Retooling for an Aging America: Building the Health Care Workforce

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

Overview

- Why is this important?
- How did this study come about?
- What are our findings?
- Where do we go from here?

Why is this important?

1. Future increases in the population
2. Older persons use more services
3. Current care is not optimal
4. Inadequate workforce

1. Future Increases

- Increased longevity
- Increase from 12% to 20% of population
- Demographic trends
  - Racial and ethnic diversity
  - Family structure

Heterogeneous Needs

- Special Populations
  - Ethnogeriatrics
  - Lesbian, gay, and bisexual persons
- Continuum of Care
  - Health promotion/disease prevention
  - Palliative care

Palliative Care and Training

- 80% of deaths occur over age 65
- Almost all medical schools and 62% of pharmacy schools provide exposure
- Medical students surveyed:
  - 20% received education
  - 39% unprepared to address patient fears
  - About half unprepared for their own feelings

Palliative Care and Residency

- Many graduating residents feel unprepared to counsel patients:
  - 41% of family medicine residents
  - 43% of internal medicine residents
- Only 2.7% of geriatric medicine fellows feel unprepared to care for dying patients

2. Older Persons Use More Services

- ~80% have a chronic disease
- Geriatric syndromes
- Current 12% of the population use:
  - 26% of physician office visits
  - 35% of hospital stays
  - 34% of prescriptions
  - 38% of EMS responses

Prevalence of Chronic Disease

	Age 18+	Age 65-74	Age 75+
Hypertension	22.9	52.9	53.8
Heart Disease	10.9	26.2	36.6
Any Cancer	7.1	17.2	25.7
Diabetes	7.7	18.6	18.3

Prevalence of Disability/Limitations

	Age 18+	Age 65-74	Age 75+
Trouble hearing	16.8	31.9	50.4
Vision limitations	9.5	13.6	21.7
Absence of all natural teeth	8.0	22.8	29.4

3. Current Care is Not Optimal

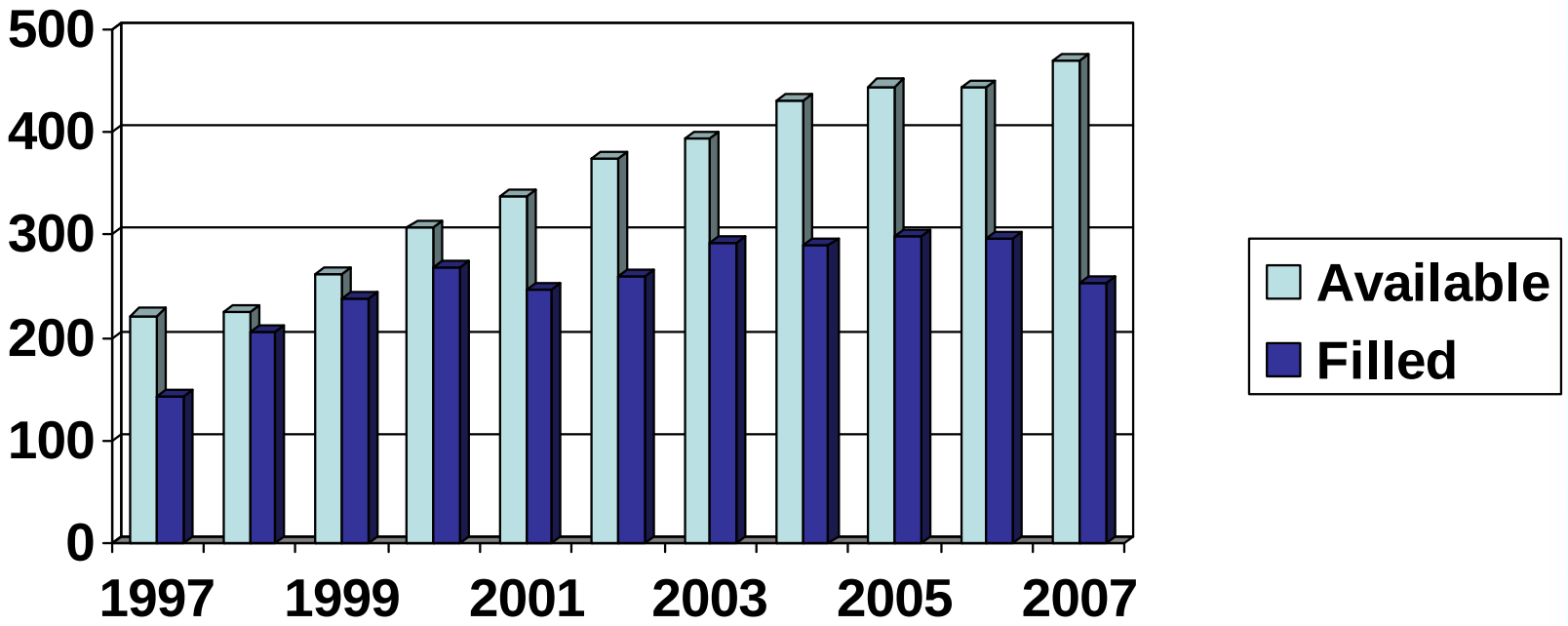
- Little guidance on effective interventions
- Proportion of recommended care that is received declines with age
- Models shown to be effective and efficient are not implemented widely
- Lack of payment for interdisciplinary care, care coordination, patient education, and geriatric expertise.

