In 1984, when Jennie Chin Hansen ’70 flew east to visit her father in a Boston nursing home after his second—and most severe—stroke, she recognized one agonizing fact: If she left him there, that is where he would die. Doctors confirmed her assessment.

They told Hansen that her father, Wing Chin, needed stomach surgery that would require him to remain in a nursing home for the rest of his life, forever tethered to a feeding tube. Hansen, who had trained as a nurse, had a different idea. She would bring her father west and let him live his last days among family in California. Against medical advice, she guided the frail man onto a San Francisco-bound plane and brought him home with her.

To do so was to undertake no small risk; a 36-year-old widow, Hansen was already raising her young son alone. After her father’s first stroke seven months earlier, she had brought her ailing mother from Boston to San Francisco and was caring for her, too. Hansen’s schedule was one of full-time

PHOTOGRAPHY BY CATHERINE KARNOW
CONSERVATIVE RADICAL: A political force with a personal touch, Hansen jokes with Lora Connolly of California’s health department at the end of a conference on long-term care (left), then crosses the city for another meeting (center). Hansen balances the political demands of health policy advocacy with the daily duties of supervising care for patients such as Tom Lai Woon, 99 (right).

work and full-time caregiving, with scant time for herself, let alone for an adult who required 24-hour attention, pureed foods and assistance completing even the most basic tasks. So she reached out for help.

Hansen enrolled her father in On Lok Senior Health Services, the innovative community health-care program where she worked as a researcher. On Lok, which is Cantonese for “happy, peaceful home,” had opened in 1972 to provide Chinatown’s oldest, poorest and sickest residents with an alternative to nursing-home care. Housed in a storefront that had once served as a cocktail lounge, On Lok offered medical supervision and social services that allowed the elderly to remain in their own homes, among family and friends. Hansen says the program’s driving philosophy was one of providing care with dignity, and within a cultural context. “We were asking, ‘Why can’t we change the rules? Why not let people age in place, in their communities?’” she says. “Imagine living 70-plus years a certain way. Why should the things that had such meaning for you for all those years not be a part of the final years of your life?”

On Lok offered Wing Chin medical care, physical therapy and nursing support, as well as the more traditional adult day-care services associated with senior-services programs. “After my father started at On Lok, the physical therapists worked with him so he was able to stretch out his body again, to unfurl,” Hansen said. “His medications went from 14 in the nursing home to three. And he had a chance to know his grandson.” Chin never underwent the stomach surgery his Boston doctors had recommended. And he regained sufficient strength to resume painting, debating and eating on his own until he died—five years later. Hansen says reuniting her parents was an accomplishment like no other.

“That night I got my father and my mother in my bed, and they slept together for the first time in seven months,” she says. “I honestly felt that if either one of them had died the next day, it would have been all right because I was finally able to put them back together again. Here were two people who had worked so hard, had struggled through so much. They had had the courage to leave their native country, losing their social order of power and hierarchy. How could I let them have an end to their lives that was less than dignified?”

Today, 14 years later, Hansen is executive director of the program that helped reunite her family. On Lok is now a $33-million-a-year nonprofit organization at the crux of an urgent health-care question. And Hansen is again at an intersection: This time her life’s work is colliding with a national policy discussion. The nation, after all, is at the threshold of the baby boom’s senescence. There are now 34 million Americans older than 65, according to Dr. Richard Suzman, chief demographer for the National Institute on Aging. That number will more than double in the next generation and will likely exceed 70 million by 2030. Further, the number of Americans older than 85 will also double, topping 7 million by 2030.

In the mainstream press, much attention has been focused on the financial burden the senior-citizen boom will bring to society, including its anticipated strain on Social Security. Less attention has been paid to issues of care. “We will soon be seeing ever-increasing costs and demands that mean we will have to make some hard trade-offs, and make them consciously,” says John D. Golenski ’69, a former Jesuit whose company, Bioethics Consultation Group, based in Berkeley, California, advises state governments and the insurance industry. “Keep in mind, this is not just any generation. This is the baby boomer generation.”
They have had better lives than their parents did and they have high expectations about how their lives should be. These are inexorable powerful factors that are going to destroy our health-care system unless we recognize them and prepare.”

