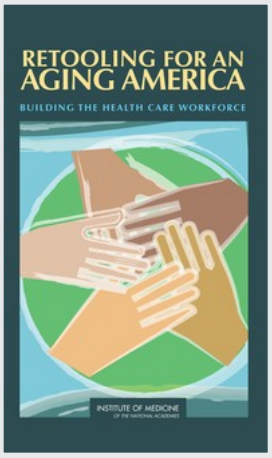

Retooling for an Aging America: Building the Health Care Workforce

DETAILS

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Summary

In 2011 the first baby boomers will turn 65, ushering in a new generation of older Americans. The 65-and-older population of the future will be markedly different from previous generations, with higher levels of education, lower levels of poverty, more racial and ethnic diversity, and fewer children. Their most striking characteristic, however, will be their numbers. The aging of the baby boom population, combined with an increase in life expectancy and a decrease in the relative number of younger persons, will create a situation where older adults make up a much larger percentage of the U.S. population than has ever before been the case. Between 2005 and 2030 the number of adults aged 65 and older will almost double, from 37 million to over 70 million, accounting for an increase from 12 percent of the U.S. population to almost 20 percent. While this population surge has been foreseen for decades, little has been done to prepare the health care workforce for its arrival.

Older Americans use considerably more health care services than younger Americans and their health care needs are often complex. The health care system often fails to deliver high-quality services in the best manner to meet their needs. Indeed, the education and training of the entire health care workforce with respect to the range of needs of older adults remains woefully inadequate. Recruitment and retention of all types of health care workers is a significant problem, especially in long-term care settings. Unless action is taken immediately, the health care workforce will lack the capacity (in both size and ability) to meet the needs of older patients in the future.

To address major shortages, steps need to be taken immediately to increase overall workforce numbers and to use every worker efficiently (i.e.,

to each individual's maximum level of competence and with an increased flexibility of roles). Additionally, the entire health care workforce, including both formal and informal caregivers, need to have the requisite data, knowledge, and tools to provide high-quality care for older patients. To improve the ability of the health care workforce to care for older Americans, the committee proposes a three-pronged approach:

- Enhance the competence of all individuals in the delivery of geriatric care
- Increase the recruitment and retention of geriatric specialists and caregivers
- Redesign models of care and broaden provider and patient roles to achieve greater flexibility

STUDY CHARGE AND SCOPE

This year marks the 30th anniversary of the first report published by the Institute of Medicine (IOM) on the health care workforce for older patients, *Aging and Medical Education*. That report and others have called for an expansion of geriatric training, but so far the geriatric discipline has grown little in numbers or in stature. This current report builds upon the IOM's broader work in the area of quality. In 2001, the IOM's *Crossing the Quality Chasm* noted that a major challenge in transitioning to a 21st-century health system is preparing the workforce to acquire new skills and adopt new ways of relating to patients and to each other.

The IOM charged the Committee on the Future Health Care Workforce for Older Americans with determining the health care needs of Americans over 65 years of age and analyzing the forces that shape the health care workforce for these individuals (Box S-1).

This study considers a range of care settings and health care team members, including professionals, direct-care workers, informal caregivers, and patients. The committee focused on a target date of 2030—by which time all baby boomers will have reached age 65—because it allows enough time to achieve significant goals, yet it is not so far in the future that projections become highly uncertain or advances in health care treatment or technologies change the medical landscape too greatly. Although the target year of 2030 may not seem to imply a sense of urgency, the contrary is true, as the preparation of a competent health care workforce and widespread diffusion of effective models of care will require many years of effort.

TODAY'S OLDER AMERICANS

The health status of older Americans has improved over the past several decades. Today, older adults (defined here as those 65 and older) live longer

BOX S-1
Statement of Task

This study will seek to determine the health care needs of the target population—the rapidly growing and increasingly diverse population of Americans who are over 65 years of age—then address those needs through a thorough analysis of the forces that shape the health care workforce, including education, training, modes of practice, and financing of public and private programs.