4. Inadequate Workforce

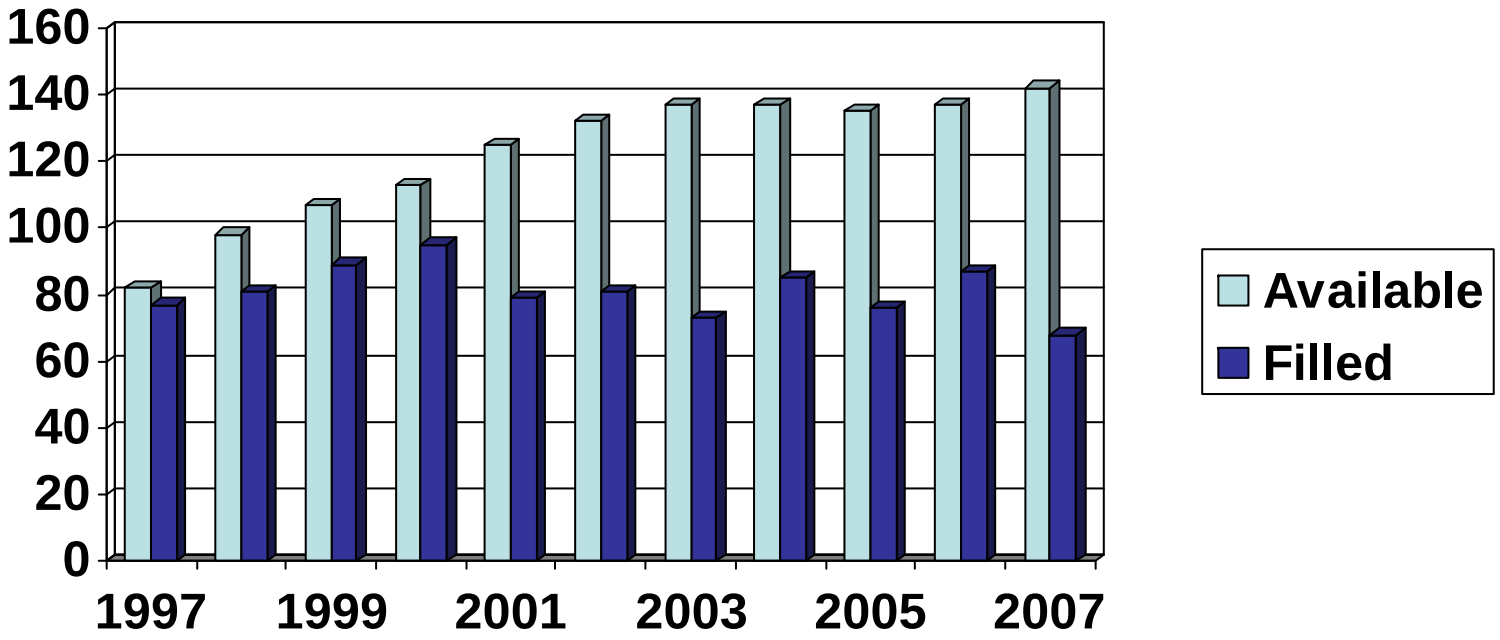
A. Not Enough Specialists

- ~7,100 geriatricians and declining
- ~1,600 geriatric psychiatrists
