Retooling for an Aging America: Building the Health Care Workforce

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Overview

- Committee charge
- Why is this important?
- What were our findings?
- What did we recommend?
Statement of Task

- Future health status and utilization
- Best use of the workforce
- Education and training
- Recruitment and retention
- Improving public programs
Why is this important?

- Changing demography
- Older persons use more services
- Current care is not optimal
- Inadequate workforce
1. Future Increases

- **Increased longevity:**
  - 1900 – 47.3
  - 1950 – 68.2
  - 2007 – 77.9

- **Baby boom:**
  - Increase from 12% to 20% of population*

- **Demographic trends:**
  - Racial and ethnic diversity; LGBT
  - Changes in family structures
  - Continuum of care

*Data in this presentation based on findings in *Retooling for an Aging America* (IOM, 2008)
2. Older persons use more services

- **Chronic disease:**
  - ~80% have a chronic disease
  - ~20% of Medicare beneficiaries have 5+ chronic conditions (2/3 of spending)
  - Geriatric syndromes

- **Disproportional use:** 12% of population use:
  - 26% of physician office visits
  - 35% of hospital stays
  - 34% of prescriptions
  - 38% of EMS responses
3. Current care is not optimal

- Little guidance on effective interventions
- Proportion of recommended care that is received declines with age
- Models shown to be effective and efficient are not implemented widely
- Lack of payment for interdisciplinary care, care coordination, patient education, and geriatrics expertise.
4. Inadequate workforce

A. Not enough specialists:

- ~7,100 geriatricians and declining
- ~1,600 geriatric psychiatrists
- <1% of nurses and pharmacists and <4% of social workers specialize in geriatrics
4. Inadequate workforce (continued)

B. Poor recruitment of specialists:

- Negative stereotypes of older adults
- Lower incomes
- High cost of training
- Lack of opportunity for advanced training
4. Inadequate workforce (continued)

§ C. Poor retention of direct-care workers:

• 71% turnover of nurse aides

• Money spent retraining

• Personal and home care aides earn about $1 per hour more than food counter attendants.

• Direct-care workers are more likely to lack health insurance and use food stamps
4. Inadequate workforce (continued)

§ D. Not enough general training in geriatrics:

- Professionals
  - *Little training in common problems*

- Direct-care workers
  - *Federal standards unchanged in 20 years*

- Informal caregivers
  - *Receive little training*
  - *More than 90% of individuals at home*
  - *$350 billion*
Professional Education and Training

- **Nursing**: 1/3 of baccalaureate programs require "exposure;" associate degree programs – unknown
- **Dentistry**: does not recognize geriatrics as a specialty
- **Pharmacy**: 10 residency programs (out of 351)
- **Physician assistants**: accreditation requires "exposure," no minimum specified
- **Social work**: 80% of BSW programs have no specific coursework

*Overall – lack of academic leaders*
Direct-Care Workers and California

- Federal minimum: 75 hours (16 hours of clinical)

- California
  - Direct-care workers: 150 hours
  - Manicurists: 350 hours
  - Skin care specialists: 600 hours
  - Hair stylists: 1,500 hours
Responsibilities of Informal Caregivers

- Schedule appointments
- Provide emotional support
- Facilitate provider understanding
- Help with medical decision-making
- Ensure communication between providers
- Interpret
- Perform wound care
- Administer medications
- Assist with ADLs/IADLs
Three-pronged approach to building capacity

- Enhance *geriatric competence* of general workforce in common problems
- Increase *recruitment and retention* of geriatric specialists and caregivers
- Implement *innovative models* of care
1. Enhancing competence

- **Professionals:**
  - Doctors, nurses, social workers, pharmacists, etc.

- **Direct-care workers:**
  - Nurse aides
  - Home health aides
  - Personal and home care aides

- **Informal caregivers:**
  - Families and friends
Professionals

$\ \$ All licensure, certification, and maintenance of certification should include demonstration of competence in care of older adults as a criterion.

$\ \$ Hospitals should encourage training of residents in all settings where older adults receive care (e.g., nursing homes, assisted-living facilities, and patients’ homes)
Direct-care workers

- Federal requirements
  - raise to at least 120 hours
  - include demonstration of competence in the care of older adults

- States should establish minimum training requirements for personal care aides.
Informal caregivers

- Public, private, and community organizations should provide funding and ensure that adequate training opportunities are available in the community for informal caregivers
2. Increasing recruitment and retention of geriatric specialists and caregivers

- Financial incentives to increase the number of geriatric specialists in all health professions.
  - Enhanced reimbursement
  - GACA Awards
  - National Geriatrics Service Corps

- State Medicaid programs should increase pay and fringe benefits for direct-care workers.
3. Implementing innovative models of care

- Disseminating known models
- Discovering newer models
- Expanding individual roles
- Improving capacity and safety
Principles for redesigning models of care

- The health needs of the older population need to be addressed comprehensively;
- Services need to be provided efficiently;
- Older persons need to be active partners in their own care.
Effective features of new models of care

- Interdisciplinary team care
- Care management
- Transitional care
- Preventive home visits
- Pharmaceutical management
- Chronic disease self-management
- Caregiver education and support
Discovering and Disseminating

- Support research and demonstration programs that:
  - promote development of new models
  - Prevention, LTC, palliative care
  - promote effective use of the workforce

- Promote the dissemination of effective and efficient models of care (known and new)
Expanding individual roles

Expand the roles of individuals beyond the traditional scope of practice (job delegation).

- Development of an evidence base
- Measurement of additional competence
- Greater professional recognition and salary
Improving capacity and safety

- Support technological advancements that could enhance an individual’s capacity to provide care for older adults.
  - ADL technologies
  - Health information technologies, including remote technologies
SUMMARY - 1

§ All providers (including family and friends) need to have the core competencies in caring for older persons

• During general training

• Lifelong

• When needed
SUMMARY - 2

- Recruit and retain a cadre of geriatric specialists
  - Teach core competencies
  - Provide care for older persons with the most complex needs
  - Develop and test new models of care
SUMMARY - 3

Redesign health care delivery to achieve the vision of care

• New models

• Changing roles, job delegation

• Changing financing to support models
Looking Ahead

“The Medicare Trust Fund [….] is one half of the problem. The other half of the problem is the geriatric health care workforce. Because even if there is enough money, there isn’t going to be anyone there to provide the care.”

John W. Rowe, 04/14/2008
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www.iom.edu/agingamerica

PODCAST: Aging Gracefully: Building the Health Care Workforce for an Aging America
www.nap.edu