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## Emerging Crisis: The Geriatric Care Workforce

*Robert B. Hudson, Editor*

The aging of America presents numerous societal and policy challenges. Far from the least of these is assuring that appropriately trained personnel are in place to meet the complex health care needs that this growing number of older Americans will have. Unfortunately, today's geriatric labor force is unable to meet current levels of need, and projections suggest that it may be less able to do so in the future.

While the existence of current and future geriatric labor shortages is beyond question, data limitations make it difficult to determine the exact magnitudes of these shortages. In the case of the professions – principally medicine, nursing, psychology, and social work – debate exists about educational and certification criteria needed to constitute “geriatric practice.” Differences here contribute to variation in formal enumeration of how many practitioners there may be. Government, professional, and independent assessments lead to varying estimates of current and future geriatric labor force capacity. A somewhat different but equally important set of issues surround determining the make-up, qualifications, and requirements of non-professional, or “frontline” care workers.

Multiple reasons have been put forth accounting for why the requisite labor force is not now in place and may well not be in the years ahead. In part, the shortage lies in workers in health care and related fields having a preference for working with younger rather than older patients and clients. It may also be that reimbursement levels for services may either be lower in the case of geriatric care or may not reflect the added complications that are often found in the care of older people, whose health care needs may be more complex and whose living situations may be more precarious. In the case of frontline workers, care provision is often demanding and onerous. Cultural and family dynamics may also intervene, making care delivery problematic for patient, worker, and loved ones alike.

The articles in this issue of *Public Policy & Aging Report* review the geriatric labor shortage, its consequences for older people, the factors behind it, and policy steps that must be taken lest the situation continue or become yet more severe. In an insightful cross-cutting article, Dennis Shea sets forth these issues, consequences, and needed steps in the case

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## Public Policy and Aging Report

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of mental health care. Inadequate mental health services lead to undertreatment, institutionalization, and even suicide in the case of mentally ill elders. Reviewing labor shortages across the mental health field, he concludes by noting the need for mental health parity under Medicare and a need for greater professional autonomy among non-physician mental health practitioners.

Susan Eaton reports on the crisis in frontline geriatric care. She details the immediate and potentially catastrophic consequences associated with labor shortages, inadequate training, and problematic working conditions. Eaton goes beyond issues of wages and hours to explore how lack of respect, poor supervision, lack of advancement opportunities, and cultural differences all mitigate against frontline work being satisfying and rewarding. Eaton reviews several innovative models being tested around the country to improve frontline working conditions and satisfaction.

Judith Gonyea, Alexandra Curley, and I address problems confronting the geriatric social work labor force. Estimating the size of the current social work labor force is complicated by the nature of key social work roles, namely, those addressing the complex needs of older clients across multiple settings, often involving the work of other professionals and practitioners. We also review concerns raised by the profession's difficulty in assuring that social work positions are staffed by individuals with appropriate training and certification in social work. Resolving these issues will be central to recruiting more social workers to geriatrics, where their abilities to help clients enter, negotiate, and exit the health care systems are beneficial to patients and payers alike.

Greg O'Neill and Patricia Barry document the shortage of geriatricians in the American health care system. Shortages are particularly noteworthy in select sub-specialties, and reimbursement is frequently deemed inadequate for frequently complex geriatric cases. In emphasizing the negative consequences of the geriatrician shortage, the authors note that geriatric units lead to better patient outcomes and that appropriate geriatric interventions lead to cost savings associated with preventative and rehabilitative services.

The "nursing shortage" has been well-documented and publicized, and nowhere is the shortage greater than in the case of geriatric nursing. Mathy Mezey and Christine Kovner provide ample evidence just how severe this shortage is and is likely to become. Here, too, the range of professional and para-professional specializations partially obscures the magnitude of the shortage, but through any number of care/patient ratios, the authors make clear that it is immense.

On a final and more positive note, all of the authors here point to recent and major initiatives that have been undertaken to address the geriatric care shortage. Repeated references are made to the investments that The John A. Hartford Foundation and, more recently, The Atlantic Philanthropies have made to augment the training, prospects, and numbers of current and future geriatric health care professionals and frontline workers. And, as noted, in several cases, these efforts have supported the preparation of the articles found here for which the authors express their thanks.

# Swimming Upstream: Geriatric Mental Health Workforce

*Dennis G. Shea*

Suppose we make a few assumptions. Assume that we can increase the number of medical school graduates that complete a psychiatric residency each year by 50 percent. Assume that we can also increase the number of those trained psychiatric graduates who choose to focus their professional practice on geriatric patients by 50 percent. Assume that we can maintain that effort for close to 30 years. If we do that we will more than double the number of psychiatrists focused on geriatrics by 2030. And we will have just barely succeeded in preventing the shortage of geriatric psychiatrists from getting much worse than it is right now.

Welcome to the world of geriatric mental health, where demographic and prevalence estimates suggest even Herculean efforts leading to massive increases in the currently inadequate mental health professional workforce will fail to keep pace with the increasing number of older Americans facing chronic mental illnesses. This article will consider the challenges our nation faces in meeting the future mental health needs of the elderly. It focuses on workforce issues based on the current, historical and projected data on the trends in demand and supply of geriatric mental health services and touches on what these data might mean for training, professional boundaries, quality of care, and mental health policy.

Any honest appraisal of the future mental health of the elderly is grim. That may seem odd at a time when advances in treatment offer great promise for improving mental health care. However, with few exceptions, the mental health workforce is falling behind the growing need for services, despite recent attempts to address the existing deficit. At this time, it is hard to see how future mental health needs of the elderly can be adequately addressed. While policy-makers should be wary of accepting every situation deemed a crisis by health professionals, this situation deserves the label (Jeste et al., 1999).

## Prevalence and Demand

The prevalence of mental illness among the elderly in the community has been reasonably well established through research like the Epidemiological Catchment Area studies (Robins and Regier, 1991). While there may be some basis for believing the estimates are underreported by 2 to 4 percent and some question over whether these data accurately capture older adults with mental illness in nursing homes, jails or other

institutions, a prevalence rate for psychiatric disorders excluding dementia of approximately 13 percent seems reasonable (Jeste et al., 1999; Bartels and Smyer, 2002). That suggests there are approximately 4.5 million persons over 65 with a mental illness today.

The first element in the geriatric mental health crisis, of course, is the simple demographic projections of population growth. By 2030, the Census Bureau projects that this population will almost double. Thus, even if we assume no change in future prevalence and no underreporting in the prevalence of mental illness

among the elderly, America will have more than 9 million older adults with mental illness in 2030.

However, this probably represents an underestimate of the future prevalence for several reasons. First, prevalence rates of mental illness and substance abuse appear to be higher among the baby boomer cohort than the prior generation of elders. Second, better treatment options may lead to lower mortality from mental illnesses for younger individuals (Jeste et al., 1999). While that is an outstanding benefit for society, it will place added pressure on the geriatric mental health system. By one recent estimate, the combination of demography and prevalence mean we will reach 2030 with more than 15 million older adults with mental illness (Jeste et al., 1999). Even a conservative view would suggest that the number would be 10 to 12 million persons.

Without significant improvements in the geriatric mental health system and workforce, the “solution” to this crisis will be the same one we accept today. This “solution” has three vital components. First, the system insures undertreatment (Department of Health and Human Services, 1999). The combination of inadequate insurance coverage (e.g., discriminatory copayments for

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mental health care in Medicare and lack of prescription drug coverage), inadequate workforce supply, and cultural stigma enables the health system to minimize the direct costs of mental health care for public and private budgets (leading quite naturally to other social costs).

The second component is institutionalization. Since older adults with severe mental illness cannot get adequate treatment in the community, we rely on nursing homes and jails to isolate these individuals from our communities. Given the lack of adequate mental health treatment in those settings, most persons institutionalized do not get any better mental health care in these locations than they do out of those facilities (Shea et al., 1994). However, they do get some basic shelter, food, and other resources that they might not otherwise be able to access on their own.

“Malthusilization” is our final solution. Persons over the age of 75 have the highest suicide rate of any age group in America (Hoyert et al., 1999). Every 90 minutes another person over age 65 commits suicide.

### Meeting the Needs: The Geriatric Mental Health Workforce

The tragic irony of our current “solution” to geriatric mental health is that there really are effective treatments for mental illness. As the Surgeon General’s report documented, treatment success rates for many mental illnesses now range from 60 to 80 percent or more (U.S. Department of Health and Human Services, 1999). The most effective treatment modalities tend to be combinations of psychosocial and pharmacological interventions. These treatments, especially among the elderly who are undergoing other age-related changes in health and experiencing comorbid illnesses, require careful and ongoing monitoring by trained mental health professionals and/or capable primary care providers. Unfortunately, the geriatric mental health workforce is not likely to be able to address the needs of the 10 million or more older adults with mental illness in 2030.

Several recent reports have provided outstanding information on the mental health workforce and, in some cases, on the geriatric components of that group (West et al., 2001; Colenda et al., 1999; Halpain et al., 1999; Rosen and Zlotnick, 2001). With only a few notable exceptions, these data suggest that the current gap between need for mental health care and workforce supply is not being closed. In fact, even as the growth in the population of older persons with a mental illness accelerates, it appears that the mental health workforce is

declining.

**Psychiatry:** As noted at the outset, even significant changes in the current number of physicians choosing to practice geriatric psychiatry will just barely allow us to keep pace with the growing mental health needs of the elderly. There are approximately 35,000 psychiatrists in the United States. About 5,000 of these psychiatrists identify geriatrics as one of their three interest areas. A similar number are estimated to have more than 20 percent of their patients age 65 or older. However, only about half (2,595 as of December 2002) of these psychiatrists have passed board certification examinations for added qualification in geriatric psychiatry and only about one-quarter are members of the American Association for Geriatric Psychiatry. Fewer than 15 percent of the psychiatrists reporting a high geriatric patient workload had completed the certificate for added qualification in geriatric psychiatry (Halpain et al., 1999; Jeste et al., 1999).

It is important to note that there is not agreement on the number of psychiatrists and other mental health professionals needed for a population. Managed care organizations sometimes advocate for 4 psychiatrists per 100,000 persons. That ratio, suggesting that we currently need about 1,400 geriatric psychiatrists, would argue that there is no shortage today of trained geriatric psychiatrists. However, a recent survey of managed care organizations found that HMOs employ, on average, 6.8 psychiatrists per 100,000 members. The same study finds that these HMOs employ, on average, 4.5 nonphysician mental health providers per psychiatrist. We might take this as a minimum standard, given the complications that elderly patients with mental illness pose for a mental health system. This is equivalent to a current need of about 2,400 geriatric psychiatrists, approximately equal to the number of persons who have passed certification examinations (Dial et al., 1998).

