

Committee on the Future Health Care Workforce for Older Americans  
Institute of Medicine  
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Remarks by Corinne H. Rieder, Executive Director and Treasurer  
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Good morning, I'm Cory Rieder, executive director and treasurer of the John A. Hartford Foundation. I am delighted to be here, and, as a funder, I congratulate the IOM in selecting a truly outstanding committee. We rely on you to develop a blueprint for what our country must do to attract, educate, retain and deploy a health care workforce that can successfully serve our rapidly aging America.

Hartford and other funders have a lot riding on your report. Every one of us here has written and spoken about our inadequate health care system. It doesn't serve the uninsured, rural populations, the urban poor, the middle class, and most important for this committee, it doesn't serve older adults.

I am going to discuss two topics; first, I will spend a few moments describing the Hartford Foundation—specifically, its commitment and contributions to improving the health care of older people—and then turn to some observations about health care and aging and their implications for this committee.

Hartford is a 78 year old, \$700 million foundation whose sole focus is improving the health care of older people. This has been our goal for over 25 years and it remains our goal. This narrow and consistent focus in a single area is unique for a foundation our size. Our peers typically have multiple foci and shorter term commitments to a funding area. Regrettably, there are also very few foundations which focus on improving the health care of older adults. Our two largest partners—The Atlantic Philanthropies and the Donald W. Reynolds Foundation—are spending down and will close their doors in a decade. With less than 2% of all foundation dollars spent on older adults, there are countless funding opportunities. Therefore, a role we take very seriously at Hartford is bringing others—foundations and wealthy individuals—to the table. One way we do this is through partnering.

As a foundation, we are also unique in other ways— we are national in scope, but work in the trenches. The foundation's observations of the problems facing older adults and the health professions and the care delivery systems that serve them are shaped by more than 100 annual site visits our 4 program officers and I make to schools of medicine, social work and nursing. We speak with students, residents, fellows and faculty members in their classrooms and labs. We also visit sites of care—homes, hospitals, nursing homes, hospices, PACE sites and

ambulatory care clinics—and serve on the boards of aging organizations. Our observations on geriatric training and care are also shaped by our annual participation in more than two dozen professional meetings, and by the hundreds of health professionals that visit the Foundation each year to seek funding or provide advice. To improve the health care of our population, the Foundation has committed \$400 million to some 200 organizations over the past 25 years. We support 3 strategies.

The first is the education and training of tens of thousands of health professionals. Among these are geriatric specialists—practitioners and academically based physicians, nurses and social workers. Because there are, and will continue to be, insufficient numbers of geriatric specialists, a major Foundation strategy is to infuse geriatrics into the undergraduate and resident medical curricula and in the curricula of students enrolled in associate degree, baccalaureate, and master’s degree programs in nursing and social work. To expand the number of health professionals skilled in caring for older adults, Hartford also funds efforts to ensure that geriatrics is a significant component in training programs for medical specialists, sub-specialists, as well as primary care physicians. We support similar programs in nursing and social work.

The second strategy is to find ways to deliver better care to older people. This is achieved through the development, testing and wide dissemination of models that address the fragmentation so prevalent in our current delivery system. Hartford’s initiatives promote: 1) interdisciplinary teams; 2) chronic care management; 3) better care transitions; 4) the creative use of technology; 5) innovative home care models; and 6) medication management.

Our final strategy is to advance knowledge and draw excellent scholars into aging research. The Foundation, in partnership with the NIH and other foundations, supports basic, clinical and health services research programs for young investigators within and across the fields of medicine, nursing, social work and other health professions. One of these is the Beeson Career Development Award, one of the most prestigious awards for young researchers in aging.

What has Hartford learned during the past 25 years that might be relevant to your deliberations? I offer 4 recommendations.

1. Be Patient Centered and Place Special Emphasis on the Frail Older Adult with Multiple Chronic Diseases

I hope that you will creatively challenge current theory and practice by starting with older adults as the center of your analysis. What constitutes quality care for older people? When and where do the health care system and professionals fall short of providing that care? You may end up with obvious but important recommendations, e.g. the need to improve workforce quality by addressing and agreeing upon the skills, attitudes and knowledge that are needed by different

providers who care for older adults. But suggest also how these improvements can best be achieved, e.g., by strongly recommending that all professional and governmental organizations that test health care providers prepare tests that include appropriate geriatric questions. I was recently shocked to learn that a prominent American medical school's curriculum committee had reduced geriatrics, didactics and experiences, to only 3 hours across all 4 years of medical school. This Committee can look to exemplars of curriculum reform, such as the partnership between NYU's Hartford Nursing Institute and the American Association of Colleges of Nursing. These organizations have developed a set of core geriatric competencies and teaching resources that are currently being disseminated to nursing faculty across the nation. What are the incentives that would induce deans and school-wide curriculum committees to increase geriatric content and experiences?