As the nation looks for ways to handle the surge in its elderly population, the On Lok model is being put to use nationwide. From Boston to El Paso to Portland, Oregon, geriatric programs have adopted On Lok’s model of community-based care, and in 1997 Congress passed—with bipartisan support—legislation to provide government funding for dozens more.

The key to On Lok’s success, according to Hansen, is the program’s commonsensical approach to meeting the needs of an aging population. Also key is Hansen herself, a 50-year-old daughter of impoverished Chinese immigrants who is determined to do no less than bring order to the chaotic world of geriatric health care.

Hansen calls herself a “conservative radical,” moved in equal parts by a commitment to 1960s-style social justice and by the Chinese cultural values of personal dignity and respect for the elderly. “I show respect for institutions and find opportunities for change from within,” she explains. “Social justice, democratic means, capitalism. That’s my three-legged stool.”

Hansen is a slightly graying five-foot-three-inch tornado of kinetic energy. Dashing down a corridor at On Lok’s headquarters en route to a meeting, she stops one of the van drivers, touches him gently on the shoulder and inquires about a recent ankle injury. She nods intently as he speaks. Later, she surveys a garden at an On Lok site in the Mission District, and listens, brow crinkled, as one participant complains that another has taken over his vegetable patch. When a home-health-aide supervisor pulls Hansen aside to tell her about a participant’s disabled neighbor who is struggling to care for a sick husband, Hansen quickly maps a course of action to get the couple immediate short-term assistance.

In June 1998 alone, Hansen crisscrossed the country twice to speak at conferences in Philadelphia and New York City; she hosted visitors to On Lok from Taiwan, the federal government and the media; and she presented a “state of the nation” report on long-term care to the San Francisco Department of Health. She also appeared on two television programs and a radio show, and drafted an op-ed piece for the San Francisco Chronicle about
KEEPING PACE: At a dayroom at On Lok’s Montgomery Street site in San Francisco, Hansen ducks inside a supervising station for a scheduled conference call.

The poor quality of low-income housing for the elderly. She attended early-morning coffee meetings with potential donors, luncheons with volunteers and an afternoon tea with a group of employees. Such perpetual motion has paid off: As she travels to promote On Lok’s success, Hansen is steadily emerging as a national player in elderly care, a kind of Marion Wright Edelman of the over-80 set.

“Jennie Chin Hansen believes she will change the world,” John Golenski says. “She has an absolute commitment to a set of ideas that she believes will make the world a better place. She is the living embodiment of the very best of my generation.”

As a maroon On Lok van winds through San Francisco’s Sunset District, one elderly participant, whose family asked that his name not be used, begins to bellow. His sounds are not words, but anguished calls from a mind diminished by strokes. The man, who is in his eighties and is strapped into a wheelchair, rolls his head, calms himself down and resumes an unfocused stare. He is almost home. His life outside of a hospital or a nursing home is something of a modern oddity. He is unable to attend to even his most basic needs. He cannot walk, eat or bathe on his own. His efforts to communicate create something closer to honks than language. But his family members continue to care for him and to outfit him smartly in his caps, vests and pleated wool trousers. They want to let him live his last days in the company of those who love him. So they turned to On Lok.

Each week, in four health-care centers spread across San Francisco, On Lok staff convene under the hot lights of overhead projectors. On the conference-room walls hover medical records cataloging the gamut of geriatric woes: the broken hips, depression, dementia, incontinence, heart failures and tremors of life near its end. Each chart represents one of 750 patients.

The staff members in attendance are responsible for all aspects of patient care; the group includes not just doctors and nurses, but recreational therapists, home health workers, social workers and occupational therapists. Together they coordinate the array of services that ease their patients’ transition from assisted living in their neighborhoods through the maze of health-care choices.
"We were asking, 'Why can't we change the rules? Why not let people age in place, in their communities?'" Hansen says. "Imagine living 70-plus years a certain way. Why should the things that had such meaning for you for all those years not be a part of the final years of your life?"

that always end in the same way, with a patient's death. By meeting in interdisciplinary teams, the staff hopes to create a degree of synergy and compassion that does not exist in much of the compartmentalized medical industry, where a senior citizen is in the hands of different caregivers at each of life's last crises.