However, it is important to note that psychiatry has had difficulty attracting students in recent years. The number of U.S. medical graduates pursuing a first year psychiatric residency declined 40 percent from 1988 to 1996 (Weissman, 1996). While the difference has been made up somewhat by increasing numbers of international medical graduates in psychiatric residencies, the growth rate in the number of practicing psychiatrists (excluding child psychiatry) has dropped from more than 2 percent per year in the early 1990s to 1.8 percent per year. The number of board

**“The tragic irony of our current ‘solution’ to geriatric mental health is that there really are effective treatments for mental illness.”**

certified geriatric psychiatrists has been growing by approximately 2.4 percent per year.

**Psychology:** There are approximately 77,000 clinically trained psychologists practicing in the United States, although nearly one-quarter of these persons practice fewer than 35 hours per week. However, estimates suggest that only 0.25 to 1 percent of psychologists qualify as geropsychologists. Dividing the nonphysician providers identified in managed care staffing equally among psychologists, nurses, and social workers with specialized mental health training, these models would call for a minimum of 10.2 geropsychologists per 100,000 elderly persons or a total of 3,570 compared to the current number of 200 to 700. Thus, while some studies indicate an abundance of psychologists practicing in the United States, geriatric mental health needs suggest the number of psychologists focused on gerontology falls far short of needs.

As with psychiatry, however, the current trend is towards fewer trainees. While the number of doctorates in psychology has continued to rise in the 1990s to more than 3,700 in 1998, the number of students studying has dropped by almost 20 percent since 1995. Only 30 percent of accredited psychology programs even offer an elective course in aging and only 10 percent offer an aging emphasis to doctoral students (Halpain et al., 1999; Wise et al., 2001).

**Psychiatric Nursing:** There are no good estimates of the number of geropsychiatric nurse specialists in practice in the United States, because the discipline is quite new and no standard certification procedure exists. However, a number of educational programs, spurred by support of the John A. Hartford Foundation, are generating increased training in this area. There are currently more than 17,000 trained psychiatric nurses in the United States, however, more than 10 percent of them are not employed in the profession and another 23 percent are employed less than full-time.

Again, assuming that a minimum of 1.5 geropsychiatric nurses are needed for each psychiatrist, current need suggests a total of 3,570 trained professionals are needed in this area. Geriatric training of psychiatric nurses and psychiatric training for geriatric nurses (the American Nursing Association estimates that somewhat more than 12,500 nurses have specialized training in geriatrics) can certainly meet some of that need. However, in both areas, training is falling short of growing needs. The number of degrees awarded in

psychiatric nursing fell 45 percent from 1985 to 1998 and the number of students fell by 35 percent over the same time period. Less than one-quarter of nurse and nurse practitioner programs focus on gerontological nursing (Halpain et al., 1999; Wise et al., 2001).

**Social Work:** There are nearly 150,000 members of the National Association of Social Workers; the Association for Social Work Boards indicates that approximately 320,000 social work licenses have been issued in the United States. The Bureau of Labor Statistics indicates that there are approximately 600,000 self-identified social workers in the United States, with over 180,000 identified as working in health care. A recent survey indicated 5 percent of these social workers identify aging as the primary focus of their practice and another 5 percent identify it as a secondary focus. Thus, perhaps 9,000 to 19,000 gerontological social workers may be employed in health care, though perhaps as many

**“Perhaps 9,000 to 19,000 gerontological social workers may be employed in health care, though perhaps as many as one half of them are not licensed social workers.”**

as one half of them are not licensed social workers. The difficulties in counting social workers are compounded by the fact that there is no national certification for gerontological social work. Still, applying the managed care staffing ratios from above, these data would suggest a reasonable supply of licensed social workers to meet the current needs of the mentally ill elderly.

Yet, gerontological social work training suffers from some of the same limitations as geropsychiatric nursing. Many graduate and undergraduate programs lack any courses in aging, much less a concentration in gerontology. As a result of lack of courses and faculty in this area, fewer than 3 percent of students studying social work pursue an aging concentration. And, like many other mental health fields, student interest in social work education is stagnant or declining. While the number of Master’s of Social Work degrees awarded rose 64 percent from 1985 to 1997, it has remained stagnant since. Bachelor’s degrees in social work have followed a similar pattern, while the annual number of doctoral degrees awarded has actually fallen by more than 15 percent since the mid 1990s (Halpain et al., 1999; Rosen and Zlotnick, 2001; Wise et al., 2001).

In summary, using a minimum staffing model from managed care, the data suggest a need for 2,380 geropsychiatrists and a total of 10,710 nonphysician mental health providers currently. There are approximately 2,595 geropsychiatrists, 200 to 700 geropsychologists, and perhaps 5,000 to 10,000 licensed social workers working in health care with a focus on

aging. If we assume that the level of interest among psychiatric nurses in geropsychiatrics is similar to medicine, nursing, and psychology, there are perhaps 750 to 1,500 psychiatric nurses with an interest in gerontology. This gives an approximate total of 6,000 to 12,000 nonphysician mental health providers (not counting other fields and professions, such as counseling, human development, psychosocial rehabilitation, geriatric nurse practitioners, etc.). Given that we have used the average level of staffing among HMOs, as our guide, we can see that the current system barely even supplies that minimum estimate.

And the current failure to attract and graduate students in these fields suggests the problems will worsen. By 2030, using the managed care ratios again and assuming no increase in prevalence, we will need more than 4,700 geropsychiatrists and more than 21,000 nonphysician mental health providers. The recent reductions in the numbers of students choosing mental health fields of study has meant that current practitioners in all of these professions are aging rapidly. In 1996, almost two-fifths of psychiatrists were over age 55. Thus, in addition to providing approximately 2,300 new geropsychiatrists, the field will need to replace approximately 1,900 retiring geropsychiatrists. Combining those two will require an increase of more than 140 geropsychiatrists for each year between now and 2030. The number of board-certified geriatric psychiatrists is currently growing by fewer than 60 per year. Doubling that number, even in the absence of any increase in prevalence, even using a managed care staffing ratio, still leaves us more than 10 percent short of the target. A similar calculation can be made for each of the other fields.

### Responding to the Challenge

The need for addressing geriatric mental health workforce issues has not gone unnoticed. Efforts by groups such as the American Association for Geriatric Psychiatry, National Association of Social Workers, Council on Social Work Education, and The Gerontological Society of America with support from organizations like The John A. Hartford Foundation, are working to improve education and training in geriatric mental health among these groups of health professionals. Still, in a society with such negative cultural stigmas regarding both aging and mental health,

these efforts continue to swim upstream. Training and education efforts must be substantially increased, focusing on training faculty to train future workers, training new professionals, and training existing health professionals who can transition to serve mental health needs (Bartels and Smyer, 2002).

While cultural biases against geriatric mental health present one barrier, lack of career opportunities must be seen as another. Greater professional autonomy and reimbursement for nonphysician providers, as well as the development of career paths that support

movement from entry-levels of geriatric mental health to more advanced levels, must be seen as one of the ways of attracting professionals to these fields. While these changes challenge existing professional boundaries, the tremendous mental health needs of the future elderly cannot be solely met through physicians. Giving

psychologists, social workers or geropsychiatric nurses autonomy to practice within primary care settings can enhance career opportunities for all professionals, as well as improve quality of care. Naturally, ending Medicare's discriminatory lack of parity in mental health benefits and adding a prescription drug benefit that would include drugs for treating mental illnesses could further enhance career opportunities in geriatric mental health (though not without some dangers of swamping the current workforce) (Shea, 2002).

Thomas Edison once wrote, "Opportunity is missed by most people because it is dressed in overalls and looks like work." The advances in pharmacological, cognitive, behavioral, and other therapeutic approaches in mental health treatment over the last two decades have given our nation the opportunity to provide an unparalleled level of mental health to our aging population. Those opportunities will be missed without concerted work by government and the private sector to create the workforce that can deliver the treatments. It will require massive changes in education, training, and health policy. Absent that work, the advances in mental health of the twentieth and twenty-first century will remain out of reach of most of our older population; by 2030, *every thirty minutes* another American over age 65 will commit suicide.

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# Frontline Caregivers in Nursing Facilities: Can Policy Help in Recruitment and Retention Crisis?

*Susan C. Eaton*

Frontline caregivers in the long-term care sector, especially in skilled nursing facilities (SNFs), but also in home health and personal care settings, are becoming increasingly hard to find, hire, and retain. In 2002, the nation's 16,137 nursing homes were unable to fill 52,000 certified nurse assistant jobs, according to a survey by the American Health Care Association.<sup>1</sup> A key question for policy-makers and care providers everywhere in the U.S. is whether public policy can support and help create a stronger, better trained, and longer-staying workforce that will also provide decent jobs. Most of the workers involved have little formal education and, for the majority of workers with families, earn no more than poverty-level wages.

## Extent of the Problem

A 2001 U.S. Government Accounting Office (GAO; 2001) study noted that 695,570 nurse aides now work in nursing homes, 388,280 in hospitals, and 344,200 in home health care. In the decade between 1988 and 1998, the number of employed nurse aides increased 40%. The number of patients over age 85, who are most in need of long-term care, will double to 8.9 million in 2030, while the supply of workers will remain almost unchanged (2001:8-9). A recent study in North Carolina found that only 41% of the 222,000 previously trained and certified nurses' aides (CNAs) in that state were still eligible to work in health care, and those who were inactive were making \$3,100 more annually and had more stable employment in other service industries (University of North Carolina Institute on Aging's Workforce Survey and Report From the NC Board of Nursing, as cited in Harmuth, 2003). In a 1999 survey, 42 of 48 responding states reported that nurse aide recruitment and retention were major workforce issues for them (North Carolina Division of Family Services, 1999). To date, at least 40 states have convened task forces and other public bodies to look into or act on the workforce shortage, most focusing on CNAs separately from the licensed nurse shortage that is also plaguing health care providers. The Agency for Healthcare Research and Quality (AHRQ), along with the Centers for Medicare and Medicaid Services (CMS), has developed programmatic resources to assist states in addressing this persistent issue. CNAs are responsible for the majority of direct, hands-on care for residents of nursing homes.

