DR. MONIKA WHITE
Interviewed by Hannah Hamovitch
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Dr. White earned both her Masters and a Doctorate of Social Work at the University of Southern California in Los Angeles. She has extensive experience as an educator, researcher, consultant and administrator. Since the mid-1970's, Dr. White concentrated her work on coordinating health and community-based service delivery systems for older adults and their families. A nationally-recognized author and lecturer in the aging field, Dr. White is the President and Chief Executive Officer of the Center for Healthy Aging in Santa Monica, California, and an adjunct professor at the USC Davis School of Gerontology in Los Angeles. In addition, Dr. White is the President of the California Social Welfare Archives.

HAMOVITCH: The purpose of this interview is to include you, Monika, and your important work, into the California Social Welfare Archives. When I conduct an interview, one of the first questions that I ask is, "What made you decide to go into social work?"

WHITE: Social work came to me, rather than me seeking it out. I'd intended to be a high school English teacher. That's what I thought I was going to do when I went to college. While I was in college, I was working as a secretary at Rosemary Cottage - you may know the agency – it's a home for emotionally disturbed teenage girls and it was full of social workers. I had a lot of encouragement to go into the field, but I was determined to be a teacher. That was something I had always wanted to do. One of the people there, a social worker named Eldene Bush got me to volunteer at the YWCA in Pasadena. That started a long career of volunteering. I call it a career, because I did so many things, starting out with the Professional Women's Business Group lunches, working with kids, interviewing families for camp, and so forth, all while I finished my undergraduate education at Cal State L.A. The day after I graduated with my bachelor's degree, I faced a life-altering decision. I had two job offers. One was from the YWCA to be a Youth Services Director - and the second was from Pasadena City College, running their Remedial Reading Center. By the way, when I was at Pasadena City College, I was a teacher's assistant in the English Department, and actually helped to write the grant that established that Center. That was the decision I had to make. I felt that my education prepared me for the remedial reading position: I was very interested in that. But I had all this experience working with people and had

gotten so much from that. After much consideration, I decided that if I took the job at the College and I looked five years ahead, I'd probably still be sitting there running the reading lab, my bachelor's degree pretty much stagnant. But if I took the job with the YWCA, anything could happen. The decision to take the YWCA job turned out to be very important because after awhile, I won a National YWCA Scholarship to continue my education in anything I wanted in the human service. At that point, I had no hesitation at all: I didn't even apply to any other university except USC, and I only wanted to go to the School of Social Work.

HAMOVITCH: Oh, that's wonderful.

WHITE: Long answer, but…

HAMOVITCH: It must have made you feel terrific to be able to come out of school like that and to have two positions offered. How flattering!

WHITE: Yes.

HAMMOVITCH: What positions have you held since then?

WHITE: At the YWCA, I had many opportunities. Starting with the Youth Services Director position, I worked with children and adolescents in after-school programs, some quite traditional like Y-Teens. I did have a chance to be part of some very creative programs like working with girlfriends of gang members. Over time, I worked with the campership program identifying and interviewing families for camp scholarships. I then spent three summers at the YWCA camp in Idlewild as program director, a wonderful experience that I will never forget. During my work with the YWCA, I also worked as the program coordinator for Job Corps and eventually for the Big Sister Program. I consider these experiences.

Graduate school changed my life again, because I became completely enchanted with research. The idea that you could study a program or a practice; the opportunity to think about the best way to approach an evaluation or to understand what worked and what didn't; the chance to assist in the development of new services—all of it fascinated me and set me off on a new direction. After graduate school, I was able to find employment in research and teaching at both USC in social work graduate courses in as a part-time lecturer and at California State

University (then college) in Fullerton in their undergraduate human services courses. I taught courses in social policy, community organization, and leadership. I don't quite know how I did it, but at the same time, I had a full-time job right upstairs of the old School of Social Work building with the Regional Research Institute in Social Welfare where I had done my second-year field placement. I worked with Dr. Genevieve Carter, a real pioneer in social policy research and gerontology who turned out to be an important mentor and friend until she died. At the Institute, I was involved in grant writing and research projects in social policy, welfare policy, employment, alcoholism, and contracts between government and private service providers and an analysis of Area Agencies on Aging contracts. This latter project was to lead to a future in my career that I never would have imagined. Three years later when I was at the dissertation stage of my doctoral program, Raymond Steinberg, then at the new Andrus Gerontology Center, remembered my work on the Triple A contracts, made me an offer to participate in a three-year, federally-funded project looking at how to keep low-income, frail elderly persons out of institutions and support them at home. I accepted the job on the condition that I could use the data for my dissertation. Out of that project came some important work on case management, something that I became an "expert" in and have been working with ever since.