Starting with the understanding that health care services provided to older Americans should be safe, effective, patient centered, timely, efficient, and equitable, the committee will consider the following questions:

1. What is the projected future health status and health care services utilization of older Americans?
2. What is the best use of the health care workforce, including, where possible, informal caregivers, to meet the needs of the older population? What models of health care delivery hold promise to provide high-quality and cost-effective care for older persons? What new roles and/or new types of providers would be required under these models?
3. How should the health care workforce be educated and trained to deliver high-value care to the elderly? How should this training be financed? What will best facilitate recruitment and retention of this workforce?
4. How can public programs be improved to accomplish the goals identified above?

and have less chronic disability than those in previous generations. Still, almost all Medicare spending is related to chronic conditions. Many older adults also experience one or more geriatric syndromes—clinical conditions that do not fit into discrete disease categories (e.g., falls and malnutrition). Older adults also tend to experience more mental health conditions (e.g., depression and anxiety). Many community-dwelling older adults need assistance with one or more activities of daily living (ADLs), such as bathing, and dressing, or with instrumental activities of daily living (IADLs), such as shopping for groceries and preparing meals. Severely disabled adults—that is, those who have difficulty with three or more ADLs—generally require more intensive care if they are to remain in the home.

Older adults receive health care in many different settings and are particularly high-volume users. Although older adults make up only about 12 percent of the U.S. population, they account for approximately 26 percent of all physician office visits, 47 percent of all hospital outpatient visits with nurse practitioners, 35 percent of all hospital stays, 34 percent of all prescriptions, 38 percent of all emergency medical service responses, and

90 percent of all nursing-home use. Just over 60 percent of disabled older adults living in the community obtain some long-term care services, most commonly in the form of help with personal care and household chores. The vast majority of these services are provided by informal caregivers, typically a spouse or child.

OLDER AMERICANS IN THE FUTURE

The future elderly population will be different from today's older adults in a number of ways. The demographic characteristics of older Americans will differ from previous generations in terms of their race, family structure, socioeconomic status, education, geographic distribution, and openness regarding their sexual orientation. All of these factors can affect health status and utilization of services. Trends in illness and disability will influence the need for services among the future older adult population, though the direction and the magnitude of the effects cannot be predicted with certainty. Declines in smoking rates, for example, could lead to a decreased need for health care services, but that decrease could be offset by increased utilization associated with high rates of obesity. Medical advances and technologies may extend or improve life for older patients. In the future, more health care may be provided remotely, and older adults may be better able to monitor their conditions and communicate with health care providers from home. Finally, older adults in the future may simply have different preferences for care than their predecessors.

Changes in Medicare or Medicaid policies could also have a significant effect on service utilization by older adults—and, given that a severe cost crisis in the Medicare program is widely expected, such changes are likely. While a full consideration of likely health expenditures is beyond the scope of the committee's charge, committee members were mindful of financial realities during the course of their deliberations. Whether or not the current patterns of health status and utilization continue, one prediction is certain: the future elderly population will have a greater collective need for health care services than those who have come before it.

BUILDING THE CAPACITY OF THE HEALTH CARE WORKFORCE

With few exceptions, all types of health care workers need to be educated and trained in the care of older adults. First, while efforts to educate and train the formal (i.e., paid) workforce in geriatrics have improved, they remain inadequate in both scope and consistency. Second, much of the care for older adults falls to informal caregivers, yet these unpaid workers receive very little preparation for their responsibilities. Finally, the

management of chronic illness requires daily decision making, and patients often lack the knowledge or the skills to be effective members of their own health care team. To the extent that patients are better able to manage their conditions, they will be less likely to depend upon members of the already limited health care workforce.