In your deliberations, you should also consider the need for more creative or radical changes, e.g. the education and training of "non-traditional" health professionals to fill roles that are now inadequately filled, e.g., geriatric specialists trained in both nursing and social work could become better case managers; geriatrically trained public health administrators and MBAs could train to be effective managers of for-profit and non-profit health care delivery organizations for older adults; and more nurse practitioners and doctorates in nursing practice could assume some primary care responsibilities for older patients. You could also change the practices of "traditional" professionals, e.g., social work therapists could be trained to work with the growing number of dementia patients and their families. Another innovation would be to have some health care education experiences occur in mixed groups of health professionals so that participating trainees would better understand the skills and functions of other team members.

Again, for both obvious and more radical changes we look to you not only to launch the ideas, but to identify the starting points to implement them, including the agencies and organizations that need to be involved.

Let me turn a moment to our frailest population and begin with a personal story. My almost 90 year-old home-bound parents have between them 17 chronic conditions: blindness (a result of macular degeneration), cancer, high blood pressure, strokes, normal pressure hydrocephalus, deafness, high cholesterol, diabetes, Alzheimer's disease, bleeding ulcers, osteoporosis, arthritis, heart disease, hypothyroidism, depression, mobility problems and serious drug reactions from their multiple medications. My parents are not atypical of adults over 85, the fastest growing segment of our population.

One obvious solution to the chronic conditions facing the medically frail is affordable, integrated care management and systems which link the professionals and paraprofessionals who provide health and supportive services. Yet care management services are neither widely available nor affordable for

many families, because the administration and coordination of health care is not a reimbursable expense.

Many of America's most complex, frail elders are cared for by untrained, unsupervised and unregulated caregivers through Gray-markets. This is a recipe for disaster. Frail older adults risk everything from medication errors, failures to recognize important changes in health, and the more insidious problem of elder abuse and neglect. But it is also important to realize that Gray-market caregivers are equally at risk, as they live a working-poor existence without benefits, preparation or support.

One outstanding model in New York City and elsewhere that helps older people of varying economic means is the Visiting Nurse Service, which serves 30 thousand patients a day in New York City alone. This is a model that needs to be further supported across the nation.

There are other creative ideas, however, that should be more widely disseminated. Among them is PACE, the Program for the All Inclusive Care of the Elderly, a cost-effective capitated program that allows older adults to remain at home and travel to a center for care and socialization during the day. We should also expand our activities in the area of health literacy and prevention by better linking organizations like senior centers with health care and supportive services. Finally, we need to support interdisciplinary teams inside our health care institutions, such as ACE units, but also link team members with health professionals and paraprofessionals working in homes and nursing homes.

Finally, the provision of care at the end of life, including hospice and palliative care, is also critically important. One outstanding program of high quality and passionate end of life care has been developed by Diane Meier. Programs like these need to be further replicated—not only in hospitals but in other settings such as nursing homes.

## 2. Think Strategy: Tackle the Biggest Problems and Take Advantage of the Greatest Opportunities

In your work we hope you will focus your attention on where the work force is most dysfunctional, e.g., attracting sufficient numbers of health professionals to geriatrics. There are the obvious and serious problems to consider, e.g. a failed reimbursement system, dominated by proceduralists, which drives many of our best young physicians away from primary care and other non-procedural specialties. These inequities are replicated at academic health centers—the beginning salary for an academic geriatrician at some of our best medical schools is \$85,000 per year. If you and your physician spouse together have student loans totaling \$300,000—the average indebtedness—it is likely that you will consider a more lucrative specialty or subspecialty than geriatrics. With MedPAC and the Congress divided on how to overhaul physician

reimbursement, the committee should explore temporary and/or relatively inexpensive solutions to attract more physicians into geriatrics. For example, institute a loan-forgiveness program for practicing and academic geriatricians, such as South Carolina has done. Similar programs could be mounted for geriatric nurses and social workers. Providing stipends to students going into geriatric social work, nursing and medicine would also be an inexpensive way to attract more students into these fields, as we have seen when the federal government wanted to increase the number of social workers working with children.

Are sub-system or system wide changes possible? Is it possible to tie reimbursement to patient care, so that patient choices, safety, and quality are financially supported? Is it possible to create a system driven by quality, efficiency and safety and would it pay for itself?

I think it is possible to address some of the existing sub-system breakdowns that are especially bad for older adults. One that comes immediately to mind is our failure to make successful transitions or handoffs from one health professional to another, from health professionals to patients and their families, and from one health care site to another. What are the best transfer models and how can they be funded? Can we creatively put technology and case management together for purposes of patient communication and monitoring? Three tried and tested Hartford-funded models already exist and incentives should be available to replicate them widely. These include Eric Coleman's Care Transitions Measure, Mary Naylor's model of transitional care and David Dorr and Cherie Brunker's Care Management Plus Health Information Technology program.

