization Committee on Aging meeting and I'd like to share some of my speaking points.

It is well recognized that the aging population is facing enormous challenges in the workplace, during economic times that some would call a perfect storm for ageism and abuse in the workplace. In his book The Longevity Revolution: The Benefits and Challenges of Living a Long Life, Dr. Robert N. Butler notes that "Ageism is a form of systemic stereotyping and discrimination against people simply because they are old" (p.40). However, mistreatment of older people is often not recognized as abuse when it occurs in the workplace.

The Madrid International Plan of Action on Ageing does address the rights of older people to serve as productive citizens and have their skills and abilities recognized and appreciated in both paid and civic engagement long after they turn 60 years of age. I urge everyone who is reading this to think of the issue around ageism and abuse in the workplace as a human rights issue.

I am often reminded of a quote regarding who and/or what determines which social problems should be addressed by policy; the quote is as follows: "Social ethics and political forces are intimately tied together, especially in terms of WHICH social problems to address, HOW to address them, and weather or not the disproportionate risk certain groups face is of paramount concern in the world of program implementation and practice" [Social Policy Analysis and Practice – Meenaghan, Kilty, Mcnutt].

Fortunately, the formation of policy to address the issue of bullying in the workplace as a social problem is occurring, and gaining strength. However, we (professionals, practitioners, advocates, and students) all have a responsibility to be aware of the need for the creation of policy that includes workplace education, organizational behavior, and the interplay between the individual and the organizational environment.

Research into the issue is needed in order to support and provide evidence for policy advocates. As I've told my students, research can be likened to creating a great symphony. Each section is in charge of carrying out their piece of music, each section supports the others, and each section has a chance to take the lead. In other words, research should not happen in a vacuum, all professions should work with each other, psychologists, social workers, economist, and public health professionals, must all play their part.

That being said, we are at a time where the coming together of professions is of utmost importance in order to answer the question: "What are the next logical and most productive steps research can take to provide outcomes and input into policy implementation and practice?"

In a presentation about psychological abuse in the workplace by Dr. Shah, two key points were raised. First, a legal definition of bullying would help employers develop policies – rules and regulations alone will not solve the problem. Second, In order to provide an effective strategy for combating ageism and abuse, we must also include education, conflict resolution mechanisms, and a commitment from employers that is based on good business practice.

However, there are also other issues to consider in terms of future research and policy formation that I would like to share with you, they are:

o The need for a clear and concise definition of abuse in the workplace in order for researchers and organizations to address the issue and to be able to measure the impact of policy implementation and outcomes (Does the implementation of a policy decrease the abuse?).

o What types of abuse are occurring in the workplace and how are workers defining abuse in the workplace? Is there consistency in the definition across industries? More importantly, how do we begin to measure ageism and abuse in the workplace?

o In terms of organizations, are there certain organizational structures that promote or prevent abuse and ageism from occurring? Or is it the culture of the organization that plays a larger role and is the key to prevention and/or promotion of abuse and ageism?

o Have prior discrimination policies been evaluated regarding the ability to implement policies within organizations? What were the challenges to implementing these policies and how can we use this information to increase the success of implementing policies regarding ageism and abuse in the workplace?

In conclusion, I want to remind everyone when investigating the issue around ageism and abuse in the workplace, to use the international human rights frame to guide us in future policy, practice, and research. Thank you!

What are your thoughts?

Mebane E. Powell is a doctoral student at Fordham University, Graduate School of Social Service. She has a Masters Degree in Social Work with a concentration in Research from Fordham University and a BA in

Psychology from the University of North Carolina at Wilmington. Ms. Powell has worked in the field of psychosocial research since 2000, focusing on elder abuse as well as vision loss in the aging population.

BARTER YOUR WAY TO CAREGIVER SUCCESS

By
Vicki Rackner MD

Family caregivers' most common lament is, "It's ever enough." Those caring for aging parents or sick relatives are short on time and energy. Now they're short on money, too. How will they get the help with errands, cooking, or childcare/eldercare services may mean the difference between sanity and burn-out?

Bartering may be the caregiver's new secret weapon.

My friend Suzy and I stumbled on a barter arrangement that works so well it feels like cheating. I offer some details of our Sunday dinner ritual in hopes that you can create similar magic in your own life as a busy caregiver.

Suzy and I are both single parents of only children. Both of us work full time outside of the home. Our children, who are the same ages, often click like siblings. Suzy is an imaginative parent who brings out the best in kids. Cooking, which is a chore for her, is recreation for me. Each Sunday Suzy helps the kids cook up some fun as I cook the meal. We eat, then enjoy the kids' offerings.

Sometimes Suzy mutters something about imposing on me since I do the cooking. I quickly remind her that the only thing she is imposing is her belief that cooking is burdensome for me. Plus I'm as grateful for the smiles she helps put on the kids' faces as she is for the meal.