Besides being inadequately prepared in geriatrics, the current workforce is not large enough to meet older patients' needs, and the scarcity of workers specializing in the care of older adults is even more pronounced. Among direct-care workers, nursing assistants provide 70 percent to 80 percent of the direct-care hours to those older adults who receive long-term care, but their shortage is well documented. Older adults account for about one-third of visits to physician assistants (PAs), but less than 1 percent of PAs specialize in geriatrics. Less than 1 percent of both pharmacists and registered nurses are certified in geriatrics. In 1987 the National Institute on Aging predicted a need for 60,000 to 70,000 geriatric social workers by 2020, yet today only about 4 percent of social workers—one-third of the needed number—specialize in geriatrics.

These shortages will only be worse in the future. By 2030 the United States will need an additional 3.5 million formal health care providers—a 35 percent increase from current levels—just to maintain the current ratio of providers to the total population. The Bureau of Labor Statistics predicts that personal- and home-care aides and home health aides will represent the second- and third-fastest growing occupations between 2006 and 2016, which will exacerbate current shortages. As of 2007, there were 7,128 physicians certified in geriatric medicine and 1,596 certified in geriatric psychiatry. According to one estimate, by 2030 these numbers will have increased by less than 10 percent; others predict a net loss of these physicians because of a decreased interest in geriatric fellowships and the decreasing number of physicians who choose to recertify in geriatrics. According to the Alliance for Aging Research, by 2030 the United States will need about 36,000 geriatricians. It may well not be possible to reach this goal, but the projection underscores the need for immediate and dramatic increases in the numbers of workers who care for older patients in order to close the gap between current supply and future demand. All segments of the health care workforce face significant barriers to recruitment and retention, but in the case of the older-adult health care workforce there are additional obstacles, including negative perceptions about working with older patients, concerns about physically and emotionally demanding working conditions, and misgivings about the financial disadvantages of such work. These issues merit persistent attention and the development of an evidentiary basis to monitor the progress made in increasing the capacity of this future workforce.

Recommendation 1-1: Congress should require an 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.[1]

While increasing the supply of workers is important, numbers alone will not solve the impending crisis. Current models of care delivery often fail to provide the best care possible to older adults, and they often do not promote the most efficient use of existing workers. While a number of innovative models have been developed to address these shortcomings, most have not been widely adopted. In short, to meet the health care needs of the next generation of older adults, the geriatric competence of the entire workforce needs to be enhanced, the number of geriatric specialists and caregivers needs to be increased, and innovative models need to be developed and implemented such that the workforce is used more efficiently and the quality of care is improved (Box S-2).

Enhancing the Competence of All Providers

The geriatric competence of virtually all members of the health care workforce needs to be improved through significant enhancements in educational curricula and training programs and then assessed through career-long demonstrations of this competence. There are a number of challenges to the geriatric education and training of health care workers, including a scarcity of faculty, variable curricula, and a lack of training opportunities. Furthermore, both education and training need expanded content in order to address the diversity of health care needs among older adults.

Professionals

For professionals, one notable way in which training is inadequate is the lack of exposure to settings of care outside of the hospital. Since 1987 hospitals have been allowed to count the time that residents spend in settings outside the hospital for graduate medical education funding purposes, but many residents still do not spend significant amounts of time in these alternative settings. Because most care of older patients occurs outside the hospital, the committee concluded that preparation for the comprehensive care of older patients needs to include training in non-hospital settings.

[1]The committee's recommendations are numbered according to the chapter of the main report in which they appear. Thus, Recommendation 1-1 is the first recommendation in Chapter 1.

BOX S-2
Recommendations

Recommendation 1-1: Congress should require an 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.

Enhancing Geriatric Competence

Recommendation 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.

Recommendation 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.

Recommendation 5-1: States and the federal government should increase minimum training standards for all direct-care workers. Federal requirements for the minimum training of certified nursing assistants (CNAs) and home health aides should be raised to at least 120 hours and should include demonstration of competence in the care of older adults as a criterion for certification. States should also establish minimum training requirements for personal-care aides.