The breadth of the problem is also demonstrated by the intense interest generated by a Request for Proposals from the Robert Wood Johnson Foundation and the Atlantic Philanthropies for the "Better Jobs and Better Care" initiative. The foundations are making available a \$15.5 million grant program to fund demonstration grants in five states. The application was extensive and

only one application per state was permitted, requiring stakeholders to form a coalition to build on existing efforts. While the funders expected 15 or so states would respond, groups from 49 states responded to the initial announcement, 40 submitted proposals, and ten states were declared "semi-finalists" with site visits occurring in April, 2003. The Applied Research portion of the program, with less funding, was similarly popular, with 200 letters of intent submitted and 42 research teams invited to submit full proposals also due in April. The research must be structured to provide concrete data for providers, and to be grounded in actual facilities and home or community settings.

**"In a 1999 survey, 42 of 48 responding states reported that nurse aide recruitment and retention were major workforce issues for them."**

## What Is the Root of the Workforce Problem?

Traditionally, critics have looked at the frontline workers themselves and found them lacking, alleging poor education, lack of a 'work ethic,' insufficient training, and unreliability. However, more recent research focuses on the organizational and institutional settings of nurse aide work, rather than rooting the problem in the employees. Some researchers point to problems of supervisory skill deficiencies as well. Additional research has focused on the organizational culture and leadership behaviors that appear to result in a more committed, qualified, and longer-staying workforce. In general, as the Institute of Medicine study on quality in long-term care pointed out, people do not like to work in a setting that provides poor quality care (Institute of Medicine, 2000). It seems clear that high turnover leads to poorer staff and resident relationships, short staffing, lack of continuity of care, and higher costs (two-thirds of which are paid from public funds).

A key part of this self-perpetuating problem is the extremely high turnover level for certified nursing assistants, more than 100% annually in 2000, and about 71% in 2001 (AHCA, 2003). This compares to an economy-wide turnover average of around 16%. Regional and local variations are large, with turnover

rates ranging from 46% in the mid-Atlantic to 111% in the West South Central states (AHCA, 2003). Most nursing assistants (who are only required to have 75 hours of training by the federal government, though 20 states have required more, up to a maximum of 150 hours) are not prepared for the actual challenging working conditions inside nursing facilities or in client's homes. They can also become discouraged by poor management practices, the depressing and even unsafe work environment, low wages and few benefits, and poor teamwork or peer support for learning. Most aides survive from paycheck to paycheck, and many hold multiple jobs to make ends meet. Nurse aides working in nursing homes earned an average \$8.29 hourly in 1999, compared to \$15.29 for all workers and \$9.22 for service workers, with a median wage of \$13,287 per year given that most do not have the option of working 40 hours a week, as 35 hours weekly is what most facilities schedule (GAO, 2001, p. 12; see also Citizens for Long Term Care, 2003, and U.S. Bureau of Labor Statistics, 2000).

A second aspect of the "workforce" problem is the lack of respect for frontline workers. Typically aides are held responsible by both licensed nurses and family members for poor treatment, neglect, abuse, loss of laundry, infections, boredom, disappearance of personal items, and many other common ills of SNFs, whether the aides are actually responsible or not. Most aides interviewed by researchers complain of a lack of dignity and respect in how they are treated by co-workers, supervisors, and visitors. Indeed, this treatment often disturbs them as much or more as the poor pay and meager benefits. Many cannot afford health insurance for themselves, if offered by their employer, much less for their families.

A third aspect of the problem is that these are mostly dead-end jobs. For many aides, the gap between a CNA and the next step up in the nursing ladder, a licensed practical or vocational nurse (LPN, LVN), seems impossible to overcome. LPN degrees require a year of full-time or two years of part-time schooling at the post-high school level, and registered nurses today most often have a bachelor's degree with special training in addition.

Fourth, there exists a cultural gap among aides and others found in nursing facilities. These gaps exist between aides (many of whom are immigrants and 90% of whom are women, although 56% are white non-Hispanic Americans) and nurses (89% of all registered nurses are white women; Bureau of Labor Statistics, 2001). They also exist between aides and residents or clients, who are mostly poor, white, old women in SNFs, but also include disabled younger people, especially in home settings. These cultural gaps make clear communication and positive working relationships difficult. Even if a registered nurse wants to train aides in how to handle dementia patients – who make up 50% or more of most nursing home populations – she may not

be able to communicate well.

Finally, organizational structure and priorities play a role. For-profit nursing facilities, making up 67% of the total nursing facility population in the U.S., have higher turnover rates and lower staffing ratios on average than not-for-profit or public facilities (Abt Associates, 2002, chapter 4). Nursing homes of all kinds have one of the highest rates of workplace injuries in the country, although those facilities with working ergonomic lifts in place, and enough trained staff to use them safely, fare much better in reducing injuries (Service Employees International Union, 1997).

### What Are Possible Solutions?

Society-level solutions may lie in re-thinking the whole concept of a nursing home and in supporting more home and community-based care. Home health aides generally are more satisfied with their jobs than nursing home aides, perhaps because they get to focus intensively on one person at a time. The relationships also become more rewarding for both parties; however, lack of higher pay and hours worked still remain a problem.

A fledgling movement called the Pioneer Network, founded in Rochester, New York by a few innovators in 1997, has begun to question the assumptions on which nursing home care is based. Pioneer advocates, many of whom are practitioners at innovative facilities, argue for a more home-like environment, more individualized care and choice, less medically and nursing-focused care, better trained caregivers who are accountable to residents, 'neighborhoods' to structure social life, and more emphasis on continuity of relationships and improved jobs for caregivers, among other things (see [www.pioneernetwork.org](http://www.pioneernetwork.org)).

A third approach, linked to the previous two but slightly different, was taken in Wisconsin by leaders of a group of 11 nonprofit nursing facilities who called themselves the "Wellspring" project. Recently evaluated by Robyn Stone and colleagues for the Commonwealth Foundation (see [www.cmwf.org](http://www.cmwf.org)), this total quality management-type approach was found to be highly effective in improving caregiver satisfaction and retention, slightly effective in improving measured clinical outcomes, and no more expensive than traditional care.

More extreme yet is the belief of some observers that nothing short of razing nursing homes will allow elders needed new institutional and social forms (see [www.edenalternative.com](http://www.edenalternative.com) and [www.thegreenhouseproject.com](http://www.thegreenhouseproject.com) for two examples).

In my research, by looking at high and low-turnover homes in the same labor market, I found five significant organizational practices that are correlated with lower levels of turnover (Abt Associates, 2002, chapter 5). These practices included: a reflective, highly trained and responsive leadership and management team; an organizational culture in which both caregivers and

residents felt respected; a bundle of 'high performance' human resource policies, including higher than average wages and benefits but also training in 'soft' skills and flexibility; thoughtful motivational work organization and care practices, such as alternate bathing and dressing techniques that cause less distress; and adequate staffing ratios and time for giving high quality care. These sound straightforward, but instituting these positive practices is extraordinarily difficult in the stressed environment of an under-funded nursing facility with two-thirds Medicaid residents and average turnover of more than 50% among nurse managers and leaders.

Currently no national standards for staffing exist, either in ratios or hours per patient day, for non-licensed nursing staff. But a major advocacy group, National Citizens' Coalition on Nursing Home Reform (NCCNHR; 1998) has proposed standards equivalent to each aide having responsibility for no more than 5 patients on day shift, 10 patients on evening shift, and 15 patients on night shift. These ratios are not met at the vast majority of nursing facilities. In fact, the 2002 Centers for Medicare and Medicaid Services report referenced above found that 97% of sampled U.S. nursing facilities did not meet a threshold level of staffing (averaging 2.9 hours per patient day of aide's care, 4.2 hours per patient day total nursing care) below which researchers found significantly worse clinical outcomes for residents.

### Is There a Role for Public Policy?

State governments and patient advocates certainly think that public policy is part of the solution to these persistent problems both of workforce shortages and poor quality care. As of 2000, at least 26 states had legislated wage and/or benefit-related solutions, (such as wage pass-throughs to frontline workers), increasing reimbursement rates for Medicaid, providing more access to health insurance, and transportation assistance. Another one-third of states have created training or other initiatives to make the jobs more attractive, including career ladder establishment (mostly as a pilot or demonstration project), scholarships, and expanded scope of duties. Some have set minimum staffing standards for direct care workers, some have tried collecting more data aimed at providing positive recognition for good performance, and some are funding demonstration projects to let the industry try to solve the problem.

Yet, virtually none of these initiatives have been established long enough – or evaluated carefully enough from a baseline – to show whether they are actually reducing turnover or increasing retention (see the Massachusetts Extended Care Career Ladder Initiative evaluation report for one partial exception; Wilson, Eaton, & Kamanu, 2003). Michigan showed that since the implementation of its wage pass-through in 1990, turnover rates have decreased from 75 percent to 68 percent. A similar study was carried out in Kansas over

a shorter period, but the documented increases are not large, nor was it possible to control for all other factors that might have affected turnover.

Secretary Thompson of HHS has decided to respond to public criticism by providing more internet-based quality information to consumers (see Nursing Home Compare, on the CMS website, [www.cms.gov](http://www.cms.gov)) with the hope that providing consumers with more information will enable market forces to eliminate dysfunctional facilities and reward excellent ones. However, advocates point out that many residents have little choice when they enter a nursing facility, either because they are arriving from a hospital and must go where a bed is available, or because of family, geography, or cost considerations. Many may not even be competent to make decisions, which reduces their consumer power close to meaningless. So far, it is not clear whether increased information will actually help reduce the problems of poor quality. Further, the required information does not include detailed staffing, turnover, or benefit data, and is not designed to address the workforce shortage directly.

### What is Realistic? Is There Hope?

The factors mentioned above – better leadership and management practices, increased respect for both residents and workers, improved staffing levels, improved wages and benefits, and revised care practices that give more choice to residents and improve the overall quality of life and organizational culture of the nursing facility – are difficult to legislate. States can and some have set improved staffing levels, and states hypothetically can also provide better wages. However, it is difficult to assure that a wage pass-through is actually passed through to the nurse aides themselves. Also, if a general statewide increase is granted, it is not certain that better-performing facilities are rewarded as opposed to all facilities regardless of quality or performance. But, in fact, few states have actually improved benefits. Finally, the likelihood of maintaining or improving wages or staffing at the state level seems small indeed in a deficit climate.