"We do our best to shepherd people through the processes," says Hansen. "This is about providing integrated health care tailored to a participant's specific needs. This is about common sense."

On Lok's main building comprises half a block in San Francisco's Chinatown. Built in 1994 to replace On Lok's original Chinatown site, it houses the administrative headquarters, a day health center, a separate program for participants with Alzheimer's disease and dementia, and 42 senior housing units. The building pulses with activity and purpose. At one physical therapy site, a man supports himself between two parallel bars and shifts his feet, one in front of the other. A physical therapist hovers nearby, as two other participants stretch on exercise mats. In a sunny spot near a window sits William H. Long, an 81-year-old immigrant from China and father of four. He is jolted from his quiet musings when his eldest son, Lawland Long M.B.A.'87, croons in his ear.

"Hello, Dad," he says. "It's me, Lawland." "Are you my son, the professor?" the older Long asks, fluttering his eyelids in confusion.

"Yes, Dad, it is me." "Do you have a job, son?" "Yes, Dad," says Long, who has earned several advanced degrees and now works as the executive director of a social-services organization in nearby Novato. "I have a very good job."

Lawland Long visits with his father, who lives in one of the units upstairs, at least once a week. Often, his father will not recognize him.

"I have to appreciate the bright spots, like when he remembers a story about growing up or can recall something we did together. I just wait for these moments," says Long. "Sometimes when I come in, he sees me and shouts, 'There is my son, the professor,' and I feel full. Who else but this man can say that?"

Long says he chose to put his father in On Lok's care because his father feared the prospect of a nursing home. "He thought it would be like waiting for a death sentence," he says. "I can sleep at night knowing my father has this kind of support. My parents, especially my father, have many medical problems. He really needs more than one-on-one attention. He needs a community, a village."

That is precisely how On Lok, essentially an HMO for senior citizens, sees itself: as a sort of extended medical village, where small gestures and vigilance prevent larger problems. All participants must qualify for nursing-home care under standards established by the state of California. The average On Lok participant is 83, lives at home and suffers from seven medical conditions, including dementia, paralysis and diabetes. The average patient lives on $640 a month and needs help with bathing, housekeeping, cooking and taking medications properly. The average length of time a patient is involved in the program is four years. And 93 percent remain at home under the supervision of On Lok's interdisciplinary teams.

The notion that the elderly will fare better at home in familiar surroundings and in the network of a community is not new. But such home-based care is expensive, often too expensive for all but the wealthiest Americans.

For each enrollee, On Lok receives about $3,000 a month from a combination of Medicare, Medicaid and, in some cases, private resources. For that amount, On Lok assumes financial responsibility for all medical care, including dental work, vision care, physical and occupational therapy,
acute hospital care—such as chemotherapy, dialysis, heart surgery—and even the cost of a nursing home when that seems the best alternative. According to Hansen, the preventive-care approach reaps benefits in dollars: The program’s participants who are hospitalized spend an average of 3.8 days in a hospital each year compared with the general Medicare population, which spends an average of 6.6 days in a hospital. Further, On Lok costs 15 percent less than the average Bay-area nursing home, and less than half the cost of care in Laguna Honda, the city-run nursing home for the poor. (Hansen cautions that such statistics may be misleading. Unlike nursing homes, for example, On Lok covers acute hospital care such as surgery and treatment in intensive care units. Nursing homes, however, provide housing while, in most cases, On Lok does not.)

In an era when cost cutting is a byword of the health-care industry, On Lok’s approach is built on the principle that quality preventive care is less expensive and more effective than emergency medical intervention. “Say someone is so poor and frail she has no access to meals,” says Kate O’Malley, On Lok’s director. “She doesn’t eat. She gets weak.

She falls, breaks her hip and lands in the hospital. Traditionally it has been only then that she would get the help she needs. For want of a $5.50 home-delivered hot meal, you’ll pay $5,000 or more for hip surgery. We’d rather spend money on meals and a guide bar in someone’s bathroom than for an orthopedic surgeon after a bad fall.”