- Less than 1% of nurses and pharmacists and less than 4% of social workers specialize in geriatrics

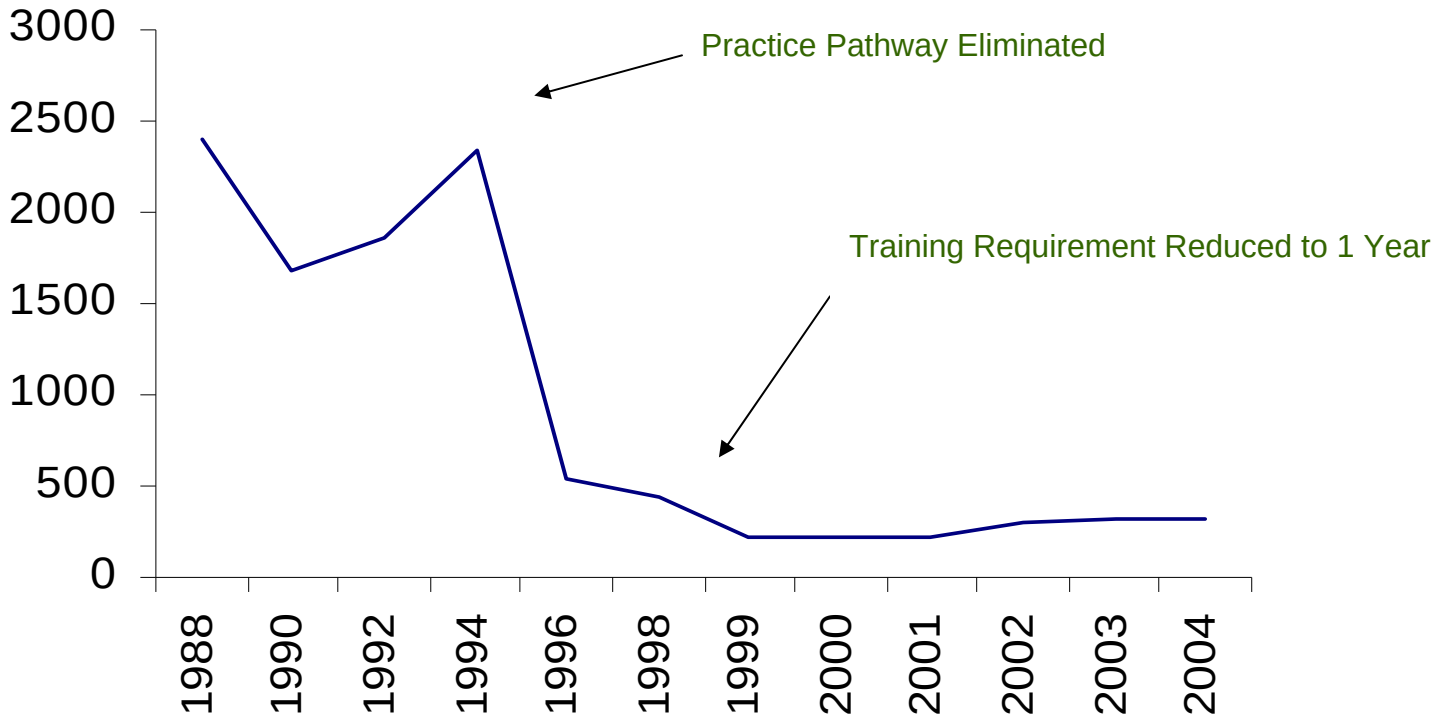
First-Year Geriatric Medicine Fellowship Positions