A far more difficult policy challenge is to require better personnel training and management, or to increase the culture of respect in any given facility. Serious, sustained training initiatives might well make a difference. States can change their requirements for nursing home administrators, but their enrollment in required training programs is at record lows these days already. And, with federal and state cuts impacting most state budgets, even promising initiatives started a few years ago have been recently discontinued or are facing the chopping block.

More research is needed to evaluate current public and private change initiatives and to clarify the outcomes that matter most to consumers and families. The Pioneer Network is one promising start, being a community of dedicated practitioners trying to share best practices and

to learn from one another. Workforce initiatives are hard to embed organizationally. But, when combined with positive work environments and possibilities for career movement, they do have direct effects on improving recruitment and retention. What is often called “culture change” is complex and hard to ‘diffuse,’ but it clearly has the potential to improve both the quality of jobs and of care. (See also [www.directcareclearinghouse.org](http://www.directcareclearinghouse.org) for additional research resources on culture change, case studies, and practice initiatives.)

Possible solutions for elders and their families include preparing in advance for a possible nursing home stay, whether it is short or long. Shopping around can make an important difference, even in the same labor market or in the same geographic area. Those who can use “Nursing Home Compare” can get a basic idea of nursing hours, the number of “deficiencies” garnered by a facility in its last two state inspections, and descriptions of current residents. For example, if 75 percent of a home’s residents are suffering from dementia and if one’s elderly mother is mentally sharp, the home may well not be a good match; or, if the home is rated in the highest quadrant for “pressure or bed sores,” further investigation is surely warranted. Advocates such as NCCNHR affiliates in the states, Alzheimer’s Associations, or state ombudspersons can be very helpful. Of course, finding a good geriatric physician can be critical, and they too are in short supply.

Finally, and most central here, families need to look carefully at the working conditions of the direct caregivers. They should be sought out directly and asked about what they earn, how they are treated, and how well they are trained. Their working conditions directly affect patient care. Today, there are growing numbers of dedicated practitioners, researchers, and advocates investigating the conditions of front-line workers in long-term care, and hopefully we will soon have solutions to this problem that are beneficial to patients and workers alike.

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# The Geriatric Social Work Labor Force: Challenges and Opportunities

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As a profession dedicated to working with disadvantaged and vulnerable groups, social work has a long history of work with older people. From the profession's early days of "friendly visiting" and settlement houses, social work aided those who were alone, poor, and frail. Growing awareness of the "aging of America" has led the social work profession to focus increasingly on the development and implementation of geriatric social work services. Yet, recent data on the social work labor force suggest that the profession is meeting neither the current nor the projected demographic challenge. Two concerns have been registered about this perceived gap. The first centers on the older clients who are not receiving social work services that could be critical to their well-being. The second is focused more on the profession itself, both why it has not moved more actively toward geriatric practice and why practicing social workers appear not to be availing themselves of possible career opportunities by working with a growing older population. Fortunately, there are currently underway several major initiatives addressing these training and labor force issues.

This article first addresses the roles of social work in geriatric care and how these roles affect our understanding of the current make-up of the geriatric social work labor force. A principal contribution social work makes to geriatric care lies in its emphasis on the social context in which the care is provided, a perspective well-suited to elders' complex and multiple health needs and their frequent transitions across types of care settings (e.g., hospitals, rehabilitative care, assisted living). Since this contribution takes place across many settings, it complicates determining both the number of social workers in geriatric care and identifying the precise contribution that they are making. Assessing social work's contribution is further complicated by the difficulty of the profession's being able to control its own practice or "brand" (i.e., determination of "who is a social worker"). These role and certification issues confound both quantitative and qualitative assessment of the social work labor force.

The article's second section presents estimates of the current size and future demand for the geriatric social work labor force. Despite the growing demand, based on both the expected growth in the older population and the ancillary need for social work services, the profession does not appear to have been adequately responding. Methodological and data limitations stand in the way of firm estimates of future unmet demand, but these may be

intensified if the profession is unable to respond.

The article's concluding section speaks to a major response that now is underway. Significant levels of

resources are being devoted to demonstrating social work's contributions in geriatrics and in expanding both the numbers and impact of those workers.

## The Social Work Mission

The breadth of the profession's approach to health and social problems is critical

to understanding the composition and contributions of the social work labor force. The approach is variously described as "holistic" (Scharlach et al. 2000), "fluid" (Gibelman, 1999), and "comprehensive" (Rosen and Zlotnick, 2001). Such breadth allows the profession to lay claim to graduate social workers' having been trained in the "physical, mental, and social aspects" of clients (Rosen and Zlotnick, 2001) and to be versed in "diagnostic assessment, community resource expertise, individual counseling, group psychotherapy, liaison and advocacy, and case management" (Howe et al, 2001). The breadth of practice is such that it can be conceptualized along multiple dimensions: fields of practice, practice settings, agency types, functions performed, client populations served, methods used, and services provided (Gibelman, 1999).

This practice breadth affords social work the ability to make manifold contributions to the well-being of older people. Through its practice and formal code of

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ethics, social work sees itself as client-centered and better positioned than other professionals to assist and empower individuals and groups. Thus, social workers engaged in clinical practice are attuned to larger resource issues such as housing and employment problems of clients as well as particular cognitive, psychic, or decision-making issues they may face. From the other end of the practice spectrum, social workers engaged in so-called “macro-practice,” helping individuals negotiate among health, mental health, community, and family “systems,” undertake this work with a firm familiarity with their personal challenges and strengths.

Social work contributions are equally strong in the case of geriatrics. Among other strengths that geriatric social workers bring to health care settings and interdisciplinary teamwork is an ability to work across institutional and community settings with both “formal” participants (physicians, nurses, administrators) and “informal” supports (family members, friends, neighbors, volunteers). Both the clinical and mediating functions of social work, as clients move among systems and settings, can be critical to individual and family health and well-being.

This breadth of roles and settings does raise issues for the profession, and these issues are no less pressing for geriatric social work than for the profession in general. Both the divergent levels of client need and the variety of settings in which geriatric social work can be practiced – across the entire continuum of care from acute health care to supportive social care – highlight the variation found in such practice. The particular skills required of the geriatric social worker might be a different mix from other health practitioners, but the breadth of such practice is surely as wide-ranging.

A particular challenge raised by the scope of social work’s role lies around its practice boundaries. Two sets of boundaries come into play. The first centers on geriatric social work’s ties to other health care professions and the degree to which social work functions overlap with those performed by other health care professionals. Clinicians, managers, organizers, and policymakers with formal training in other fields (psychology, nursing, counseling, public administration, planning, and policy analysis) lay claim to some of the domains that also constitute social work’s range of

practice. A strong case can be made that professional social workers work in and negotiate between these domains more readily than do other professionals, but they may do so at the risk of being perceived as “generic” (Gibelman, 2000).

The second boundary issue is quite different but perhaps more troubling. Here the question is to what extent do policymakers and others believe that “social work” roles can be played by individuals who have little or no formal training in social work. Currently, a large but unknown number of jobs – informally understood to be “social work” or that are formally classified as “social work” – are held by individuals who are not recognized by the profession as social workers. The profession sees these individuals as failing to meet professional standards by virtue of lack of formal education in social work (either at the BSW or MSW level) or licensure or certification

in social work at the state level. Perhaps most starkly, Gibelman (2000) notes that in the 38 states without title protection acts, almost anyone can call themselves a social worker.

Geriatric social work may suffer less from the boundary definition problems associated with lack of formal training or inappropriate job classification than is the case in other social work/welfare venues, such as public welfare. Health care settings require quite clearly delineated skill-sets for various job functions, whether from social workers or other professionals. However, geriatric social work does encounter the boundary issues involving other health care professions. In this regard, the major professional challenge for geriatric social work in health care settings lies in demonstrating to various stakeholder groups that social work can perform clinical, case management, and administrative functions as effectively and/or as efficiently as other professional groups. Clarifying these role issues would bode well for the future growth and enhancement of geriatric social work, and, indeed, efforts are now underway directly addressing them.

### The Geriatric Social Work Labor Force

The demographic imperative of an aging society is often cited as evidence of the need for greater numbers of geriatric social workers. The National Institute on Aging’s 1987 report, *Personnel for Health Needs of the*

**“Both the clinical and mediating functions of social work, as clients move among systems and settings, can be critical to individual and family health and well-being”**

*Elderly through the Year 2020*, for example, estimated that by 2000 approximately 40,000 to 50,000 social workers would be needed to serve the nation's aging population and that these numbers would rise to 60,000 to 70,000 social workers by 2020. In recent years, the U.S. Bureau of Labor also has consistently identified social work as a growth profession. In 1992, the Bureau of Labor Statistics (BLS) projected that the need for social workers would increase by 39 percent during the next decade. The BLS currently estimates that the employment of social workers will grow by 45 percent between 2000 and 2015 (BLS, 2003).

The anticipated rising need for social workers to serve older adults and their families—particularly with the aging of the baby boom generation—is cited as one of the critical factors in the profession's projected growth in the BLS 2002-3 Occupational Outlook Handbook:

The elderly population is increasing rapidly, creating greater demand for health and social services, resulting in particularly rapid job growth among gerontology social workers. Social workers also will be needed to help the large baby-boom generation deal with depression and mental health concerns stemming from mid-life, career, or other personal and professional difficulties. The number of social workers in hospitals and long-term care facilities will increase in response to the need to provide medical and social services for clients who leave the facility. Social worker employment in home healthcare services is growing, in part because hospitals are releasing patients earlier than in the past. However, the expanding senior population is an even larger factor. Social workers with backgrounds in gerontology are finding work in the growing numbers of assisted-living and senior-living communities.

In the face of this demographic imperative, one would expect to find geriatrics to be a significant growth area within social work professional practice. However, there is some evidence of a mismatch between the social trend and the social work profession's response. The National Association of Social Workers (NASW), the profession's primary professional organization, has repeatedly surveyed its membership to gain insights into their demographic and work characteristics. Comparison of NASW data for the available study years of 1988,

1991, 1995, and 2000 reveals that the percentage of members who identify aging as their primary practice area has remained slightly below 5 percent throughout the past twelve years. Similarly, the percentage of NASW members who identified aging as a secondary practice area has not grown over time; it too has hovered around the 5 percent mark (Gibelman and Schervish, 1997; PRN, 2001).