Among the issues the team addresses are end-of-life wishes. At a time when 7.5 percent of the nation’s total personal health-care dollars—some $45 billion—are spent on the last six months of life, just how a patient chooses to die becomes a critical question. At On Lok, social workers try to help families decide how much intensive medical intervention is appropriate. The challenge, says Hansen, is finding the balance between medical measures that do little more than prolong a patient’s suffering and efforts that may help maintain a patient’s health and comfort level.

Very often, she says, the participants themselves know what they want and make their wishes known. Hansen recalls one participant who at first seemed to refuse to discuss how she wanted to die. The conversation moved to other matters, concerns about her diet, her family. The woman then
whispered, "The road is long enough. Yes. The road is long enough."

"This kind of work takes compassion, skill and temerity," Hansen says. "Most people do not want all the bells and whistles when they die. But we need to have that conversation. This is the stuff of living."

On Lok’s type of care—preventive, compassionate, interdisciplinary and sensitive to a patient’s ultimate needs—is the embodiment of Hansen’s philosophy. She arrived at her conclusions by watching others in her field and deciding what she didn’t want to be.

Her abhorrence of the rigid hierarchy and what she calls the soullessness of big-money, hospital-based healthcare reaches back to BC’s School of Nursing, and her training at a Boston hospital. Once, while she was tending to a patient, a doctor and a team of young interns came into the room and formed a horseshoe around the patient’s bed. The doctor began explaining the man’s medical condition and his prognosis: One leg would have to be amputated. Hansen watched as the old man’s eyes widened and his body went rigid in terror. He had just learned he would lose his leg.

"I couldn’t help myself," she said, her eyes flashing with anger almost 30 years later. "I went to the doctor and said, ‘Couldn’t you see what your words were doing to that man?’" The doctor was taken aback, shocked not by the pain he had caused the patient but by the fact that he was being questioned, and by a nursing student no less.

Hansen graduated from BC with a B.S. in nursing in 1970 and headed west, where she entered a master’s program at the University of California, San Francisco, and met and married fellow student Christopher Hansen. The couple settled in Moscow, Idaho, and Hansen became a county nurse. "I opted for community nursing, where you work with people directly; you use your judgment, consult when you need to and make decisions." It was there, while trying to persuade a local school board to hire a full-time school nurse, that she led her first political charge. "This was farm country. There was a high teen-pregnancy rate. There was child abuse. The need was obvious," she says. "I knew it was going to be a tough sell, so I did my research. They were spending thousands of dollars on football. I went before this all-male, all-white school board and made my case: If we can afford football we can afford health care. Talk about naive, attacking American football. The door was slammed shut before I could even get a toe in."

For Hansen, quitting was not an option. She changed tactics, mobilizing the support of local families. "As I continued my home visits and the rest of my traditional public-health work, I realized I could use these families as leverage," she recalls. "They could see how tough it was to get health education and health care. Ultimately it was the parents who asked for the nurse. It took a year and a half, but they got one."

And Hansen learned a lesson in strategy. "Get the facts, understand the politics and package your information so it makes sense to the people you are trying to serve, or convince, or whatever. If you want people to do what you want them to, you have to realize what is important to them," she says.

Hansen and her husband, who was then suffering from a brain tumor, left Idaho in 1975. The couple traveled to California, where Hansen had been offered a tenure-track teaching position at San Diego State University’s nursing school. A year later Christopher Hansen died, leaving his 28-year-old wife with Erik, their toddler son. Urged by friends to remain at the university, Hansen taught
“I have to appreciate the bright spots, like when he remembers a story about growing up or can recall something we did together. I just wait for these moments,” says Lawland Long, M.B.A. ’87. “Sometimes when I come in, he sees me and shouts, ‘There is my son, the professor,’ and I feel full. Who else but this man can say that?”

for another four years. “You’ll be set for life,” she recalls her friends saying. “You have a son. You’ll have your summers off to be with him.” Indeed, there were many reasons to stay in San Diego, but eventually Hansen confronted one very compelling reason to leave: “I needed a challenge and I needed to be in the thick of things.”