I graduated in 1980 with the doctorate and was immediately offered a position with the State of California Health Department in the research and evaluation project of a two-year Medicaid demonstration project. They needed someone with knowledge about case management to test alternatives to nursing home placement, train pilot site staff and generally figure out how case management should be done. That project eventually became the Multi-Purpose Senior Services Program (MSSP), still operating and expanding. I then went back to work with Ray Steinberg on a study of board and care facilities in Los Angeles County and I continued teaching part-time at Fullerton.

Then, in 1985, I got a call from June Simmons, another USC School of Social Work graduate, then Director of Social Work at Huntington Memorial Hospital. She asked me to join

her in the development of a new, hospital-based program for seniors. With support from a major bequest, we were able to develop one of the first and best programs of its kind—a program that still stands as a model of outreach, health promotion, life planning, case management, caregiving and efforts to integrate acute and community care of older adults and their families. It was an exciting time that provided me many opportunities to participate in the development of ground breaking, cutting edge programs and services, many of them replicated throughout the country. I was also able to write, teach, conduct professional seminars and provide consultation to other organizations developing their senior programs in response to a growing awareness of the aging population. At the Senior Care Network, as we called it, I was primarily the Associate Director and Department Head for eight years under June, then Director for two. I left to accept the position I now hold as President/CEO of the Center for Healthy Aging (formerly Senior Health and Peer Counseling) in Santa Monica.

HAMOVITCH: Okay, Monika, we talked about the positions that you held. What were some of the frustrating positions, some of the frustrations that you experienced?

WHITE: I had a couple of frustrations as I went along. One was certainly in the research arena, when I discovered that you do all this work, and it ends up on the shelf. I did have that happen more than once, and it is frustrating in that you do your best to find the truth—I don't mean to sound Pollyannaish—and back it up with documentation and research methodology, and then nobody pays any attention to it. I think it takes you a while to settle with yourself that does happen on projects. The other is that in research and evaluation you can see in hindsight what didn't happen and what you missed. If I can give an example, in MSSP, after years and millions of dollars of research for a major effort across the country, we discovered that we saved the Federal Government money, but not the State. It's complicated to explain why it turned out that way, but that was not the intention of the project. It was partially the way the study was structured. There was a lot of having to say, "Is this what we want to do? What can re-direct this?" There has since been quite a bit of work done in that regard.

Another frustration, which is quite pervasive in my work in aging and continues to this

day, is rather major. That is the inability of the acute-care system and the community-care system to coordinate and work together. The medical/health care system is simply where the money, support and policies go. We've done incredible work in coordinating and building some bridges. But in my mind, I see one of those rope bridges across the water that's very shaky and unstable. I don't know what will make that difference. It has to do with reimbursement, with turf issues among professionals, with traditional perspectives, with the inability, somehow, of policy-makers and decision-makers at a high level to see the extreme importance and necessity for care to be looked at in a much broader way than just health care. People have other needs like difficulty getting out of bed in the morning and taking a bath. This is just as important to an individual who is experiencing that problem as getting medical care. We haven't solved that issue. It would take many hours to articulate some of the things we may wish to go about that. But it is a continuing frustration. I feel like I have spent 25 years of my life working on that. I've worked on it in smaller arenas but have had quite a number of opportunities to make input at the State, County and City levels and have been involved in some national activities as well to try to move toward that integration. I'm not in a position to make it happen, but continue to participate in that direction.

HAMOVITCH: In a perfect world, how would you go about it? What is the salient point that you'd like to see happen?

WHITE: In a perfect world, we would have a pot of money that is designated to people's care.

HAMOVITCH: Okay, but elaborate on the type of care that you're talking about.

WHITE: The type of care that I'm talking about is that if you need a by-pass surgery for your heart, you could tap that money. If you are unable to see the cans at the grocery store shelf or to need someone to escort you to the store and help you, you could also tap that money. Or, if you need someone to come in and cook meals or to provide day care, that's needed just as much as medications or a medical procedure. It's a wild dream, because what we have right now is many streams of funding and reimbursement. As long as a problem is tied to medical care or acute care, or follow-up to it, there is some type of help. If you fall on the street, someone is going to

pick you up and take you somewhere, even if it's to a County facility.

HAMOVITCH: Right.

WHITE: But if you have trouble putting your clothes on in the morning, or if you have trouble taking a bath or cooking your breakfast, there's nothing to help you pay for that kind of help. You have to have family or know someone who will do that or have enough money to pay privately.

HAMOVITCH: Or carry groceries or...

MONIKA: Yes. We have a very fragmented system and, in a perfect world, we wouldn't have that. It would be about taking care of people, not because people fit some rigid criteria to be eligible. Eligibility restrictions in our current system specifically exclude many people in need.