Recommendation 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

Recommendation 4-3: Public and private payers should provide financial incentives to increase the number of geriatric specialists in all health professions.

Recommendation 4-3a: All payers should include a specific enhancement of reimbursement for clinical services delivered to older adults by practitioners with a certification of special expertise in geriatrics.

Recommendation 4-3b: Congress should authorize and fund an enhancement of the Geriatric Academic Career Award (GACA) program to support junior geriatrics faculty in other health professions in addition to allopathic and osteopathic medicine.

Recommendation 4-3c: States and the federal government should institute programs for loan forgiveness, scholarships, and direct financial incentives for professionals who become geriatric specialists. One such mechanism should include the development of a National Geriatric Service Corps, modeled after the National Health Service Corps.

Recommendation 5-2: State Medicaid programs should increase pay and fringe benefits for direct-care workers through such measures as wage pass-

continued

BOX S-2
Continued

throughs, setting wage floors, establishing minimum percentages of service rates directed to direct-care labor costs, and other means.

Redesigning Models of Care

Recommendation 3-1: Payers should promote and reward the dissemination of those models of care for older adults that have been shown to be effective and efficient.

Recommendation 3-2: Congress and foundations should significantly increase support for research and demonstration programs that

- promote the development of new models of care for older adults in areas where few models are currently being tested, such as prevention, long-term care, and palliative care; and
- promote the effective use of the workforce to care for older adults.

Recommendation 3-3: Health care disciplines, state regulators, and employers should look to expand the roles of individuals who care for older adults with complex clinical needs at different levels of the health care system beyond the traditional scope of practice. Critical elements of this include

- development of an evidence base that informs the establishment of new provider designations reflecting rising levels of responsibility and improved efficiency;
- measurement of additional competence to attain these designations; and
- greater professional recognition and salary commensurate with these responsibilities.

Recommendation 6-1: Federal agencies (including the Department of Labor and the Department of Health and Human Services) should provide support for the development and promulgation of technological advancements that could enhance an individual's capacity to provide care for older adults. This includes the use of activity-of-daily-living (ADL) technologies and health information technologies, including remote technologies, that increase the efficiency and safety of care and caregiving.

Recommendation 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.

After receiving formal training, the mechanisms used most often to ensure the general competence of health care workers are state- or jurisdiction-

based licensure and national board certification. Often, neither licensure nor certification examinations have explicit geriatric content, or the content is inadequate to ensure competency in the area of geriatrics. Since educational curricula are often devised to prepare students for these examinations, the explicit inclusion of geriatrics in standardized examinations may encourage programs to enhance geriatric content.

Recommendation 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.

Direct-Care Workers

Similar mechanisms are needed to enhance the competence of the direct-care workforce in caring for older adults. Direct-care workers are the primary providers of paid hands-on care and emotional support for older adults, yet the requirements for their training and testing are minimal. Furthermore, even though patient care has become much more complex, the federal minimum of 75 hours of training for nurse aides has not changed since it was mandated in 1987 (although many states have higher numbers of required hours). Home health aides have similarly low requirements, and very little is done to ensure the competence of personal-care aides. The committee concluded that current federal training minimums are inadequate to prepare direct-care workers and that the content of the training lacks sufficient geriatric-specific content.

Recommendation 5-1: States and the federal government should increase minimum training standards for all direct-care workers. Federal requirements for the minimum training of certified nursing assistants and home health aides should be raised to at least 120 hours and should include demonstration of competence in the care of older adults as a criterion for certification. States should also establish minimum training requirements for personal-care aides.

Informal Caregivers

Informal caregivers—most often family members and friends of the patient—play an enormous role in the care of older adults, and there is growing awareness of the benefits of providing them with better training and improving their integration with the formal health care team. Informal caregivers often feel insufficiently prepared to assist with home-based technologies, medically oriented treatments, or even basic tasks such as lifting and feeding.