### Trend Spotting and Data Limitations

Several caveats must be stressed, however, in interpreting this data. First, NASW is a voluntary professional organization. A bachelor's degree in social work (BSW) is the minimum requirement for entry-level professional jobs; a master's in social work (MSW) is typically required for certification for clinical practice as well as most health and mental health positions and supervisory roles; and the Ph.D. or DSW degree is most often found in academic and research institutions. Although NASW represents all post-secondary degree graduates, nine out of every ten members has a MSW degree (PRN, 2001). In fact, the under-representation of BSW social workers in NASW may mask to a certain degree social work's labor force presence in geriatrics. In 1995, 16.7 percent of BSW members cited aging as their primary practice area compared to only 4.2 percent of MSW members and 3.7 percent of PhD-DSW members (Gibelman and Schervish, 1997). BSW social workers are most often employed in nursing homes and assisted living sites.

Determining geriatric social work labor force trends is made more difficult because of the use of multiple definitions to describe the social work profession as well as variations in states' standards for the accreditation and licensure of clinical social workers. Although all 50 states and the District of Columbia have licensing, certification, or registration requirements regarding social work practice and the use of professional titles, these standards vary by jurisdiction. Typically, states may legally regulate four categories of practice: Basic (BSW degree upon graduation), Intermediate (MSW degree with no post-degree experience), Advanced (MSW with two years post-master's supervised experience), and Clinical (MSW with two years post-master's direct clinical social work experience). It is important to note that some states offer social work licenses to non-BSW or MSW individuals who possess degrees in related fields. Moreover, the majority of states lack title protection acts; therefore, almost anyone can call themselves a "social worker." The Association of

Social Work Boards currently estimates the number of accredited clinical social workers nationally as totaling 350,000. Yet, given the lack of state certification in subspecialties (i.e., geriatrics, substance abuse, child and family practice) the number of currently licensed clinical social workers with a proficiency in geriatrics cannot readily be ascertained.

The U.S. Census Bureau's Current Population Survey (CPS) and the Bureau of Labor's Occupational Employment Statistics (OES) are also two valuable data sources for assessing social work labor force trends. The CPS has the advantage of being a stratified probability sample of the nation's noninstitutionalized civilian population aged 16 and older. A key limitation of the CPS data, however, is that individuals determine their own occupational category. In 2001, 782,000 CPS respondents chose to self-identify as a "social worker." Yet, as economist Michael Barth (2003) notes, almost 30 percent of respondents who self-reported as a social workers had less than a bachelor's degree education. Piecing together these two data sources—NASW and CPS statistics—into a detailed analysis of the social work labor market, Barth (2003) points out:

Given that CPS data include education, however, some idea of the potential limitations of NASW's database as a reflection of the population of social workers as defined by NASW is possible.... (I)t is unlikely that almost three out of every four people who appear eligible for membership on the basis of CPS data would actually prove ineligible on the basis of the information they would furnish on NASW's membership application form (p.10).

The Bureau of Labor Statistics OES data offer additional insights into the social work labor force. The OES program collects data from employers (versus individuals) on wage and salary workers in nonfarm establishments in order to produce employment and wage estimates for over 700 occupations. Yet, use of the OES 2001 data to determine the current numbers of employed geriatric social workers is also limited due to its classification of the 446,180 employed social workers into three broad categories: child, family and school social workers (257,100), medical and public health social workers (103,480) and mental health and substance abuse social workers (85,550). It may be reasonable to assume, however, that a significant share

of geriatric social workers is captured in the medical and public health category. In fact, social workers in the medical and public health realm have the highest median annual wages, \$34,790, as compared to child, family and school social workers (\$31,470) and mental health and substance abuse social workers (\$30,170) (OES, 2000). Yet, even within the medical and public health category, salaries vary significantly with setting. Median annual salaries for social workers in 2000 were: hospitals, \$40,020; health and allied health, \$36,230; local government (except education and hospitals), \$35,300; nursing and personal care facilities, \$31,580; and individual and family services, \$29,730.

The NASW membership survey, currently the only available national data source on geriatric social workers, is a valuable tool for beginning to identify both labor force trends and characteristics of social workers who focus their practice in aging. Yet, as NASW notes, there are significant limitations in generalizing from their membership to the larger social work labor force. For example, CPS "social workers" are approximately 72 percent female, 62 percent White, 25 percent Black, and 8 percent of Hispanic origin. In comparison, the NASW membership is approximately 80 percent female, 88 percent White, 6 percent Black, and 3 percent of Hispanic origin. Moreover, as previously noted almost one-third of the CPS respondents who identified as "social workers" lacked even a bachelor's degree.

Answering questions about the social work job market and social worker employment characteristics (including geriatric social work) will require the commitment (e.g., funding) of a national probability longitudinal study of BSW and MSW graduates. The NASW, in surveying its membership, has attempted to answer their question of "who we are"; however, significant questions remain about the social work national labor force.

### New Resources and Renewed Interest

Toward addressing these issues associated with the roles and make-up of the geriatric social work labor force, several initiatives are underway. They involve both the social work community itself and funding sources interested in documenting and enhancing the contributions made by geriatric social work. The John A. Hartford Foundation has instituted a wide-ranging initiative with these objectives. It has supported the Council of Social Work Education's Strengthening Aging and Gerontology Education in Social Work (SAGE-SW), which focuses on faculty development

and curricular materials for teaching social work; a Doctoral Fellows program, which provides dissertation support for promising scholars in the field; a Faculty Scholars program, which enhances the work of junior faculty interested in aging; a Practicum Partnership program, connecting communities and practitioners through innovative internship programs; and a Geriatric Social Work Education program, designed to expand and sustain geriatric content in social work schools so that all graduates have minimum competencies in the field. The Hartford Foundation has also generously supported geriatric labor force development in nursing and medicine.

The Atlantic Philanthropies has made aging one its core funding areas, including a major national initiative in social work – the Institute for Geriatric Social Work (IGSW) at the Boston University School of Social Work, which is embarking on research, education, and policy initiatives in geriatric social work. The Atlantic Philanthropies, in conjunction with the Robert Wood Johnson Foundation, has also launched the “Better Jobs for Better Care” initiative, directed at front line workers in nursing facilities and community-based long-term care. It has also funded the American Nurses Foundation to coordinate efforts of nursing specialty associations whose members care for large numbers of older adults.

Other initiatives, some fairly longstanding, have been undertaken by the Department of Veterans Affairs, supporting social work and other health care professionals working in interdisciplinary team settings through the Geriatric Education and Clinical Center (GRECC) program. The Health Resources and Services Administration has funded Geriatric Education Centers (GECs) since 1985; 34 such centers were awarded funding by HRSA in 2000.

Finally, there has been growing recognition of mutuality of interests and needs across both geriatrics and social work. The relevant geriatric organizations – The Gerontological Society of America, the Association for Gerontology in Higher Education, and the American Society on Aging have each increasingly highlighted social work research and training issues in recent meetings and publications. In complementary fashion, the Council on Social Work Education and the National Association of Social Workers are giving new prominence to aging-related activities. Both SAGE-SW and AGE-SW represent the institutionalization of these efforts, a critical step as both social work and geriatrics move to build social work capacity.

In summary, through both growing professional

interest and the infusion of new resources, geriatric social work is now positioning itself far better for addressing the “demographic imperative” than it has to this point.

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# Training Physicians in Geriatric Care: Responding to Critical Care

Greg O'Neill  
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As the nation's older population grows, the U.S. will require a well-trained workforce of health care providers with expert knowledge in geriatric medicine. Compared with younger adults, older Americans use a disproportionately larger share of health care services provided by physicians, nurses, pharmacists, physical therapists, and other practitioners. While people over age 65 represent 12 percent of the U.S. population, this group consumes one-third of healthcare services and occupies one-half of all physician time. Unfortunately, only a small share of the 650,000 medical doctors in practice today—including specialists whose patients are disproportionately elderly—receive the necessary training and education in geriatrics to provide older Americans with the best possible care.

Only three of the nation's 145 medical schools have a full-scale department of geriatrics that requires a mandatory rotation in geriatrics for students and residents, and less than 3 percent of all medical students take even one course in geriatrics. In contrast, every medical school in Great Britain and 19 of Japan's 88 medical schools have such a department (ILC, 2001). A mandatory geriatrics rotation in all U.S. medical schools would be welcomed, but it would not solve the problem. Indeed, even if all of the 16,000 medical students who graduate each year started to receive geriatrics training today, it would take more than 40 years before the entire U.S. physician workforce would be adequately prepared to address the complex and distinctive needs of their elderly patients.

The U.S. cannot afford to wait that long. In less than 10 years, the baby boomers will start turning 65. Although schools of medicine, nursing, and social work are beginning to take steps to attract new students to the field of geriatrics, it's imperative that the existing health care workforce—practicing physicians, nurses, therapists, pharmacists, and social workers—receive the training and education necessary to address the needs of their expanding pool of older patients.

## Older Adults' Use of Services

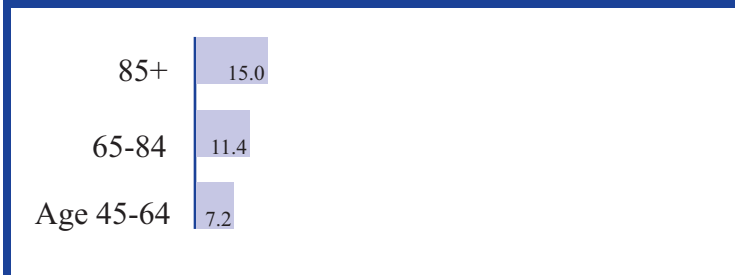
Older patients tend to use health care services more than younger adults. Patients 65 and older visit physicians an average of 11.4 times a year, compared with 7.2 visits for the population between the ages of 45 and 65. The oldest old—those at least 85—average 15

physician visits each year (see Figure 1).

As a result, though adults 65 and older made up only 12 percent of the population in 2000, they made 24.3 percent of all office visits that year—about 200.3 million visits, according to the National Center for Health Statistics. About 45 percent of all visits were made to primary care physicians (see Figure 2).

For most medical specialists, the elderly represent a disproportionate share of their practices (see Table 1). For family practitioners, 20.4 percent of their total patient visits in 2000 were made by people age 65 and older, and for internists, older adults made 39 percent of total visits. The percentages climbed higher for cardiologists (59.7 percent), urologists (53.1 percent), and ophthalmologists (51.5 percent).