HAMOVITCH: In other words, you don't qualify.

MONIKA: That's idealistic to a certain extent, but we could have systems of care that work. It doesn't have to be all or nothing. We could have systems of care where there are truly integrated partners in the community with a hospital, nursing homes, home care, both medical home health and non-medical, home care where we have services within the community such as legal or financial. They could work together. It really is possible. But you cannot tap the medical reimbursement. Why should they let it go? Whether it's managed care or private care, they will not slice that pie any other way. While it is understandable because health care is so expensive and impacts the rest of our lives so significantly, it still needs to incorporate a broader perspective as we grow older and older as a society. Until we figure out a way to either create a new funding stream for the non-medical care or share the funding stream and expand it to include various levels of care, we're not going to solve it.

Non-medical care is funded with what I call "exceptions," meaning waiver programs for very specific types of people, usually old, poor, sick, frail, and vulnerable to expensive illness and placement in expensive care facilities. These exceptions may be in place by legislation or through a lot of black and blue knees from begging for money from fundraising, donations and writing grants. That's just how that non-health care system gets funded and the fragmented

funding leads to fragmented services—one reason case management and the coordination of care is so important.

HAMOVITCH: It's part of the problem that all the programs are fragmented. The money is fragmented, and different people are taking a little from here and a little bit from there. Do you think that there are different parts or different legislation that is provided for and it's too fragmented, that there's not one core?

WHITE: We have a categorical system. It's legislated and it's accepted that way. Everything is in categories. Now we could talk about the positive side of that, because there are many people in any of the human services field who worry that if it were all in one pot with no categories, there could be other problems. The whole is sometimes less than the part. If we pool money, for instance, there is a risk of having less money than there used to be. An example is the elderly and disabled. Currently these populations each have their own funding and programs. In California, we're starting to put long-term care populations together into one category so that the younger disabled and the elderly are in one pot. The economy of scale you get could result in less money for both.

HAMOVITCH: Is that true?

WHITE: Probably. A simple example would be that it takes more people to run two programs than one. You have two directors, two accountants, two secretaries—the reduction of staff alone, would be a major cost saving.

HAMOVITCH: Right, so it should be cost-effective to have one.

WHITE: That remains to be seen, but this is the direction we are going in California but very slowly. We continue to develop policies, write legislations, allocate funds and provide services in categories. I'd like to give you a very concrete, brief example. At the Center for Healthy Aging, where I now work, we have a clinic, a health program as well as mental health and community services. In the clinic, we have a wonderful program through a contract with the State of California, Department of Health, for breast and cervical cancer screening for women without insurance or access to health care. By no insurance, I mean no Medicare, Medicaid,

HMOs, or any private coverage of any type.

HAMOVITCH: Is this just for the elderly?

WHITE: It's for women 50 and older. The money is only for screening. Now I have another piece of money that I was able to get from the Avon Foundation for outreach, to find the women who need screening. So the outreach grant doesn't pay for the screening, which means physical examinations and mammograms. It pays only for the outreach, and the State contract only pays for the screening. If we find a cancer, I have no money to pay for treatment.

HAMOVITCH: Oh, that's awful.

WHITE: We find ways: we beat on the system, and there are pockets of money, where, because of the nature of the population. Now I have to find the people who will treat that cancer: surgery, chemo, radiation, whatever, with either no money, or I have to find some other pocket of money to pay for that. It's an example of the fragmentation and the categorization that we live with. Many programs work like that.

HAMOVITCH: How frustrating!

WHITE: Yes, that's frustrating.

HAMOVITCH: Was there a social movement that you were involved with that seemed important to you but didn't lead to the goals you wanted to obtain? Did we talk about that?

WHITE: Probably not in that context. The thing that comes to mind for me, immediately, is there was a time when I was very interested in the blurring of lines between the public and the private sector. I, at one time, thought that I would like to do my dissertation on that topic, and, in fact, I wrote a brief proposal. I think I was working with Sam Taylor at that time. I wrote a brief proposal, because I had done work with contracts and seen how the service sectors were intertwining. There are very few private, non-profit organizations that don't have some public money now. Locally, there are agencies with a broad mix of public and private monies, for example, Jewish Family Services, Huntington, and AltaMed. I was real interested in that trend, but I didn't get to follow that up. The other one that we have mentioned, and I won't repeat it all, is there was a time when it looked like there really was going to be an effort to integrate

levels of services like acute and long-term and community care. I was part of a national consortium of systems that was piloting new ways of serving people, providing services and pooling funds. They're still working on it, but it has not happened.

HAMOVITCH: How many years have they been working on it?