First-Year Geriatric Psychiatry Fellowship Positions



New Certifications in Geriatric Medicine, 1998-2004



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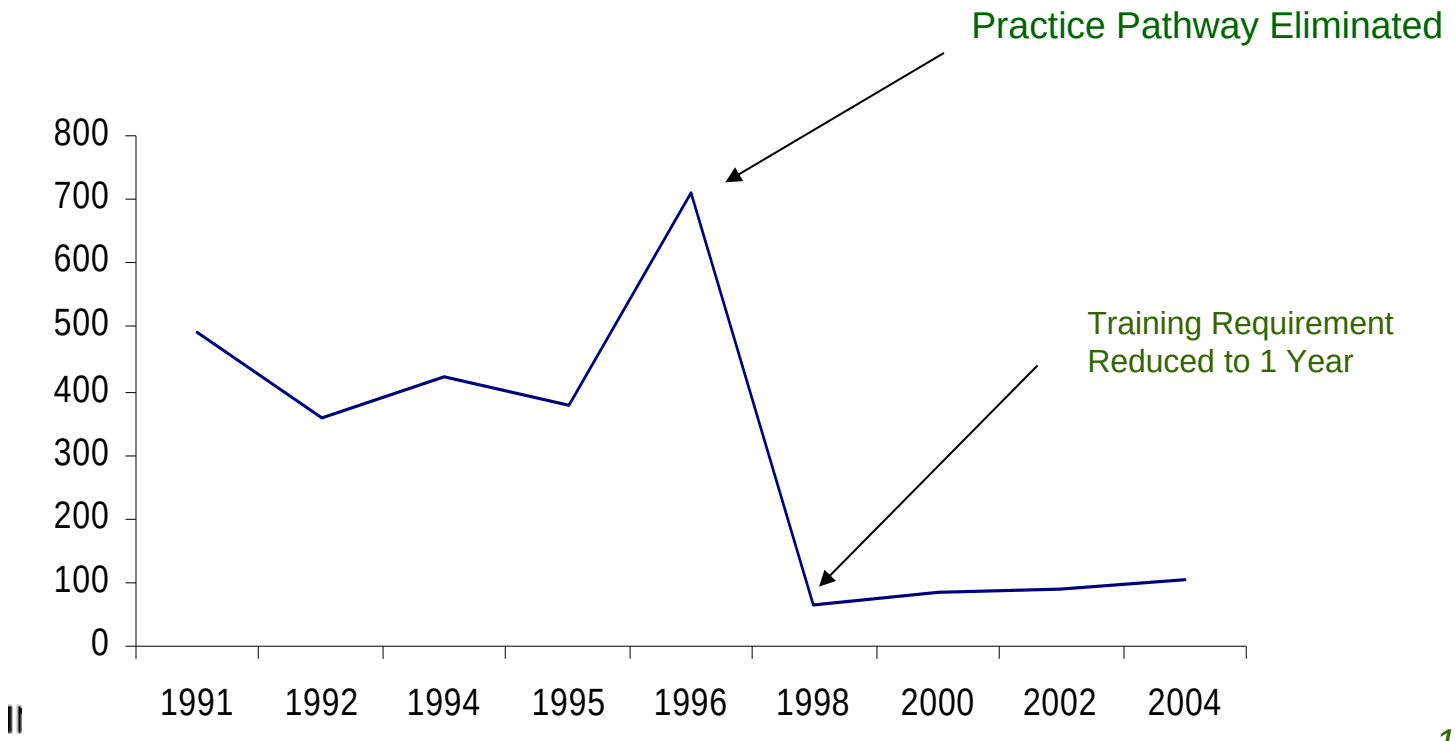
New Certifications in Geriatric Psychiatry, 1991-2004



