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Megan McHugh
Study Director and Senior Program Officer
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Dear Ms. McHugh:

The American Geriatrics Society (AGS) is pleased to provide input into the questions that the Institute of Medicine is addressing in its committee on "The Future Health Care Workforce for Older Americans". The enclosed document responds to questions 2-5 that were posed in the recent IOM Statement of Task and that are posted on the IOM Web page. This document was produced on behalf of the American Geriatrics Society by a working group composed of AGS members in leadership roles (membership listed below). The American Geriatrics Society is a nationwide, not-for-profit association of geriatrics health care professionals, research scientists, and other concerned individuals dedicated to improving the health, independence and quality of life of all older people. We believe that the work of the IOM on this issue is of critical importance and we hope that the Committee finds our input helpful to the process. Please note that the responses are annotated and we have provided copies of the supporting literature in this package.

If the IOM Study Group has any questions or we can be of further assistance, please do not hesitate to contact me.

Sincerely,

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Enclosure: *American Geriatrics Society Response to IOM*
Supporting Literature

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Responses to Institute of Medicine Request for Comment on its study The Future Healthcare Workforce for Older Americans

Question 2.a.

What is the best use of the health care workforce, including, where possible, informal caregivers, to meet the needs of the older population?

- Age is associated with an increasing frequency of chronic disease and, therefore, more utilization of numerous professional care providers. The specialist-driven organ system approach imbedded in a health care delivery system dominated by small physician groups or solo practices does not provide optimal health care quality or high value care to the aging population. Multiple chronic illnesses require a patient-centered approach that prioritizes optimal function and independence rather than focusing primarily on organ system function. Changes are necessary in the health care delivery system to ensure best use of the workforce. The system must become sufficiently interconnected and supported to allow improvements in monitoring quality and efficiency across the continuum of care. Some suggestions for how best to utilize the formal and informal health care workforce are listed below.

  - Primary care physicians: All persons should have a "medical home." The physician-led team practice takes into consideration the complexity of patient conditions, the need for effective interaction with specialists, the greater expertise of non-physicians in areas such as patient education and motivation, the limited supply of primary care physicians, and the imperative to maximize efficiency. The importance of the physician in this core unit of health care must be recognized, apart from other roles the professionals may play. Both office and homecare teams are needed.

  - Nurses/nurse practitioners: Nurses and nurse practitioners are central to the delivery of care in hospital, ambulatory, home care and nursing home settings. Nursing has always played a central role in education, coordination of care, and in the maintenance of continuity across settings. Advance practice nurses teamed with physicians perform many services that would otherwise require a physician, improving access particularly in underserved urban and rural settings. (1,2)

  - Certified nursing assistants: Certified nursing assistants are essential to the success of long-term care, regardless of setting. In order to expand and support this workforce, certified nursing assistants must be empowered, better trained and offered more fulfilling work environments.

- Physician’s assistants: As with advance practice nurses, the physician’s assistant is a highly trained professional who can improve access and continuity of care as a member of a physician-led team.

- Pharmacists: Pharmacists need to diversify from their basic role in the dispensing of drugs to a much higher level of engagement with nurse/MD teams in the community. Pharmacists are uniquely placed to reduce the risk of adverse drug events and polypharmacy. By collaborating in the management of conditions that require long-term pharmacological therapy such as diabetes, hyperlipidemia, hypertension, coronary artery disease and long-term anticoagulation, pharmacists can increase health care efficiency and quality. (3-6)

- Social workers: Important roles for social workers include coordinating services across settings, training families to provide support, facilitating discussions regarding advance directives, and providing direct therapy to patients and their caregivers.

- Therapists (physical therapists/occupational therapists/speech pathologists): Important roles include treatment of deconditioning, rehabilitation, and in implementing programs designed to preserve function and mobility and prevent falls. As part of a primary care unit, physical therapists can train other caregivers to recognize opportunities for timely therapeutic and preventive interventions. Such preventive interventions should be utilized whether or not the patient has reached the threshold of impairment required for a separately reimbursed skilled service. (7-9)

- Geriatricians: Geriatricians provide leadership and support for the health care team. They consult on complex patients and lead the primary care team in treating a small percentage of frail elderly patients. Geriatricians play a vital role in imparting core principles to the larger workforce that are providing the bulk of care. They also play a key role in advancing the geriatric knowledge base through research. Their interdisciplinary training places geriatricians in an ideal position to assume leadership roles in clinical and health care industry settings as well as in guiding policy decisions. (10)

- Informal caregivers: Non-professional informal caregivers have always participated in supporting aspects of overall care such as care coordination, case management, information transfer and adherence issues. An improved system will better support such caregivers, educate and empower them, and explicitly recognize their central role. When personal circumstances are such that informal caregivers are unavailable (e.g., no family), trained and monitored informal caregivers may perform many supporting care functions. (11, 12)

Question 2.b.
What models of health care delivery hold promise to provide high quality and cost-effective care for older persons?