WHITE: They've been working on it now for going on ten years. It's the National Chronic Care Consortium; a wonderful organization headquartered in Minneapolis. I was lucky to be one of the founding members of that Board. They're doing wonderful work, and they're fighting, trying to get it going, and have made some headway, but it hasn't happened.

HAMOVITCH: In the social movements, what successes would you like to talk about?

WHITE: I think incredible things have happened for the elderly, for caregiving, for acknowledgment of the complexity of an aging society. Of course, my attention and my work have been in aging, so that's the area I feel most knowledgeable about. Specifically, this is in the area of case or care management which is about the coordination of services. There's a tendency to now call it "care management", and there is some debate about distinctions between the terms and the definitions of "case" and "care" management. It's become a very popular approach that centers on figuring out what people need then planning, locating and often arranging the resources and services that address those needs. The whole concept of working this way is being funded through public-sector funds, some insurances and private fees. Case management is now used in nearly every service and setting, not just in aging. It's in hospitals, in mental health, in managed care, in senior centers, to name a few. It's in organizations of every type, serving kids, serving families, serving aids victims, serving the elderly. Aging didn't invent it: there's always been something like that around in the human services. As I've noted in some of my writings, nearly every discipline claims to have invented it and probably each has contributed to its methodology. It's use, however, grew rapidly when the government became interested in keeping nursing home eligible, low income elderly out of institutions and in their own homes, utilizing case management to coordinate alternative services.

HAMOVITCH: Not to this extent, though.

WHITE: It's not really a big social movement, but it's a way to assure that people get services of one kind or another, and it's become the preferred way to bring people and their needs together. As I said earlier, it's being supported by many different sources, including public monies, private monies, fee for services and insurance money for the acknowledgment. It's really a response to the fragmentation we've created—a way to put it together and navigate a difficult, often duplicative and complex "non-system" of services.

HAMOVITCH: So somehow out of the mess, services are being provided.

WHITE: They are indeed.

HAMOVITCH: Than that's amazing.

WHITE: It's amazing, and I've not only seen that happen, but actually, I've been a part of it. I have trained many hundreds if not thousands of case managers. I have probably been responsible for assisting agencies all over the country in developing this type of service. That's really rewarding. I think the social movement is about aging and figuring out what to do about it, acknowledging that it's happening in our society and developing policies, funding streams, and solutions to the issues associated with longevity.

HAMOVITCH: One of the questions I was going to ask you is what significant changes have you observed since you first began to work in presently, but I think that you've almost answered that. If you'd like to add to that.…

WHITE: Yes, there is one area that we should keep an eye on. It's going to be very interesting, even to social work, as a profession. That is the professionalization of case management. Case managers are from every discipline: they're nurses, they're psychologists, they're gerontologists, they're social workers, they are even attorneys and physicians.

HAMOVITCH: They're professionals, also.

WHITE: They're mostly professionals. Of course, it's big in the private sector. Fee for services case management is a very successful business. But what is happening is that it's becoming professionalized. I call it that, though not everybody does. There's professional development training, continuing education, and, increasingly, special certification. There are

now beginnings of degree programs and we will probably see a growth in this in our educational institutions.

HAMOVITCH: I think it's wonderful.

WHITE: There are very specific skills and a knowledge set: there are things you have to know how to do to be a case manager. I have a strong bias about social workers having the best professional training to do the work, at least for the community-based, long term care, psycho-social aspect of care. You have the individual, the group, the community perspective and, at the risk of using a cliche, a holistic perspective. And, in social work, you learn how to form relationships. I call it "relationship and trust-building, 101." You learn about that, you talk about it, it's part of the program. I have not found that to be true in other disciplines. However, there are times when you would want your case manager to be a nurse because of the setting that you are in. If you are in a hospital, for example, it would be beneficial to have the health perspective and the credibility that the nurse will have with the physicians. There is room for many, many of these disciplines.

If we have someone coming out of the liberal arts bachelor's degree, going right into a case manager's degree, we don't have the clinical grounding or the health care grounding and there are issues about that. This is happening. We have research and we have exams. I, myself, am the Chair of the Exam Committee of the National Academy for Certified Care Managers, and we developed a certification exam for people who meet criteria for education and experience. We test their knowledge of the case management process and ethics, as well as some legal questions. They get a certificate on top of whatever degree they have, so that they can go out there, whether they're in a non-profit or private practice or hospital setting and say that they are certified. It's a validation for what they know and what they do. There are about 15 organizations credentialing case managers. Of these, 15 are focused on insurance, rehabilitation, worker's compensation and medical care.

HAMOVITCH: Oh, my.

WHITE: For many of them, you actually have to be licensed to even sit for the exam. Ours is

for case managers who are community-based, working with long-term care, chronic populations and has a psychosocial focus. This is something that we need to keep our eyes on because we definitely need to raise the bar on who is qualified to perform case management functions. I predict that case or care management will soon become a type of profession with university level degrees. Although NASW recently developed a certification for social work case managers, social workers have resisted case management.