**Figure 1** Average Number of Physician Visits Among Older Adults, 1999



Source: Department of Health and Human Services

## The Unique Healthcare Needs of Older Adults

Older patients often have several chronic conditions, take multiple medications, and respond to treatments and medications differently than do younger persons. For these reasons, diagnosis and treatment can often be difficult. Few physicians are trained to recognize or address the unique and complex needs of the elderly, nor are they able to perform an effective geriatric assessment. As a result, physicians often consider conditions like memory loss or incontinence to be the expected side effects of aging, though appropriate interventions can improve these conditions. In many cases, physicians hesitate to prescribe exercise regimens or cholesterol lowering strategies, even though patients

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could benefit. Depression, which physicians often confuse with the onset of cognitive impairment, is often undiagnosed in older adults. In addition, many physicians are not trained to consider the social, environmental, and psychological factors such as retirement and isolation that can compound the effects of a patient's illness.

### The Role of Geriatric-Care Professionals

Health care professionals who are trained in geriatrics can help to maintain the health and quality of life of older patients. The complex needs of older patients often require a team of health care providers with aging-related expertise to work together to assess the patient's physical and mental well being and to coordinate care in a variety of settings—the patient's home, the physician's office, the hospital, and the nursing home. Geriatric-care teams also work cooperatively with caregivers, such as family and friends, who play a crucial role in helping the older patient maintain health and independence.

Older patients who receive specialized geriatric care tend to do better than those who receive usual care. In one study, patients who received inpatient and outpatient care in geriatric units experienced large reductions in functional decline and improvements in mental health at no additional cost (Cohen, 2002). In another study, older patients cared for by nurses trained in geriatrics had fewer readmissions to the hospital and were less likely to be transferred from nursing facilities to a hospital for inappropriate reasons (Kovner et al., 2002).

Specialty health care professionals could also benefit from training in geriatrics. A cardiologist, for example, might be more likely to look for signs of depression, which often worsens conditions like hypertension and heart disease. Family doctors and

internists would be more likely to help frail patients prevent fall-related injuries by reviewing medications and checking vision.

### Potential Savings

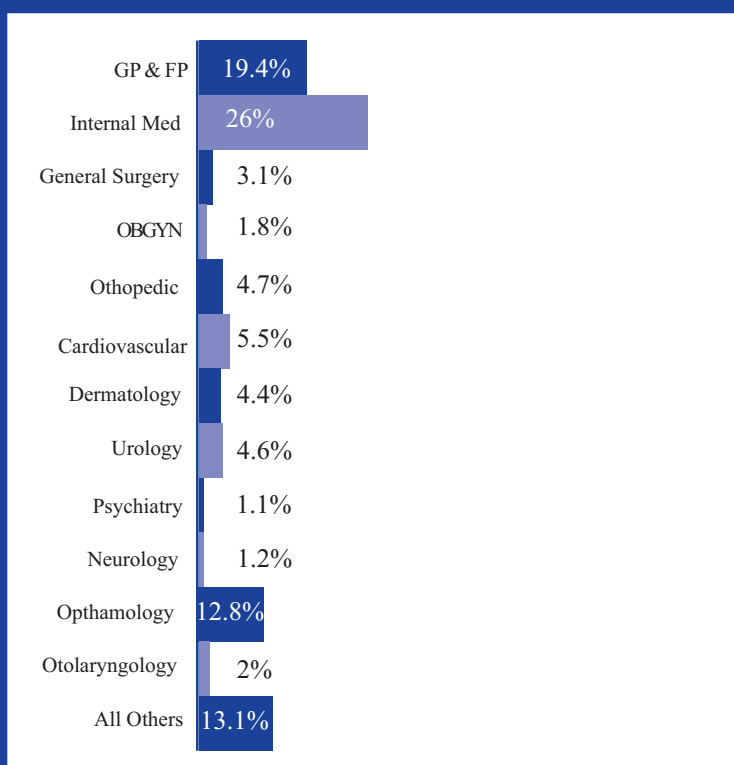
The financial benefits of care provided by physicians and other health care workers trained in geriatrics are potentially enormous. Health care professionals trained in preventive and rehabilitative care, in prompt intervention, and appropriate testing can help reduce costs arising from avoidable hospitalizations and nursing home admissions. The Alliance for Aging Research estimates that proper geriatric care could reduce hospital, nursing home, and home care costs by at least 10 percent a year, saving \$50.4 billion in the year 2000 and \$133.7 billion in 2020. The GAO (GAO, 1995) has estimated that medication-related problems among the elderly, including improper dosing and adverse reactions, costs approximately \$20 billion a year in hospital stays. According to the Centers for Disease Control and Prevention (CDC, 2000), fall-related injuries among

older Americans cost \$20.2 billion in direct medical costs each year. The CDC notes that the number of falls could be reduced substantially through a prevention strategy of exercise, vision correction, medication review, and home modifications, such as bathroom grab rails.

### A Growing Crisis

The projected increase in the number of older baby boomers comes alongside another demographic certainty: The decline in the size of the working-age population needed to support rising numbers of elderly. In 2000, there were three workers to support every senior; by 2044, there will be two workers for every senior, according to the Social Security Administration.

**Figure 2** Distribution of Office Visits According to Physician Specialty for Adults 65+, 2000



Source: National Ambulatory Medical Care Survey

This projection has profound implications for the health care workforce. The number of trained professionals, most of them baby boomers themselves, may decline as the need for them rises. For example, about half of registered nurses are at least 45 years old, higher than average across occupations. Their retirement will aggravate an already severe nursing shortage. The U.S. Bureau of Labor Statistics estimates that employers will need to find replacements for 331,000 RNs between 1998 and 2008.

Academic institutions are woefully unprepared to address these population trends. Medical schools have yet to make the same commitment to geriatrics that they've made to pediatrics. All U.S. medical schools have a department of pediatrics—a leftover from the early days of the baby boom. In 2000, there were 62,386 pediatricians to treat 59 million children up to age 14 (one pediatrician for every 945 children). In contrast, there were just 9,000 geriatricians to treat about 35 million persons 65 and over (one for every 3,888 older persons). According to the Alliance for Aging Research (2002), the number of geriatricians is expected to fall to less than 6,000 in the next few years, as many leave the lower paid field or retire, while it is estimated that the nation will need 36,000 geriatricians in the next 30 years.

The International Longevity Center (ILC) estimates that a minimum of about 1,450 academic geriatricians are necessary to ensure that no student graduates from medical school, regardless of specialty, without receiving education and training in geriatrics. This modest number would be sufficient to place about 10 academic geriatricians at every medical school to prepare the physician workforce for our aging population. However, there are currently less than 600 faculty members who list geriatrics as their medical specialty.

## Legislative Action

There are indications that Congress is trying to promote geriatrics training, although progress is slow. On February 13, 2003, Congress provided a dramatic increase in funding for geriatric programs operated by the Health Resources and Services Administration (HRSA). These programs include the Geriatric Education Centers (GECs), Geriatrics Training Fellowships for Physicians, and the Geriatric Academic Career Award (GACA). These programs received

\$12.4 million in 2001, but Congress increased funding to \$20.4 million in 2002 and another increase to \$28 million in 2004. The 2004 appropriation specifically provides \$4.7 million for the GACA, which will help promote the development of a cadre of academic geriatricians to be present at every U.S. medical school.

Members of Congress have also introduced legislation calling for financial incentives to encourage more physicians to provide more geriatric care. Currently, physicians who specialize in caring for the elderly spend more time with each patient and see fewer patients but are reimbursed less through Medicare's payment schedules based on the "average patient." The *Geriatric Care Act of 2003*

would authorize Medicare coverage of comprehensive geriatric assessment and care coordination services. Because low Medicare reimbursement also discourages physicians-in-training from entering the geriatric care workforce (Medicare Payment Advisory Committee, 1999), the bill also includes financial incentives designed to attract medical students to the field. Specifically, it would amend title XVIII of the Social Security Act to expand the number of residency slots funded by Medicare. Medicare's graduate medical education program (GME) spends about \$6 billion to support

**Table 1** Percentage of Total Visits to Various Medical Specialties Made by People Age 65 or Older, 1981, 1991, 2000

Specialty	Percentage of Total Visits in:		
	1981	1991	2000
All Specialties	18.4	23.2	24.3
General/Family Practice	19.3	19.9	20.4
Internal Medicine	34.4	37.7	39.0
Cardiology	46.1	53.4	59.7
Ophthalmology	39.3	55.0	51.5
Urology	37.6	45.8	53.1
General Surgery	20.4	32.2	30.1
Neurology	17.7	19.9	28.5
Dermatology	13.4	27.9	26.3
Otolaryngology	16.9	17.7	22.3
Orthopedic Surgery	13.7	17.9	20.4
Psychiatry	4.6	7.0	6.6
Obstetrics/Gynecology	2.6	4.5	4.7

Source: *National Ambulatory Medical Care Survey*

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98,000 residencies each year, yet very little of these funds are used to support the training of geriatricians. In fact, in 1999, there were less than 500 individuals in geriatrics fellowships. Ironically, the federal program that finances healthcare for older Americans spends less than 0.5 percent of its dollars on training physicians to care for elderly.

### A Call to Action

To prepare for the coming demographic realities, the U.S. must take immediate steps to reform professional health education, equipping future physicians, nurses, and other health workers with skills in geriatrics. Medical schools must create departments of geriatrics. Nursing programs must introduce geriatrics content into their required curriculum. Students in health professional education programs should have required courses concerning the care for older adults.

However, the nation also must ensure that the *current* workforce of health care professionals develop the necessary knowledge and techniques to address the complexity of delivering care to the older population. The immediate goal should be to provide every health care worker today with some education and training in geriatrics. To reach this goal, we propose these steps:

- **Engage physicians, nurses, and other health care professionals in lifelong training in geriatric medicine.** Academic schools of medicine, nursing, and social work must develop continuing education programs in geriatrics for local professionals. Education programs should be geared to professionals who do not have any training in geriatrics and those who need to maintain existing expertise. Academies and boards that represent specialties should work with universities on course development and encourage their members to take these courses.

- **Mandate a specified number of credits in geriatrics as a condition for license renewal.** This would apply to states with requirements for continuing medical education (CME) for the re-licensing of physicians, nurses, pharmacists, and other health care professionals.