While caregiving is hard for everybody, it's hard for different people in different ways. Once you know what's easy for you and what's hard for you, you can join forces with others in the same way Suzy and I do.

Consider pooling resources with neighbors, friends and family. Barter your way to caregiver success. Consider swapping trips to the pharmacy, dog-walking, home-cooked meals, massages, carpooling or an hour of home maintenance.

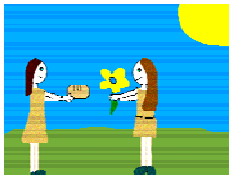
Here's what a caregiver swap community listing might look like:

I offer you:

- *Two trips to the pharmacy*
- *Weekly vacuuming*
- *A home cooked meal for four*
- *A manicure and pedicure*
- *Two hours of home maintenance*

In exchange for:

- *Bathing my dog*
- *Taking my kids to swim lessons*
- *Mowing the lawn*
- *A neck massage*



How you can help family caregivers release hopes for a cure without giving up hope

By
Vicki Rackner MD

Jill wonders what to do. After six months of grueling rehab, her father-in-law has not made a complete recovery from his stroke as everyone hoped. The doctors predict he won't get beyond this plateau. Jill passed along news of a promising experimental treatment to her father-in-law. He said, "Thanks, but I'm done fighting. It's time to just learn to make peace with my body as it is."

Someone like Jill may turn to you for guidance. How do you counsel her when she asks whether it's time to wage war against disease, or whether it's time to wage peace? What is your answer when she asks how family members can release hopes for the victorious cure without giving up hope? And then how to heal the rift when family members disagree?

When my patients and their family caregivers posed these questions to me, I was hardly a neutral observer. I quietly wondered how I could see myself as a competent physician when I failed to cure my patient.

Then one day, in a light bulb moment, I realized I was making this conversation about ME. I was falling short of the professional standards I set for myself. Medical professionals, after all, put the needs of the patient above their own.

Once I put the focus back on the patient, magic happened. When the chances of cure are remote, we're paradoxically invited into the heart of the mission of a physician or nurse or mental health care professional. We're here to alleviate pain and suffering.

In so doing, we serve our patients at a time of need. Further, we model behavior that can guide family members' actions.

Here's what I tell family caregivers like Jill, feel free to reproduce it for your clients and patients.

How caregivers can release hopes for a cure-- without giving up hope

Vicki Rackner MD
July 2009

Sue says, "We have a family motto. 'We're here to help Mom live and die on her own terms.' Whenever there's a disagreement about medical choices, we return to our motto. Even if it's not what any one of us wants for Mom, we can usually figure out what Mom wants for herself." The most fulfilled family caregivers let their loved ones' hopes and dreams guide the way.

Many families struggle as the hope of cure fades away. Do you ramp up treatment in an effort to fight the disease, or do you surrender to the most likely outcome? Here are some concrete tips to those caring for aging parents or a sick partner or friend at this fork in the road.

1. Ask rhetorically, "Now, who is the patient?" In many ways it's harder to stand by as a loved one's caregiver than to be the patient yourself. While the medical choices your parents or your partner or your friends make influence your life, it's their body. They get to choose. As the family leader, you can come back to the phrase, "Let's remember who the patient is."

2. Define the reality. Make an honest assessment of where you are right now. How much do you know? When will you know more?

Seek information from the experts about what usually happens to people in your loved one's shoes. What are the chances of a full recovery? What will day-to-day life be like once the situation stabilizes?

3. Remember there are no right medical choices. If only there were! Your religious beliefs and personal ethics guide big life-and-death choices. Most choices, though, fall in the grey zone. How many doctors will you take your brother to see about his mysterious symptoms? How much pain will your partner endure before finally taking medication? How aggressive will you be with the dietary modifications that saved the friend of a friend? These are all judgment calls best left in the hands of the body's owner.

4. Do some detective work and tease out the factors driving your loved one's decisions. Do your very best to see the world through their eyes. Ask, "What did you hear the doctor say?" Gently explore the factors driving the decision with questions like, "What keeps you up at night?" Or "What's most important to you?" You may trip over their belief you need to challenge like, "I don't want to be a burden."

Ed says, "A few weeks before my wife died, she told the hospice nurse she would rather die than have nausea. I wonder if that's just the choice she made when she said no to chemotherapy. I regret we never had the conversation. I'll never know whether she knew about the new medications for nausea." This is the kind of regret you want to avoid.

5. Stay flexible Patients, including your loved ones, are allowed to change their minds. Sometimes patients just wake up one day and decide it's time to stop fighting. Sometimes they decide it's time to start fighting again.

6. Assure that depression is not speaking. Even an emotionally healthy person facing pain, sleepless nights and social isolation can experience clinical depression. Make sure the depression is treated before your loved one makes life-altering choices.