HAMOVITCH: Why?

WHITE: That's a good question. It's not sitting with someone for 50 minutes and doing therapy; it's not clinical in the traditional way. It's running around the community and organizing, locating, arranging services. Outside of the assessment process that has a clinical evaluation feel, the perception seems to be that it's not substantive work. But it is substantive work. I promise you that we will, as a field, regret this, because the nurses, the medical profession, rehabilitation folks are right on top of this, and they are getting paid, increasingly, to do this work. We're going to one day say, "Why do the nurses get all the money?" We really have missed the boat, so far, as a field. Most social workers will not and do not want to do case management. We all do it in a way, but they don't call it that. It's very, very difficult. I hope that that changes. I hope to see social work and gerontology schools, nursing schools, even psychology schools, begin to offer case management at least as a course. At least the content is creeping in there, but I see very little of that happening.

HAMOVITCH: I wonder if part of the reason that social workers are kind of bucking it, is because it's a heavy responsibility. It's a responsibility to find all these services, to coordinate all these services, where if they're doing social work, like you said, they're sitting behind a desk. It isn't quite as demanding.

WHITE: I think of it differently - it could be that they think they're already doing that. Many social workers will tell you, "Oh, we've been doing that for a hundred years." As I mentioned earlier, in some respects, every human services discipline does it, and every human services field claims to have invented it. The mental health professionals say they invented it, nurses will tell

you that nurses invented it, community, public health nursing say they invented it, and social workers will tell you that they invented it. My experience is that everybody can claim some part of it. It isn't about who invented it. Everybody thinks they do it. What happened in the arena is that it became systematized and formalized in a way that we have not done in the past. There really is a process, and all of us bring a piece to it of how it's done, who it's done to, where it's done, how it gets paid for, how it's organized, and all that can vary. But basically, there's a core set of tasks that everybody does. My experience is that social workers think whatever they do, they already do it, and they don't need another letter behind their name, or additional training to do something that they know about. That's my perspective and my experience.

I've lectured and taught all over the world on case management, long-term care service delivery systems and related topics. Really, it's not just only case management or care management, but also all that goes with it like systems building and coordination of services and resources for people in need. I've probably spoken three times in all these years to social workers.

HAMOVITCH: Why?

WHITE: I do speak at schools of social work once in a while, but in terms of any major groups such as NASW, no. I've spoken much more to nursing organizations and health care and physicians and anybody interested in aging. But I'm talking about formalized, social work groups. I've also found that social workers as a group are not very interested in aging and that is one area where case management has grown so much. That's another story. They want to work with kids and families and the clinical piece and mental health services, but very few social workers say, "I want to work with older people." They think they're not going to work with older people, but of course, we all will work with them in one way or another. Even if you're working with kids or adolescents or young adults, you're going to run into older people. I would wish that we had more content in aging. Of course, we try. USC has tried. I've been involved when they have an aging concentration, and people didn't sign up.

HAMOVITCH: That's interesting. I'd like to go back to your talking about case or care

management. What changes would you like to see happen? What legislation or bills would you like to see passed to make this effective?

WHITE: The whole area of case management credentialing is volatile right now. Personally, I have some misgivings about certifying case managers, and certainly, about offering degrees in case management, because I believe we need our professional background. As I said before, it's wonderful to have the clinical background and foundation underpinning this work. But we are seeing a move in some arenas toward requiring or preferring case managers who are certified. You can look in the Los Angeles times, and you will see in the ads for nurses that it will say, "certified case managers preferred."

HAMOVITCH: But certified by whom?

WHITE: Well, that's the thing, certified by whom? There's no one organization or body that certifies. There are many. You can get a certificate from the Commission on Rehabilitation, which is there just to certify rehab case managers. I can't remember all the names because there are so many of them. I'm part of the National Academy of Certified Case Managers. Certification is not a license. It's a certificate. A credential could be a license or a certificate.

HAMOVITCH: Should it be a license, legislated by the State?

WHITE: There are state waiver programs, like MSSP, that are looking at asking for their case managers to be certified to work in that program. It's not legislated yet, but some of us who are in that arena, think that it's coming. I don't think it will ever be a state license because of the many other licenses such as the LCSW and the nursing licenses. There are also issues about why someone with an MSW, or an LCSW should be required to be a certified case manager. Somebody who's a licensed RN, should they also be required to have a second license in case management?

HAMOVITCH: But isn't it a specialty?