### 3. Address Function and Site

Another recommendation that comes from Hartford's experience is to consider function and site in your deliberations. As a nation we have serious health work force shortages. Recent reports suggest that the United States could face a shortage of up to 800,000 nurses, 200,000 doctors, and tens of thousands of geriatric social workers. Clearly we need to address these shortages. An obvious solution is to provide incentives for higher education institutions to increase the number of students they train. It is widely known that there are more qualified students who want to enter these fields than can currently be enrolled. For example, there are 130,000 qualified young men and women each year that cannot enroll in nursing programs because there are too few places, and too few faculty members. A more radical solution is to identify health care functions that can be performed by other professionals and paraprofessionals, perhaps even less expensively, e.g. can social workers assume some of the non-direct-care related functions now performed by nurses?

There is also the need to rally the entire nursing community around preparing all future RNs with the knowledge and skills needed to care for older adults.

Currently, 63% of the RNs caring for older adults are trained at the community college level. These nurses prepare for and must pass the same exam to become RNs as do baccalaureate-prepared nurses. We ignore or otherwise call for their elimination at our own peril. Facing a huge nursing shortage that cannot be met in the future by either foreign- or baccalaureate-trained-only nurses, will require more, not less, collaboration and educational partnerships between community college and baccalaureate nursing programs and leaders.

With regard to sites of care, look closely at them. Addressing the acute care needs of older adults does not always have to take place in a hospital. Indeed, for older adults hospitals can be dangerous places. A Hartford-funded program that was developed and tested by Johns Hopkins and the VA in Portland, Oregon and in other sites, brings the traditional hospital to the home by offering sophisticated medical oversight—including nurses and doctor’s visits, X-rays and other tests—to patients in their homes. Results showed solid savings and participating patients preferred it to being in the hospital. Health professionals should be trained to work in teams and non-traditional settings and expect to do so.

#### 4. Promote Leadership and Knowledge Growth

Building strong leadership within and across the health professions that serve older people is critical. Why should this be a priority? There are many reasons, but I’ll mention three.

First, we need leadership to raise the visibility of older people and their health care needs. As a population, older adults are nearly invisible except to their families. Their health care needs don’t elicit the same concern as do the health care needs of children and they are often portrayed in the media as “geezers” or worse still, “greedy geezers.” Ageism in all its forms remains alive and well in our society. While the AARP is a very significant force on issues such as Medicare and Social Security, we need the health professionals that care for older people to: 1) advocate for better geriatric training and practice in schools of medicine, nursing, and social work among their peers; 2) serve on and influence curriculum committees; and 3) develop productive relationships with deans, development offices and local community, state and national leaders.

Second, we need research leaders to expand our knowledge base, in both basic and clinical research. In short, geriatrics needs to strengthen its foundation. More financial and human resources need to go toward understanding the biology of aging, the diseases that disproportionately impact older adults, and how the two interact.

Third, leadership is needed to bridge the gap between what we know and how we practice. The NIH has put great emphasis on translational research—in their terms the application of basic research findings to understanding and treating

human disease—from bench to bedside. This has shown itself to be a powerful strategy and with the new advances in genetics and molecular biology, it will almost certainly provide great benefits to patients with such diseases as Alzheimer's, Parkinson's and cancer.

But the concept of translational research needs to include not only basic and clinical research, but the translation of health services research into common practice, specifically the dissemination of sound models that deliver better care. Many of these models have developed business plans that show potential adopters how they can be implemented. Yet at Hartford, when our projects have outstanding results and good business plans, it has not been easy to find health care institutions that seek out innovations developed elsewhere and are ready to adapt them in their own institutions. Yes, we need more good models, as prior IOM reports have urged, but we also have a number of cost-effective models with impressive health outcomes and there is not a market for them. With scarce resources, we can ill afford to reinvent the wheel.

What does this have to do with leadership? I would argue that there are few powerful motivators—carrots or sticks—to push our entrenched systems and personnel to deliver health to older people in substantially different ways. While there have been important changes in acute care, e.g., in surgery and shorter in-patient hospitalization, the care of the chronically ill geriatric patient has not significantly changed. Only determined, visionary leaders, in health care and in government, will bring about fundamental changes in delivering care to older patients.

Because of the high regard in which the IOM is held, the philanthropic and health care communities will take your recommendations very seriously. Hartford relies on you to set our agenda and challenges you to make that agenda actionable, widely disseminated and focused on the health care of older adults.