4. Inadquate Workforce

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

C. Poor Retention of Direct-Care Workers

- 71% turnover of nurse aides
- Money spent retraining
- Personal and home care aides earn $8.54. Food counter attendants earn $7.76
- Direct-care workers are more likely to lack health insurance and use food stamps

Direct-Care Worker Turnover

- 40-60% of home health aides leave in one year; 80-90% in first 2 years
- Assisted-living staff turnover: 21-135%
- CNA turnover: 71% on average
- Turnover costs employers $4.1 billion annually

4. Inadequate Workforce

D. Not Enough General Training

- Professionals receive little training in the common problems of older adults
- Direct-care workers - federal training minimums have not changed in 20 years and may be lower than for dog groomers, cosmetologists, and crossing guards.
- Informal caregivers receive little training

Registered Nurses

- Less than 1% of RNs certified in geriatrics
- 29% of baccalaureate programs have a certified faculty member
- 1/3 of baccalaureate programs require exposure to geriatrics
- Associate degree programs - unknown

Advanced Practice Registered Nurses

- 23% of office visits and 47 of hospital outpatient visits
- About 2.6% of APRNs certified in geriatrics
- 300 geriatric APRNs graduate annually

Dentists

- Geriatrics not recognized as a specialty for certification
- 13 programs for academic geriatric dentistry
- No residencies specific to geriatrics
- Geriatrics not explicitly tested on board examinations

Pharmacists

- Less than 1% certified in geriatrics
- 10 residency programs in geriatric pharmacy (out of 351)
- One fellowship position (Alzheimer's Disease)

Physician Assistants

- 32% of office visits
- Less than 1% specialize in geriatrics
- Accreditation requires exposure, but no minimum specified
- No advanced training programs in geriatrics

Social Workers

- In 1987, the NIA estimated a need for 70,000 geriatric social workers by 2020
- Today, only 4% specialize (about 1/3 of that estimated need)
- Between 1996 and 2001, the number of students specializing in aging decreased by 15.8%

Social Workers

- 40% of schools lack faculty in aging
- 80% of BSW programs have no coursework in aging
- 29% of MSW programs offer aging focus
- In the 1980s, almost half of MSW programs offered specialization in aging

Other Professions and Occupations

- None of the following specialties has a subspecialty certificate in geriatrics
  - Dermatology
  - Emergency Medicine
  - Physical Medicine and Rehabilitation
  - Surgery
- All have certificates in pediatrics

Other Professions and Occupations

- EMT national curriculum does not have a module for geriatrics
- 22% of undergraduate dietetics and nutrition programs offer courses in aging
- Only 1 of 8 schools of podiatric medicine lists a course devoted to geriatrics

How Did This Study Come About?

- AARP
- Archstone Foundation
- Atlantic Philanthropies
- California Endowment
- Commonwealth Fund
- Fan Fox and Leslie R. Samuels Foundation
- John A. Hartford Foundation
- Josiah Macy, Jr. Foundation
- Retirement Research Foundation
- Robert Wood Johnson Foundation

Committee Members

- **John W. Rowe** - *Chair,* Columbia University
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- **Stuart H. Altman**, Brandeis University
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- **Paul C. Tang**, Palo Alto Medical Foundation
- **Joshua M. Wiener**, RTI International

Statement of Task

- Future health status and utilization
- Best use of the workforce
- Education and training; recruitment and retention
- Improving public programs to support the above

Committee Process

- 15 month study
- 4 in-person meetings
- 6 commissioned papers
- 2 public workshops with 18 speakers
- 14 external reviewers

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

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 (4.2)

All licensure, certification, and maintenance of certification for health care professionals should include demonstration of competence in the care of older adults as a criterion.

Professionals (4.1)

Hospitals should encourage the training of residents in all settings where older adults receive care, including nursing homes, assisted-living facilities, and patients' homes.

Direct-Care Workers (5.1)

States and the federal government should increase minimum training standards for all direct-care workers.

continued

Direct-Care Workers (5.1), continued

Federal requirements for the minimum training of CNAs and home health aides

- raise to at least 120 hours
- include demonstration of competence in the care of older adults as a criterion for certification.

continued

Direct-Care Workers (5.1)

States should also establish minimum training requirements for personal care aides.