WHITE: It's a specialty in a way. That's just the issue. We don't have it worked through—should it be? I think it can't hurt to say you have certification to show that you have some core knowledge or core skills in case management, but you're really coming at this as a social worker

or a nurse. We need both, not either/or. That's why I hesitate to say it should be legislated. We don't have it worked out. It's unresolved; something we're in the middle of right now. But we are seeing is the words, "case management," in legislation and funding for case management, and, we think, eventually there will be some certification requirements.

Some insurance companies are already requiring it. In long-term care insurance, for example, some companies require certification in case or care management in order to be a provider for their enrollees. Also, there are now about three insurance companies that provide liability insurance for case management practitioners, and they require that practitioner to be certified. There's also a whole movement of network-building: a national network of case managers, so that if you have an aunt in Ottumwa, Iowa, you can call me up, and through my network affiliations, I would be able to find you a case manager in Ottumwa. Some of these networks are formal while others are less formal. But many of these networks require their members to be certified as a case or care manager. So those are the directions that we are seeing that point to something more formal happening in the future.

HAMOVITCH: Case management is in the really infant stages.

WHITE: Yes, it is.

HAMOVITCH: I'm going to ask you, because I think we've covered quite a bit, what you would like to add. I know that in your teachings - and this is an open-ended question, but I think that you could teach us, and we could learn from your expertise. Could you add something that we have left out?

WHITE: Sure.

HAMOVITCH: Good!

WHITE: What I'd like to add is that we need to convince ourselves, our families, the students that we teach, our colleagues, our friends, and somehow, in a broader way, our communities, that we really are going to be old. For the most part, and you and I have both experienced people who didn't get to be old, but the majority of us are going to be old. I use the term, "old" affectionately and respectfully. Statistics are with us: we are going to live a long time, but we

need to be better prepared for aging. The truth is that nobody prepares us to be old. I think often of Genevieve Carter, who used to speak of her experience with aging quite a bit. I realize, increasingly, how right she was. She used to complain that nobody ever told her what it was really going to be like, and she lived to be 92. I used to say to her, "Gen, please write this down. Let's write about it. Talk about it." I got her a tape recorder and asked her to talk about her experiences so we could learn from that. Unfortunately, she was unable to do it, but I think the lesson is that there are things to be learned, and we have to teach each other. Maybe it's good that we don't worry about it. We shouldn't worry about it but we need to "get real" about aging. We need to learn from our role models—people like Frances Feldman. We all want to be like her.

HAMOVITCH: Absolutely!

WHITE: For the most part, people ignore it. In my work, I see it in dramatic ways: the surprise about aging whether it's yourself or somebody in your family. With 76 million baby boomers coming along - somebody turns 50 every 7 seconds - we must do something to prepare people a little bit better. That in itself could have tremendous implications for what we have to do for those people who really need a lot of help, because it has a bearing on the system of care. We need to get people to take responsibility and do some planning for getting older. I don't have the answer, but it's something that I would like to say. We need to increase the awareness that we're going to be around a long time. How are we going to do that and how do we best plan for that?

HAMOVITCH: Monika, how do you prepare for old age?

WHITE: You prepare for old age by first of all planning for a long life. It sounds so obvious and trite, but there are things that need to be considered. Basically, you have to think about five things: your health, finances, legal issues, housing or environment and your personal supports. Unanticipated health issues can certainly surprise us, but there are a lot of things we can anticipate by knowing about our family histories, by doing the things we all know we should do about eating right, exercising, getting enough rest and so forth. Simply stated, we have to take care of ourselves. It is something we have to work at for the long run.

We have to think about our finances. Most of us are not going to be rich, most of us are not going to have a lot of money, but we still have to survive financially. It's not about everybody being millionaires as they age, but it is about having to figure out how to live later on, perhaps 30 to 40 years after retirement. It's about budgeting and financing and planning for that. *** We also all have to think about some legal issues. We have to think about what's valuable to us in two ways: one, our material things, and what's valuable to us in terms of our preferences. in what we care about, in having someone that you can trust who you designate to take care of you. I always say that even if it's your grandmother's favorite ring, you ought to write down what you want done with it. There's a whole legal arena that you can plan for. And you can do it any time. It's not only about age; you could be in a car accident and find yourself incapacitated and have to make the same decisions as someone who is much older and unable to make decisions because of Alzheimer's or another dementia.. You can always change those things, and you should, in fact, review those things. So it's about health, it's about money, it's about the legal aspects of protecting your interests, material or personal. It's also about housing. Where are you going to live? Everybody says they want to stay at home, but it's inappropriate for some people to live in the place where they've always lived. There are so many housing options that it wouldn't hurt for people to think about alternatives, or at least know about them. If they decide to stay at home, then the home needs to be a place where they can not only live, but where they can die. That takes a lot of planning and preparation and thinking about it. Finally, you really have to think about your support system. It could family, it could be friends, it could be an organization, but the connection, to be connected to someone, and to plan those connections is what you need to do. Now if you and I had no connections but to people our own age, we could be very lonely at 100, and we could be very alone. We need to connect with a variety of ages and people. That doesn't just happen. It takes an awareness and a very pro-active stance to have younger friends, to have a network of support. You can plan for that. If nothing else, you can hook up with a community organization, a Jewish Family Services, a Center for healthy Aging, a religious or spiritual group; some connection. All those things