Recommendation 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

Professionals

Among most health care professions, the opportunities for advanced training in geriatrics are scarce or nonexistent and among the professionals who do have the opportunity to pursue advanced geriatric training, very few take advantage of these programs. Aside from their clinical expertise, specialists in geriatrics are needed because of their role in educating and training the rest of the workforce in geriatric issues. Resistance to entering geriatric fields may arise from significant financial issues.

Recommendation 4-3: Public and private payers should provide financial incentives to increase the number of geriatric specialists in all health professions.

The costs associated with extra years of geriatric training do not translate into additional income, and geriatric specialists tend to earn significantly less income than other specialists or even generalists in their own disciplines. In part, this income disparity is due to the fact that a larger proportion of a geriatric specialist's income comes from Medicare and Medicaid, which have low rates of reimbursement for primary care activities in general. Moreover, reimbursements fail to fully account for the fact that the care of more frail older patients with complex needs is time consuming, leading to fewer patient encounters and fewer billings.

Recommendation 4-3a: All payers should include a specific enhancement of reimbursement for clinical services delivered to older adults by practitioners with a certification of special expertise in geriatrics.

Similar financial burdens affect the recruitment and retention of faculty in geriatrics. For example, in spite of their extra training, junior faculty in geriatric medicine have lower compensation than junior faculty in family medicine or internal medicine. The Geriatric Academic Career Awards (GACAs), awarded by the Bureau of Health Professions, have been instrumental in the development of academic geriatricians. Similar opportunities for geriatric faculty in other health professions are rare.

Recommendation 4-3b: Congress should authorize and fund an enhancement of the Geriatric Academic Career Award (GACA) program to support junior geriatrics faculty in other health professions in addition to allopathic and osteopathic medicine.

Many efforts to recruit and retain health professionals seek to relieve at least part of the financial burden associated with the personal cost of their education and training. The committee concluded that programs linking financial support to service have been effective in increasing the numbers of health care professionals who care for underserved populations and that they would serve as a good model for the development of similar programs to address the shortages of professionals in geriatrics.

Recommendation 4-3c: States and the federal government should institute programs for loan forgiveness, scholarships, and direct financial incentives for professionals who become geriatric specialists. One such mechanism should include the development of a National Geriatric Service Corps, modeled after the National Health Service Corps.

Direct-Care Workers

Recruitment and retention is especially dire among direct-care workers. They receive low wages and few benefits, they have high physical and emotional demands placed on them, and they are at significant risk for on-the-job injuries. These workers report high levels of job dissatisfaction resulting from poor supervision, a lower level of respect among colleagues, and few opportunities for advancement. Not surprisingly, then, there are high levels of turnover among these workers. Overall, the successful recruitment and retention of direct-care workers depends on a significant culture change to increase the quality of these jobs through improvements in the job environment and adequate financial compensation for their current and expanding roles.

Recommendation 5-2: State Medicaid programs should increase pay and fringe benefits for direct-care workers through such measures as wage pass-throughs, setting wage floors, establishing minimum percentages of service rates directed to direct-care labor costs, and other means.

Redesigning Models of Care

The U.S. health care system suffers from deficiencies in quality, and the health and long-term care services provided to older patients are no

exception. Simply expanding the capacity of the current system to meet the rising needs of older adults would not address the serious shortcomings in the care of this population. The committee created a vision for the future that rests on three key principles:

- 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.

The committee's vision represents a vast departure from the current system, and implementation will require a shift in the way that services are organized, financed, and delivered. Several models have been shown to improve quality and patient outcomes, sometimes at a lower cost. Other newer models have not been adequately tested, but appear promising. After reviewing the available evidence on a variety of models of care for older adults, the committee determined that there is no single approach or best model that could be broadly adopted for all older patients. Older adults have diverse health care needs and a variety of models are necessary to meet those needs.

Identifying successful models of care is only the first challenge to improving the delivery of care to older adults. The models need to be replicated widely to reach the larger patient population. However, the dissemination of successful models has been slow and some of the interventions have been unsustainable due to a number of challenges, including an inadequate mechanism for reimbursement. Many of the models require the delivery of services that are not typically reimbursed under Medicare.