Informal Caregivers (6.2)

Public, private, and community organizations should provide funding and ensure that adequate training opportunities are available in the community for informal caregivers

Increasing Recruitment and Retention of Geriatric Specialists and Caregivers

- Professionals
- Direct-Care Workers

Professionals (4.3)

Public and private payers should provide financial incentives to increase the number of geriatric specialists in all health professions.

Professionals (4.3a)

Enhancement of reimbursement for clinical services delivered to older adults by practitioners with geriatric certification.

Internal Medicine Subspecialties

Subspecialty	Fill Rate (1st year)	Median Compensation
Geriatric Medicine	54%	$163K
Endocrinology	92%	$189K
Hematology & Oncology	95%	$358K
Infectious Disease	93%	$205K
Rheumatology	96%	$207K

Professionals (4.3b)

Enhancement of the Geriatric Academic Career Award (GACA) program to support junior geriatrics faculty in other health professions in addition to medicine.

Professionals (4.3c)

- Loan forgiveness, scholarships, and direct financial incentives for professionals who become geriatric specialists.

- National Geriatric Service Corps

Direct-Care Workers (5.2)

State Medicaid programs should increase pay and fringe benefits for direct-care workers.

Median Hourly Wages, 2006

Nurse Aides	Home Health Aides	Personal and Home Care Aides	Food Counter Attendants
$10.67	$9.34	$8.54	$7.76

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

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

Disseminating Known Models (3.1)

Promote the dissemination of those models of care for older adults that have been shown to be effective and efficient.

PACE

- Adults 55+ eligible for nursing home care
- Combines Medicare and Medicaid funds plus individual contributions
- Provide Medicare and Medicaid covered services
- Also provide adult day care, nutritional counseling, recreational therapy, transportation, and personal care services

PACE
Interdisciplinary Care Team

- Primary care physician
- Registered nurse
- Social worker
- Physical therapist
- Pharmacist
- PACE manager
- Occupational therapist
- Recreational therapist
- Dietitian
- Home-care coordinator
- Personal care attendants
- Drivers

PACE - Results

- Higher satisfaction and quality of life
- Improved health status & functioning
- Increased # of days in community
- Lower mortality
- Among frailest, lower rates of hospital and nursing home utilization

continued

PACE – Results, continued

- 12% annual turnover rate of aides
- Payments ~10% higher
- Savings for Medicare, higher costs for Medicaid

PACE – Dissemination

- 1997 – permanent Medicare provider
- By 2004, 180 PACE programs authorized, but today only 42 operating in 22 states
- Only about 10,000 of 3 million eligible adults being served

continued

PACE – Barriers

- Requires start-up funding for initial investment
- Insufficient patient base – especially sparse rural populations
- High costs for older adults not eligible for Medicaid

Why Aren't Successful Models of Care Implemented Widely?

In general, innovative models of care for older persons are difficult to diffuse because of administrative and financial barriers

Discovering Newer Models (3.2)

Increase support for research and demonstration programs.

- promote development of new models
- promote effective use of the workforce

Expanding Individual Roles (3.3)

Expand the roles of individuals beyond the traditional scope of practice, such as through job delegation.

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

Improving Capacity and Safety (6.1)

Support technological advancements that could enhance an individual's capacity to provide care for older adults.

- ADL technologies
- Health information technologies, including remote technologies

Monitoring (1.1)

Annual report from the Bureau of Health Professions to monitor the progress made in addressing the crisis in supply of the health care workforce for older adults.

Next Steps

- Need everyone
- Cost implications
- Need to act now

Summary

- All providers (including family and friends) need to have the core competencies in caring for older persons
  - During general training
  - Lifelong
  - When needed

continued

Summary

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

continued

Summary

- Redesign health care delivery to achieve the vision of care
  - New models
  - Changing roles, job delegation
  - Changing financing to support models

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