sound, maybe, simplistic, but they're not. It's takes an awareness, a consciousness and an acknowledgment of "Hmm. I'm going to be around for a long time." Right now, we have almost 60,000 people who are almost 100 and older, and they're the fastest growing population in our country.

HAMOVITCH: Is that the good news or the bad news?

WHITE: I don't know, but fifty percent of them are not in nursing homes.

HAMOVITCH: You mean, 100 and older, and they're not in nursing homes?

WHITE: Right. They might be living with family, or they might be - I'm not saying they're in a swinging singles apartment complex, but they're out there in the community. That's how it's going to be; we can look towards that. I think we need to become more conscious in a positive way. When I do focus groups with older people in their 80s and their 90s, I say, "When do we start talking about aging to people?" There are people who say, "We ought to start introducing it in elementary school." There should be much more exposure to it, and not in a bad way, but in a good and positive way. It's an attitude, it's an awareness, and it's very pro-active kinds of activities that one can engage in. Life changes, of course, but we could be a little more conscious, and as a society, this has to happen.

My experience with the baby boomers is that they are the worst group that I have seen in twenty-five years in the field about denying. The first studies are coming out about the boomers, and they say you have to have a minimum of a million dollars to retire, but as a group, a small percentage of them have a hundred thousand. This is just in a study. Anyway, I don't want to get off on that.

But that is how you prepare a little bit: we need more exposure, and we need more consciousness, but in a positive way. We don't want to say, "Oh, you're going to be old and gray and sick and frail." The majority of people 65 and older are just fine. They really manage. But there are roughly twenty to twenty-five percent who need all this help we've been talking about.

HAMOVITCH: At what age?

WHITE: Age 65 and older, and most of them are 85 and under.

HAMOVITCH: It seems to me that the average age of entry into a board and care was 85 when I left 10 years ago.

WHITE: Yes, 85 and older is a real - there's a certain vulnerability that set in at 85. We don't know exactly what it is, but it's a vulnerability. It's not a "have to," but one gets vulnerable. Most of the people who are in nursing homes or in institutions of care such as residential facilities are 85 and older. But the statistics are always looking at 65 and older.

HAMOVITCH: That seems young.

WHITE: It is young. A 65-year-old today is a very different person than 20, 50 years ago.

HAMOVITCH: Absolutely.

WHITE: We need to redefine aging, and we certainly need to redefine our whole perspective of old.

HAMOVITCH: Because if aging, and your Center - we haven't even touched on your Center, and I think we should. We need to talk about your Center for Health Aging. Earlier you talked about people getting breast screening at your Center at the age of 50, and people are living to 100, that's 50 years of being old? That's a little unrealistic. (Laughter)

WHITE: Yes, that's true. We think 50 is young.

HAMOVITCH: Now that we've passed 50.....

WHITE: That's for sure. Now, the Center for Healthy Aging used to be called Senior Health and Peer Counseling. I've been there five years, and one of the first things that I advocated for was to change the name of the agency. It was called Senior Health and Peer Counseling because those were the first services that were provided there in Santa Monica in 1976. It focused there, and in fact, it is the premier - to this day, it is the premier organization for senior peer counseling. We still do peer counseling. But it has broadened dramatically with focus on prevention, on health care, on mental health to add, not to the peer counseling, but professional mental health and psychiatric services. There are also some real gap-filling in-home and community services that are provided at the Center. I thought with a lot of support from Board members and staff

that we ought to rename ourselves to better reflect what it is that we do. The new name, then, was not only to reflect better what we do, but to also set the tone for where we need to go, which is, that if we're going to age well, we can't start at 65 or 70 or 85. I believe it's never too late, but I think it's never too early. I'm not interested, and neither is the Board or the staff for that matter, in beginning to serve young people. That is not our goal. But we do need some services for younger people, to begin this process, as I said earlier, of raising awareness that we're going to be around a long time. But the name change leaves us wide open to do whatever needs to be done.

I believe that a small organization like the Center needs to be extraordinarily flexible to change and respond to the different directions that the community goes in and the emerging needs and the issues that come up. I just wanted to be able to have a more open venue than Senior Health and Peer Counseling. I just thought that was narrow and narrowing. That was perfect for the time. It used to be called something else, all together, when it first started.