The committee concluded that a new method of reimbursement is needed to support the implementation of effective and efficient models of care.

Recommendation 3-1: Payers should promote and reward the dissemination of those models of care for older adults that have been shown to be effective and efficient.

The committee supports reimbursement for services that are not currently covered (e.g., interdisciplinary teams); provision of capital for infrastructure (e.g., health information technology); and the streamlining of administrative and regulatory requirements. Payers need to also eliminate existing impediments to the use of innovative models by older patients, such as Medicare's copayment disparity for mental health services.

The broad efforts to develop new models of care indicate not only a recognition that services for older adults need to be improved, but also a

willingness among providers, private foundations, and federal and state policy makers to commit resources to learning about better ways to finance and deliver care. The committee supports the continued development of newer models, especially in areas that have traditionally been overlooked or for more effective use of the workforce.

Recommendation 3-2: Congress and foundations should significantly increase support for research and demonstration programs that

- **promote the development of new models of care for older adults in areas where few models are currently being tested, such as prevention, long-term care, and palliative care; and**
- **promote the effective use of the workforce to care for older adults.**

Delivering care within all of these new models will require adaptations by the workforce. For example, many successful models require providers of different disciplines to work collaboratively in interdisciplinary teams, but reimbursement for team care is currently lacking, and many providers are not trained to work effectively in teams. Also, several successful models of care require members of the health care team, including patients and their families, to take on new roles and assume greater levels of responsibility. Shifting various patient-care responsibilities (e.g., through job delegation) will be essential to create meaningful improvements in the efficiency of the health care workforce, but will require the training of many workers both in the skills needed to deliver more technical services, as well as the skills needed to be effective delegators and supervisors.

Recommendation 3-3: Health care disciplines, state regulators, and employers should look to expand the roles of individuals who care for older adults with complex clinical needs at different levels of the health care system beyond the traditional scope of practice. Critical elements of this include

- **development of an evidence base that informs the establishment of new provider designations reflecting rising levels of responsibility and improved efficiency;**
- **measurement of additional competence to attain these designations; and**
- **greater professional recognition and salary commensurate with these responsibilities.**

Finally, many new models incorporate the use of various technologies. Health information technologies, such as electronic health records, facilitate the sharing of information among providers and improve their ability to coordinate the complex care of older patients. Remote-monitoring technologies can efficiently extend the reach of health care professionals into the home. ADL technologies can extend the independent functioning of older adults and reduce the demands placed on direct-care workers and informal caregivers.

Recommendation 6-1: Federal agencies (including the Department of Labor and the Department of Health and Human Services) should provide support for the development and promulgation of technological advancements that could enhance an individual's capacity to provide care for older adults. This includes the use of ADL technologies and health information technologies, including remote technologies, that increase the efficiency and safety of care and caregiving.

CONCLUSION

The United States today faces enormous challenges as the baby boom generation nears retirement age. The impending crisis, which has been foreseen for decades, is now upon us. The nation needs to act now to prepare the health care workforce to meet the care needs of older adults. If current reimbursement policies and workforce trends continue, the nation will continue to fail to ensure that every older American is able to receive high-quality care. The dramatically rising number of older Americans, along with changes in their demographic characteristics, health needs, and settings of care will necessitate transformations related to the education, training, recruitment, and retention of the health care workforce serving older adults. This in turn will require the commitment of greater financial resources, even at a time when program budgets will already be severely stretched.

The committee asserts, however, that throwing more money into a system that is not designed to deliver high-quality, cost-effective care would be largely a wasted effort. Instead, this report serves as an appeal for fundamental reform in the way that care is delivered to older adults. In doing so, it provides a vision for how the workforce can best be developed and organized to improve its capacity to deliver the care that a new generation of older adults will soon be needing.