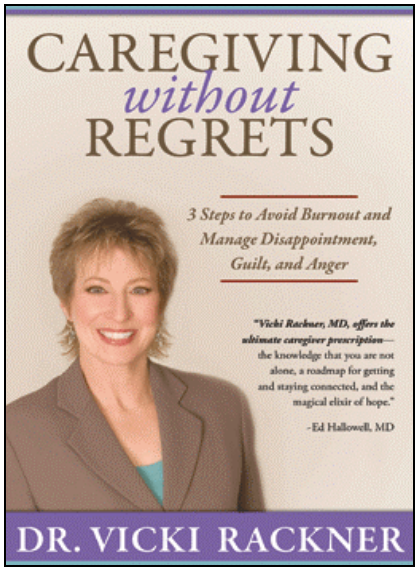
Your loved one may have grown up at a time when depression was a shameful condition. You don't even have to use the word. Say, "You know how your body feels run down? Your emotions get run down, too. The doctors can prescribe medication for this pain just like they treat your back pain."

7. **Keep hope alive.** Hopes and dreams are like a vase filled with flowers. Hope is like a special vase that holds the belief that you can expect a better tomorrow. The dreams are like the flowers that change over a season.

For most patients the dream is a medical cure-- and a long drink in the fountain of youth. Even when cure is not an option, you can replace it with a different dream. It's like going into the garden in the winter to find an interesting branch for the vase.

Let your loved one paint the dream. Then let these hopes and dreams be a source of strength that guides you and your family to solid footing and beyond.

Frank conversations about these topics offer clarity at confusing times. There is comfort in the understanding that your job is not to ask, "What do I want for my loved one?" but rather, "What does my loved one want for himself, and how can I help make that happen?"



Vicki Rackner MD is a former surgeon and founder of The Caregiver Club
www.TheCaregiverClub.com
She's an author and speaker; her latest book *Caregiving without Regrets: 3 Steps to Avoid Burnout and Manage Disappointment, Guilt and Anger* is described as a "must read" for family caregivers.

MEMBERS IN THE NEWS!

Dorothy Hickey, MA, MPH, RN is a clinical adjunct professor of community health nursing. She presented two posters at the International Council of Nurses Congress in Durban, South Africa this past June. The first poster titled "Innovative Education/Community Partnership for Elders," is based on CareLink, a program in which NYU undergraduate students collaborate with nurses from The Visiting Nurse Service of New York. The second poster is called "Nursing Services in a Community-Based Food Program," and is based on the Momentum Project HIV program – which brings communal meals and supportive services to New York City residents with HIV/AIDS and their family members. Dorothy is a nurse consultant for this program.

IMagineAge

The ***ImagineAge*** Blog is designed to stimulate conversation between people interested in finding out about boomer generation topics in a single forum. This blog is a blend of information from the world of "academia" with real life experiences voiced through your participation. Read, watch videos, and learn how to live your life Healthy, Wealthy and Wise. Keep up-to-date with trends and take a workshop. Get the info you need and share your thoughts. It's an opportunity to discuss topics you express interest in, all here, in one place, in a format you can use.

VISITE THE
IMAGINAGE WEBSITE
at

blog.imagineage.com

Read about the importance of staying hydrated, especially for the elderly, during the summer in **Vicki Rackner's**

Caregiver's Club blog

thecaregiverclub.wordpress.com

SAVE THE DATE

"Caregiving and an Aging Population"

October 15-17, 2009
The Hyatt Regency
Rochester, NY

37TH ANNUAL CONFERENCE OF THE STATE SOCIETY ON AGING OF NEW YORK

For SSA Abstract Submission Information:

www.ssany.org

Abstract Submission Deadline: June 29, 2009

SSA Webpage: www.ssany.org

Dear Colleagues,

Mark your calendars –The State Society on Aging (SSA) of New York is hosting its annual conference in Rochester – October 15-17, 2009. Our theme for 2009 is "Caregiving for an Aging Population." We would also like to invite you to submit an abstract for a paper, workshop, poster or artistic work on a gerontological topic. Visit our webpage for more detailed information about the conference and directions on how to submit an abstract. Any questions about the conference should be directed to the SSA Conference Program Co-Chairs:

Diane Rehse diane_rehse@urmc.rochester.edu
Christeen Verchot cbverchot@utica.edu

We look forward to seeing you in Rochester!

Sincerely,

Thomas V. Caprio, MD, SSA President, 2009

Check the SSA Webpage: www.ssany.org
for Abstract submission details

Abstract submission deadline – June 29, 2009

The State Society on Aging of New York provides a forum for the exchange of information, exploration of issues and concerns, and the development of policy recommendations in the field of aging.

To become a member of the SSANY visit our website www.ssany.org and fill out an application. Please send all applications to:
Carmen Morano, PhD
Brookdale Center for Healthy Aging and Longevity
425 East 25th Street, 13th Floor North New York, New York
10010

*Please make all checks payable to:
New York State Society on Aging

Isabella Geriatric Center
Attn: Meredith Morris
515 Audubon Avenue
New York, New York 10040