She quit teaching and headed to San Francisco for an 18-month research position at On Lok, a program she remembers as humble but spirited. “There was something about just being there. You could feel the changes. Here were really smart people ready to try something new,” she says. Hansen has stayed at On Lok for 18 years, advancing from researcher to director to executive director, and helping transform a local solution into a national model.

When On Lok began looking at ways to spread its health-management gospel in the mid-1980s, Hansen became its lead evangelist. There are many angles from which to sell the On Lok model, and Hansen uses them all. Addressing liberal activists, she peppers her conversations with words such as compassionate and soulful. Talking with families of potential participants, she emphasizes care and support and the program’s promise of all-inclusive care, with no co-payments, red tape or fight for coverage. To city politicians, she talks about harnessing resources and meeting the needs of the most vulnerable constituents. With potential donors she focuses on quantitative results and an alternative to the bewildering world of traditional health care.

When necessary, Hansen even offers up personal stories, including her father’s experience. “I use these stories when I need to drive home a point,” she says. “I can feel them, and because I do I can help others to feel these issues in their guts.”

Her passion has earned her fans. In 1997 the San Francisco League of Women Voters named her a recipient of its Women Who Could Be President Award. That same year she was named one of California’s 100 most influential health-care leaders, and she was the subject of a local television segment “Profiles in Excellence.” “She is a communicator like few others,” says Dr. Catherine Eng, On Lok’s medical director. “This is not just a professional thing; this is what she believes in and that’s why she articulates the concepts with such feeling and talks with such a passion.”

The On Lok model is not without its critics, however. Leaders in the nursing-home industry have questioned how effective the model would be outside the context of a Chinese immigrant community, which has been recognized—and even stereotyped—as especially self-reliant, respectful of the elderly and uncomplaining. Others have said that while the model is less expensive than nursing-home care, it is still costly and labor-intensive. And even among On Lok advocates, there is some concern that if the private sector adopts such a model, the quality of care will be compromised.

Within the city of San Francisco, On Lok has already answered some of this criticism. Since 1980, On Lok has been serving the elderly of several non-Chinese communities, including the Russians of Russian Hill, the Italians of North Beach and the Hispanics of the Mission District, demonstrating that the model can work in other ethnic communities.

In 1990 On Lok was faced with an opportunity to address how well its model translates. By then six locally run operations based on the On Lok model were functioning, serving the elderly in such cities as Boston; Portland, Oregon; and Columbia, South Carolina. All six sites were receiving
Medicare and Medicaid funds, and new federal legislation had been passed that would allow nine more organizations to follow suit. The model had even earned its own name: Program of All-inclusive Care for the Elderly (PACE).

Seeking support for further expansion, Hansen turned to U.S. Representative Bill Thomas, a California Republican who serves as chairman of the House Ways and Means Committee's subcommittee on health. "When Congressman Thomas first met with Jennie, he was prepared for a pleasant visit with a constituent. Those meetings are usually about 10 or 15 minutes. Their meeting lasted an hour and a half," says Allison Giles '88, legal counsel to the subcommittee. "Her model was a good example of a market-based program that provides better service, better care than many other options."

In 1996 Hansen testified before the House Ways and Means subcommittees on aging and health in an effort to secure more government funding for programs based on On Lok's model. Provisions for such funding were ultimately included in the Balanced Budget Act of 1997. The bill's passage ensured even more expansion of such programs—some 28 new sites based on On Lok are being developed this year, and another 20 may launch each year after that. All current programs are nonprofit, but the budget law permits public support for 10 for-profit programs on a test basis.

For Hansen such progress is a sign that the government, teamed with locally run organizations, is searching for new, community-based responses to a growing national need. And she finds it heartening that a broad coalition of forces is forming around issues that are so difficult and so tightly entwined with "the stuff of life."

"We need simplicity so we don't contort people's lives at the end," Hansen says. "There isn't a lot of glamour in this work, but there is so much life to it. The person over there drooling was a bride once, a person with memory and history and dreams for herself. We all are born once and we die once. And we have to remember that for this family it is the only time they are going through this, and that years of history, joys, sorrow, hopes and arguments are coming to an end."