- While all persons should have a "medical home" there is a need for the selective use of more intensely interdisciplinary and collaborative care for target populations, conditions and settings. A common characteristic of effective systems is the ability to maximize efficiencies by cross-subsidization or cost shifting within the system of care. In such a system, patient needs and quality of care issues rather than a fragmented payment system will determine resource allocations. While this question addresses delivery models, financing models may need to be revised to support health care delivery models, as has been demonstrated in many cases (see also question #4). (9, 13-25)
    - Examples of effective and/or promising models for various settings:
        - Nursing home: Evercare
        - Community: PACE, hospice, GRACE, Medical Homes, IMPACT, home-based primary care, in-home preventive visits, case management for congestive heart failure, guided care, care management plus
        - Hospital: ACE units
    - Examples of target populations where interventions and/or models of care have been effective:
        - Frail elderly persons
        - Age $\geq$ 85
        - Low income
        - Terminal care
    - Examples of target conditions:
        - Falls
        - Hip fracture
        - Dementia
        - Depression
        - Congestive heart failure
        - Stroke
        - Delirium

- Wide adoption of data systems that facilitate access to accurate patient health information is essential, particularly for older persons as they transition across care settings. A core principle for a successful information system is effective connectivity. Electronic silos will have a very limited capacity to improve quality, safety and efficiency.
    - Effective and/or promising examples of information systems: (26,27)
        - Electronic medical records (outpatient, inpatient and long-term care)
        - Physician order management systems
        - Medication dispensing systems

    - e-prescribing
    - Electronic support of medication reconciliation
    - Decision support, e.g., application of evidence-based guidelines to decision-making in practice
    - Electronic communication among providers

- Other health care delivery systems (e.g., military medicine, systems in other countries) may serve as effective models.

Question 2.c.

What new roles and/or new types of providers would be required under these models?

- Expanded roles for nurses and social workers in case/care management, e.g., preventive care, patient empowerment, caregiver support
- Possible development of certified care coordinators
- Enhancement of the role of informal caregivers
- Role of team leader assumed by primary care physician
- Role of organizational leader and educational leader assumed by geriatrician
- Lay leaders recruited for chronic disease self-management programs
- Community facilitators recruited for caregiver education and support programs

Question 3.a.

How should the health care workforce be educated and trained to deliver high-value care to the elderly?

- It is not feasible to train enough specialists in the range of geriatric care fields (nursing, social work, pharmacy, medicine, physical therapy, mental health, etc.) to care for all older Americans. Education that provides relevant information while developing appropriate attitudes and skills necessary to care for older persons (including interdisciplinary interactions) needs to be part of the core curriculum for most, if not all, health care workers. Engaging, upbeat educational methods for teaching geriatrics must be developed and disseminated. (28-30)

- Education accreditation agencies must develop required standards for curricula on caring for older persons to ensure wide adoption of such curricula and training (e.g., Liason Committee for Medical Education, Accreditation Council for Graduate Medical Education, American Association of Colleges of Nursing, American Nurses Credentialing Center). (31)

- The geriatrics content and standards of the USMLE exams, certifying boards (e.g., ABIM, ABFM, subspecialties), and recertification processes (including CME) should be increased.

- Mechanisms need to be developed to increase the number of geriatrics educators and researchers (nursing, social work, medicine, physical therapy, pharmacy, mental health, etc.).

- Training needs to facilitate the development of competency in interdisciplinary care and include collaborative care settings that are effective models of care. (32) Team training models from other fields (e.g., the military) may be instructive.

- Training needs to emphasize evidence-based approaches to care, where such data are available

- Education and training need to take appropriate advantage of technology (e.g., e-learning). (33)

- Formal members of the health care workforce need to be trained to be educators for patients, their families and other informal members of the health care workforce. (34)

- Geriatricians need formal training in organizational leadership and educational methods.

Question 3.b.
How should this training be financed?

- Training should be financed by significant enhancements to existing financing methods (e.g., Medicare and Medicaid DGME and IME, HRSA)

- The financing of training should be facilitated by incentives to trainees (e.g., loan repayment programs, grants) and incentives to the training entities (e.g., enhanced payment for services, grants, tax incentives)

- The private sector: Managed care organizations, disease/care management companies, hospital organizations, the pharmaceutical industry, and primary care networks should support training through monetary and/or in-kind support (e.g., sponsorship of practicums/fellowships).

Question 3.c.
What will best facilitate recruitment and retention of this workforce?

- Equitable earnings, relative to other health care workers, will facilitate recruitment and retention. Our current volume-based payment system that only considers team care and non-face-to-face services in a very limited manner has resulted in earnings that are not comparable to peer professionals. Addressing this will require different payment methodologies that will not make primary care

less remunerative. Ignoring this issue will make recruitment into and retention of professionals in careers in geriatrics and primary care unachievable. Educational initiatives alone will be insufficient to counter current trends. (35-43)

- The transformation of primary care to the envisioned model of the "medical home," with continuous quality improvement, will provide a more supportive model for those interested in primary care of the elderly. These practices will be recognized for excellence and the esprit de corps will promote recruitment and retention.

- Loan forgiveness programs at the local, state and federal level will help recruitment into geriatric and primary care fields. (44,45)

- Adequate funding for research and enhanced opportunities for early career professionals to participate in meaningful research are needed. (46)

- Incentives for implementing student mentoring programs and summer work opportunities will facilitate recruitment. (47-51)

- In order to preserve physician participation in nursing homes, tort reform is required.

Question 4.

How can public programs (e.g. Medicare and Medicaid) be improved to accomplish the goals identified above?

- Use the payment system to drive the provision of care into effective care models and to stimulate a restructuring of the delivery system.

- Encourage the federal government (e.g., NIA, AHRQ) to seriously invest in health services research with a focus on effective models of care and comparative cost-effectiveness of treatments.

- Seek mechanisms to further the deployment of cost-effective programs with demonstrated quality. For example, identify and address regulatory hurdles, create incentives to expand adoption of new programs, and provide risk-adjusted monthly service fees with pay-for-performance incentives for certified medical homes.

- Supplement the current fee-for-service system to support functional provider teams targeting selected settings and populations.

- Facilitate development and implementation of quality measures that are valid for older populations, especially frail elderly populations, e.g., in the areas of communication, care coordination, patient empowerment, non-visit-based patient management and follow-up.

- Implement better data collection and feedback processes to reduce the interval from research to implementation

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