- **Base CME for physicians in geriatrics on new models of practicing-physician education.** Research shows that formal CME conferences are not effective (Oxman, 2002). The Practicing Physician Education

Project funded by the John A. Hartford Foundation and the American Geriatrics Society, found that models using small groups, physician leaders in the community, and interactive case studies were able to initiate changes in physician practice. For example, toolkits on memory loss and incontinence help physicians to improve the way in which they evaluate and treat these conditions (Barry, 2002).

- **Require that state regulators, who oversee nursing homes, assisted living facilities, and home health agencies, provide specialized geriatrics training to their paraprofessional staff.** These workers should develop specific skills related to caring for patients with Alzheimer's disease, physical disabilities, and depression.

- **Congress must reconsider its reimbursement policies under Medicare.** The Medicare payment system rewards procedures, tests, and technology-driven care instead of a more patient-centered form of care. Because geriatricians depend heavily on Medicare by virtue of their patient population, low reimbursement for complex, intensive evaluation and management of conditions reduces incentives for providers to seek certification in geriatric practice. The lack of billing codes for comprehensive geriatric assessment makes it difficult to compensate physicians for the time they spend working on care plans and coordinating geriatric-care teams. Congress should pass the *Geriatric Care Act of 2003* (H.R. 102), which would authorize Medicare coverage of geriatric assessment and care coordination services provided to older adults with a serious or disabling condition.

Despite decades of concern from policy leaders, educators and physicians, geriatrics remains only a small part of American medicine. The first White House Conference on Aging in 1961 noted the small number of trained professionals in the field of aging, and the 1971 Conference reported that most of those providing care to older patients had no formal training in the specific needs of this population. With the baby boom closing in on old age, the American medical community is ill-prepared to meet current and future demands for physicians with geriatrics training. The field of aging needs to actively support policy initiatives that are being proposed to remove obstacles that stand in the way of improvements in geriatric care. We need to take steps now to assure that older Americans, particularly those with complex or

**"The number of trained professionals, most of them baby boomers themselves, may decline as the need for them rises."**

multiple health conditions, receive the care they need in the decades to come.

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# Nursing's Geriatric Workforce: Caring for Older Adults

*Mathy Mezey  
Christine Tassone Kovner*

With older adults now and in the future as the “core business” of health care, we argue that every nurse must have basic preparation in geriatrics and also access to geriatric nurse experts. While we have seen some modest progress, the number of nurses specializing in geriatrics continues to fall far short of demand. Overall, less than 1% (21,500) of the nation's 2.2 million working RNs are certified in geriatric nursing. Geriatric content is woefully lacking in nursing programs, and generalist and specialty nurses (e.g. oncology nurses) who are likely to care for large numbers of older patients are inadequately prepared in geriatrics.

## Nurse Workforce Preparation in Geriatrics

The nurse workforce that cares for older adults can be described by their education and training, by the current and future need for them, and by where they are employed and what is the current and future need in those settings. While this article focuses on registered nurses (RNs), the nurse workforce encompasses a non-professional workforce that includes unlicensed assistive personnel (UAP; certified and not certified) and Licensed Practical/Vocational nurses (LPNs/LVNs). We know very little about the geriatric preparation that takes place in the UAP programs and in the 1,100 state-approved year long programs providing practical nursing training (U.S. Department of Labor, 2003).

However, two organizations that represent LPNs/LVNs (National Federation of Licensed Practical Nurses; National Association for Practical Nurse Education & Service) offer a national Certification in Gerontology or Long Term Care.

Registered nurses (RNs) are prepared in baccalaureate, associate degree, and diploma nursing programs. In 2000, 31% of new RN graduates and 30% of the nation's practicing nurses were baccalaureate prepared. While all baccalaureate programs in nursing have required pediatric rotations, a similar commitment to geriatrics has yet to emerge. Of the approximately 670 baccalaureate nursing programs, in 1999 (Rosenfeld et al., 1999):

- Only 30 (four percent) met all criteria for exemplary geriatric education, such as a stand alone geriatrics course, two or more clinical placement sites in geriatrics, and at least one full-time faculty member nationally certified in geriatrics.

- Only 23% had a required course and only 14% had as an elective a stand-alone geriatric course. The remainder of the programs integrated geriatric content into one or more courses.
- 58% of the programs had no full-time faculty certified in geriatric nursing.
- 80% had no part-time certified faculty members certified in geriatric nursing.

**“While it is clear that the U.S. needs more nurses prepared in geriatrics, there are an insufficient number of nursing faculty to educate the next generation of nurses.”**

While it is clear that the U.S. needs more nurses prepared in geriatrics, there are an insufficient number of nursing faculty to educate the next generation of nurses. In 2002, registered nursing programs nationally reported 1,106 unfilled full-time faculty positions (Rosenfeld et al.,

2003). These vacancies reflect current demand. Not only are there an insufficient number overall, but in particular there is a lack of nursing faculty prepared in geriatrics. Rosenfeld et al. also found that 6.4% of baccalaureate programs reporting unfilled positions had a position available in geriatrics. Although this is a small percentage of programs, most troubling is that recruiting faculty prepared in geriatrics continues to be a low priority for nursing programs. Based on Rosenfeld et al.'s numbers, we would expect a substantially larger percent of programs to report vacancies for geriatric positions.

Preparation of advanced-practice geriatric nurses (i.e. geriatric nurse practitioners and clinical specialists) is equally worrisome. These nurses, by virtue of having met State Board of Nursing criteria and/or passed an examination offered by the American Nurses Credentialing Center (ANCC), can provide primary care to older adults, including prescribing medications, and are eligible for Medicare and Medicaid reimbursement.

The 58 masters programs and 40 post-Master's programs that prepare geriatric nurse specialists graduate approximately 300 students a year. In 2002, the number of graduates was 125 (AACN, 2002). In 2002, fewer than 5,000 nurses were ANCC certified as geriatric nurse practitioners or clinical specialists, representing two tenths of one per cent of the nation's practicing nurses, and 4% of all certified nurse practitioners and clinical specialists (AACN, 2002).

While older adults represent the majority of the patient caseload of family and adult nurse practitioners, women's health practitioners, nurse specialists in critical care, and cardiac and oncology nurses, Master's programs preparing these nurse specialists lack specified requirements in geriatrics. Mental health and psychiatric conditions are common in old age. Many older adults with dementia also have co-existing medical conditions, and these patients are significantly more likely to have more, longer, and costlier hospital stays (Maslow, 2003). Thus, it is quite shocking that only 5 schools of nursing offer master's programs to prepare gero-psychiatric nurses. The annual graduations from these programs are unknown and there is no national examination to certify nurses in gero-psychiatric nursing.

**"Unfortunately, while such projections exist for medicine, there are no existing accurate data related to current and projected geriatric nurse workforce needs."**

### Future Needs for a Geriatric Nursing Work Force

The National Center for Health Workforce Analysis (NCHWA, 2002) reported that the nursing shortage that was expected to begin in late 2002 had already begun by 2000. They estimate that by 2015 the shortage will be about 20%, or about 507,000 fewer RNs than demanded. In part, the increased demand is driven by an expected larger proportion of older adults in the U.S. population. Thus, in addition to an overall shortage of RNs there is likely to be an even greater shortage of RNs prepared to care for older adults in the future.

One of the reasons that we have so little data on geriatric care is that many surveys do not even ask about geriatrics. For example, the National Sample Survey of Registered Nurses (Spratley et al., 2002) in question 14b asks, "What types of patients are primarily treated in the hospital unit in which you work?" Geriatric practice was not a choice, although pediatric practice was a choice. Thus from this national survey conducted by the federal government every 4 years, we do not know how many nurses care for geriatric patients. That number can only be estimated using various sources.

Among the critical health workforce issues is how many nurses trained in geriatrics does the U.S. need. Clearly we don't have enough and we will need more (Kovner et al., 2002). But the available evidence does not provide enough information about how many more we need. Does every older adult need a geriatric nurse practitioner? No. Does every older adult need a nurse who has some education and training in geriatrics? Yes. Do these providers need access in person, by phone, or via electronic communication to a geriatric nurse practitioner, other health providers such as physicians trained in geriatrics, and a geriatric team? Yes.

The negative consequences of a nursing shortage and of too few nurses prepared in geriatrics, make themselves apparent in a number of ways. As they age,

people tend to use more health services. Among those who used health services, older age groups had more visits than younger people. In 1997 there were more than 85 million office-based visits and more than 9.6 million outpatient visits to nurses and nurse practitioners (Kovner et al., 2003). About 209,000 registered nurses are employed in ambulatory care (Spratley et al., 2002); unfortunately little is known about these nurses. Health care settings that serve primarily older adults are more negatively impacted by the nursing shortage than other work settings. An example of this is nursing facilities. In 2000, approximately 7 percent of practicing RNs were employed in nursing facilities (Kovner et al., 2002; Harrington et al., 2000). The percentage of RNs employed in nursing facilities as compared to other settings decreased sharply between 1996 and 2000, a time of nursing shortage, as compared to a substantial increase between 1992 and 1996, a time of nursing over-supply. The shortage of RNs in nursing facilities is a serious concern because, as the sole professional provider in these facilities, RNs are responsible for overseeing the work of other licensed and non-licensed nursing staff.

### Policy Recommendations

We propose that there is a need to assure that all Registered Nurses (and LPNs/LVNs) have some education in geriatrics and that these nurses have access to geriatric experts. This can be achieved by:

- Educating more nurses as experts in geriatrics
- Increasing geriatric content in nursing programs
- Insisting that health providers employ nurses with

- training in geriatrics and
- Requiring health settings (e.g. hospitals, home health, nursing facilities) to provide care for older adults by nurses with geriatric training.

Achieving these objectives requires cooperation from professional nursing organizations including those representing education, licensure, clinical practice, and administration. It also requires the involvement of state and federal regulatory and reimbursement agencies, and other stakeholders such as AARP, the Veterans Administration, MedPAC, and trade unions, to stimulate discussion and action concerning the geriatric workforce.

Accurate workforce projections as to the need for geriatric nurses is a critical step if we are to make informed recommendations and decisions related to changes in education and practice. Unfortunately, while such projections exist for medicine, there are no existing accurate data related to current and projected geriatric nurse workforce needs, including what would be an appropriate balance as to numbers, geographic distribution, and distribution between geriatric specialists and generalist providers. Among the questions to be answered are:

- How much of the care provided to older adults requires nurses prepared in geriatrics?
- What is the appropriate ratio of people prepared in geriatrics to the older population?
- What types of patients need care from geriatric specialists rather than generalists with some geriatric training?