HAMOVITCH: Before Peer Counseling?

WHITE: Yes, it used to be called the Santa Monica Bay Area Health Screening Program for the Elderly. I think I have it close. It was something like that. Then, a couple of years, Bernice Bratter, who was my predecessor for 17 or 18 years, did a remarkable job of putting this small organization on the map. It was a terrific effort, and she did a great job. It's a wonderful organization.

The Center, because of its size - about a $2,000,000 budget, the size of its staff, maybe 100 to 150 volunteers, and we usually have 10 to 12 graduate interns from various schools such as psychology, nursing, social work, gerontology - relatively small, really cannot do what the hospitals and the major organizations like Jewish Family Services with 400 staff can do. We can't really compete in that way. Nor can we compete with the private, non-profit sector, because the majority of our funding comes from the private sector, rather than the public sector. We also can's compete with those senior services organization that get hundred of thousands, if not millions of dollars from Older Americans money or the County or Triple A. We can't really

fight for those funds, and I, as the head of the agency, am a grateful leader in not duplicating the services that already exist in a community. I would rather work with those other organizations and do what I can to enhance their quality rather than saying, "I can do it better, and we're going to do it, too." That's my preference. So, our focus is to fill gaps and to augment the systems that exist and to come up with, to create and develop the services that are not being provided, either because others don't, won't can't - I don't know why they're not there, but they're not there.

HAMOVITCH: Can you give an example?

WHITE: Sure. We have a number of these what I call "gap filling" augmentation services. One of them, clearly, is our Daily Money Management Program. It's not the only one in the world like it, though it has some unique characteristics. It's a program where we actually go into a person's home twice a month, open their mail, pay their bills, reconcile their checkbook, go through their insurance forms with them, or whatever kinds of forms they need help with. That's because there are people who can't see well enough, or they have some other kinds of conditions, maybe they're confused or can't remember.....

HAMOVITCH: I could use that.

WHITE: We all could in some ways. We do this with volunteers, so it's very cost-effective. It's scary for non-profits to use volunteers for something like this, but our model of utilizing volunteers is very, very excellent. Our training and our supervision, our in-services - we're really on top of all our volunteer programs. If you volunteer with us, you really have lots of rules and regulations and requirements. We watch everything very closely, and we've never had any problems. Nobody else does that on the Westside. Believe it or not, there isn't anyone else who's doing Daily Money Management.

HAMOVITCH: It's kind of a risk that no one wants to take.

WHITE: It is. We also have a program - this is a little different direction - where we provide a professional person who is like a care manager type of person, to a major medical group like a primary care medical group, who is available to them, just with a call, if they run into someone for whom they're doing all the medical things, but someone in the office recognizes that

someone may need something non-medical. It could be a nurse, it could be an office manager or it could be a physician. So they can call us, and this person is available to the person to make the links to the non-medical community system of services. That's a real gap filler. We're augmenting health care, we're augmenting the physician's office. It's a wonderful project. We have others like that, but that's the project that was developed at Huntington. One of the projects that we created and developed there, and I've adapted to fit into this community.

We also have another example of that; a program where we work with retired nurses, and they actually help to manage medications for home-bound people who may have a whole range of other services, but somehow, they're not doing well with their meds. These volunteer, retired nurses are programmed to go into the home and figure out what to do about it and to help the person or the family or whomever, to organize and to make the medication work. It's such a risky thing not to take your meds right. I work with physicians and the pharmacists or whatever is needed.

We could go on, but those are a few of the things that we do. The direction that I think we need to go in and that has served us well, is to look for the gaps and to address them. Of course, we have to find the money, write grants, beg and plead, but we do it.

HAMOVITCH: And you've done a beautiful job.

WHITE: Thank you.

HAMOVITCH: Monika, I want to thank you. I think you're fantastic, and I'm really impressed. Not only that, but I'm preparing for my aging, because I don't believe I'm old yet. I've learned a lot, and I think that anyone reading your interview will also learn a lot. I thank you profusely.

WHITE: Now that you've really closed the interview, I would like to add one small thing.

HAMOVITCH: Oh, good.

WHITE: I'm sorry, but I don't want this interview to go by and not say this. I do a lot of writing as you've seen from my resume, and I just want to say that I think it's critical and essential for people who work in the field to write, to contribute to the literature, to the

professional literature. I think it's critical, and I would encourage people who are not in academia to write.

HAMOVITCH: Absolutely, so it doesn't get lost.

WHITE: That's right. There's a lot that we can contribute. I've written from the academic side, and I think it's important for people in the field to write.

HAMOVITCH: Well, your list of publications is really impressive, along with everything else. Thank you, once again.