Even in the absence of accurate data, it is reasonable to recommend that all students enrolled in a nursing professional education program have some required content in geriatrics as well as experience in caring for older adults. At a minimum, all university based nursing programs need faculty with specialty training in geriatrics, and either departments, divisions, or sections of geriatrics. Therefore, the number of nursing faculty who should have preparation in geriatrics is unclear. Using medical school geriatric faculty projections as a guide, and taking into account that university based nursing schools have fewer students than medical schools, it appears that an additional 4,000 Master's and doctorally prepared geriatric nurses would be needed just for baccalaureate programs to assure a pipeline of appropriately prepared geriatric nurse faculty.

Interestingly, over the past 10 years, a number of government agencies and private foundations have made major investments in geriatric nurse work force preparation. HRSA has funded several initiatives,

including the funding of 41 Geriatric Education Centers (GECs) whose primary mission is the preparation of geriatric faculty, and grants to schools of nursing to encourage baccalaureate nursing programs to use long-term care facilities as clinical sites for the training of students. The Department of Veterans Affairs offers scholarships to nurses to complete their Master's and Doctoral education in geriatrics.

The Hearst Foundation has endowed scholarships to encourage full time students to pursue preparation in geriatrics in five programs in nursing. The John A. Hartford Foundation (JAHF) has invested over \$35 million dollars in geriatric nursing programs to assure the development of geriatric curriculum and the preparation of geriatric nursing faculty. These programs are:

1. The JAHF Institute for Geriatric Nursing at NYU to promote the highest level of competency in practicing nurses.
2. The JAHF Program Building Academic Geriatric Nursing Capacity: a program administered by the American Academy of Nursing that funds five Academic Centers of Excellence to develop academic leaders, provide scholarships and develop best practices in geriatric nursing.
3. The JAHF Geriatric Nursing Education Project: a program administered by the American Association of Colleges of Nursing that has awarded 20 baccalaureate and 10 advanced practice nursing programs grants to increase gerontological nursing content in nursing programs.
4. The JAHF Nursing School Geriatric Investment Program: a program administered by the American Academy of Nursing that awards 7 schools of nursing funding to expand the capacity for leadership in the field of geriatric nursing.
5. The JAHF Creating Careers in Geriatric Advance Practice Nursing: a program administered by the American Association of Colleges of Nursing to support scholarships for students enrolled in advanced practice nursing programs in geriatrics in order to develop careers and enhance practice and leadership capacity in geriatric nursing.
6. The JAHF Geriatric Interdisciplinary Team Training (GITT) Program: a program administered by the New York University Division of Nursing to develop and disseminate models of academic geriatric interdisciplinary team training.

As a result of these activities, nursing programs are moving to substantially increase geriatric content into baccalaureate nursing programs, to attract more nurses to graduate specialization in geriatrics, and to increase the geriatric preparation of adult and family nurse practitioners and clinical specialists. The approximately 13,200 nurses ANCC certified as adult nurse practitioners and 22,400 certified as family nurse practitioners, represent an untapped pool of health care workers whose practice encompasses many older adults but whose educational preparation currently contains minimal geriatric content.

Nurses working in specialty practices care for large numbers of older adults. For example, patients 65 and over represent 56% of all ICU days, and 77% of all cancers are diagnosed in people age 55 and over. In what constitutes the first major initiative to address the needs of practicing nurses to provide “best practice” in the care of their older patients, in 2002, The Atlantic Philanthropies, Inc. awarded the American Nurses Association –through the American Nurses Foundation, and in a strategic alliance with The JAHF Institute for Geriatric Nursing at NYU– a \$5 million, 5 year grant to work with over 50 nurse specialty associations. Activities of this grant, titled “Nurse Competence in Aging” include:

- Promoting geriatric activities within national specialty nursing associations
- Promoting national gerontological nursing certification and
- Developing a web-based comprehensive Geriatric Nursing Resource Center

A major aspect of Nurse Competence in Aging focuses on encouraging nurses to become Certified Gerontological Nurses, a credential of ANCC that is open to RNs irrespective of educational preparation. Currently, approximately 17,000 nurses hold this certification.

While these activities have the potential to make major inroads into improvements in care for older adults, they do not directly engage ambulatory care facilities, hospitals, home care and nursing homes in recognizing their critical responsibility in assuring high quality care to older patients. We propose several approaches that would strengthen nurses’ hand in promoting quality care for older adults. These include:

1. The Joint Commission of Accreditation of Healthcare Organizations (JCAHO) implement more stringent standards for geriatric competence of staff.

2. State mandated theoretical content and clinical experiences in geriatrics in nursing education requirements, as currently exists in six states (Arkansas, California, Delaware, Florida, Indiana, South Dakota).
3. State specified continuing education credits in geriatrics as a condition of re-licensure for nurses (CEU now required in 21 states for re-licensure as an RN).
4. Evidence of staff training in geriatrics as part of Medicare and Medicaid requirement for participation for home care agencies and nursing facilities.
5. Congressional support for increased allocation of funds for geriatric workforce initiatives in policy proposals such as is evident in the Nurse Reinvestment Act, but could also be adopted in the Nurse Employment and Education Act, and the National Nurse Corps.
6. Health Resource and Service Administration (HRSA) support for training programs and scholarships in nursing should be directed to promote training in geriatrics. Similarly HRSA should direct additional funds to support Geriatric Education Centers (GECs).
7. Government payers, such as Medicare, should provide financial incentives such as higher reimbursement rates for facilities that employ geriatric specialists.
8. Private payers, such as managed care organizations, should offer higher reimbursement or other financial incentives to those facilities that have staff with geriatric training.
9. CMS should create incentives to encourage nursing facilities to use geriatric nurse practitioners.

As with many areas of health care, there is a continued need for research about the geriatric nursing work force and the organizations in which they work. This research should include:

1. Factors associated with nurses’ selection of specialty and work setting.
2. The association between nurse preparation in geriatrics and patient outcomes.
3. Research comparing outcomes between patients cared for by geriatric nurse specialists and those cared for by generalists.
4. Health services research to assess the effectiveness of different models of nurse

training, staffing, organization of care, and their relationship to patient safety and outcomes.

We look forward to the time when Departments of Geriatric Nursing will be as common in nursing programs as Departments of Maternal and Child Health, when nursing students express the same enthusiasm for studying geriatrics as they do for other specialties, and when older adults in this country get nursing care from nurses educated and experienced in geriatric nursing.

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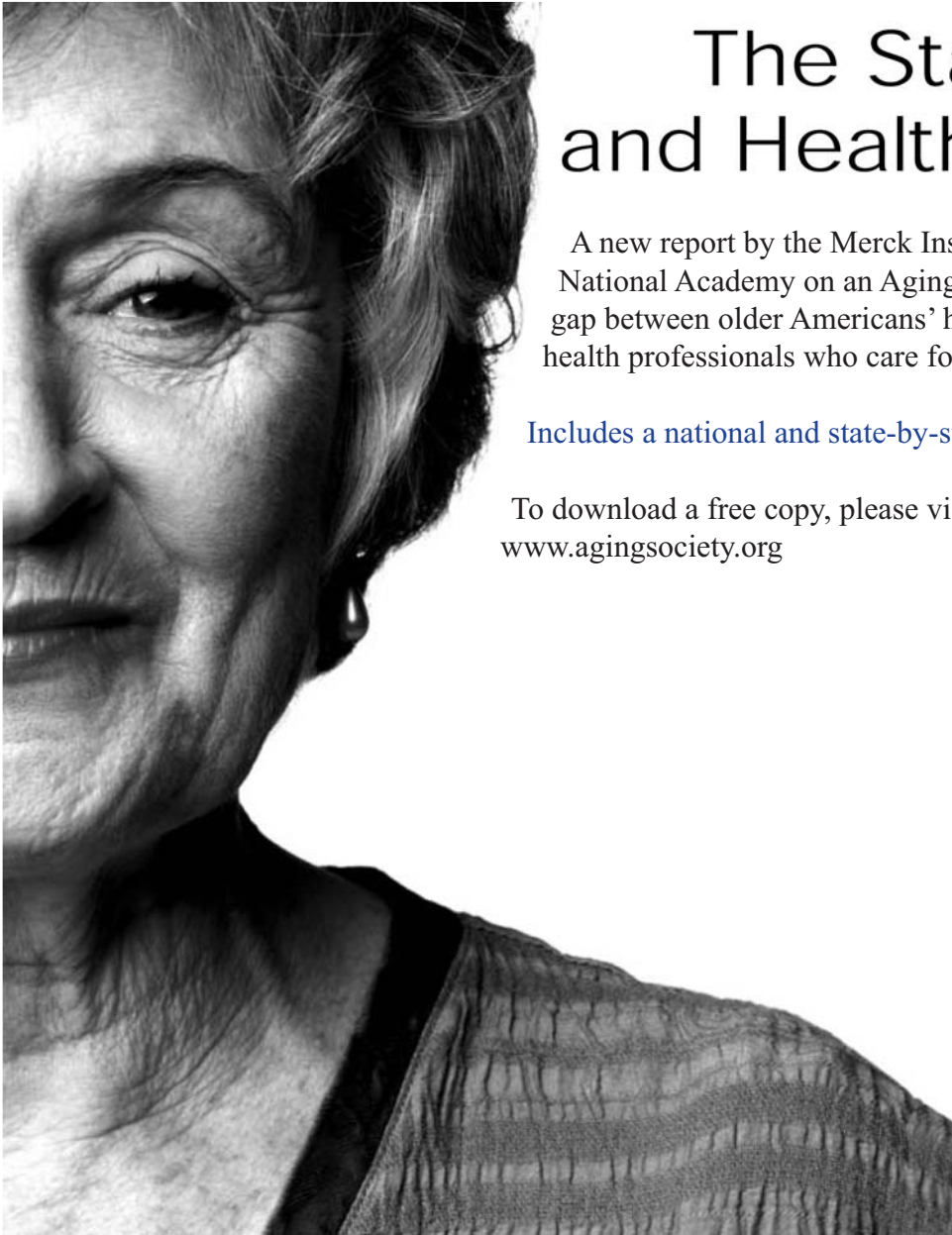
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