2009 HOUSE HUMAN SERVICES

HB 1374

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1374

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: January 28, 2009

Recorder Job Number: 8005

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz called hearing to order on HB 1374.

Rep. Kerzman sponsored and introduced the bill: See Testimony #1.

Rep. Holman: (Inaudible)(something about alluding to limitations and something about family practice) comments on that?

Rep. Kerzman: I thing that is where it should be at (inaudible).

Rep. Potter: With geriatric medicine thought this was a specialty already defined position.

Rep. Kerzman: May well be in certain areas of state, but not in all areas. Lot of differences in how you treat the elderly person. Bones more fragile.

Chairman Weisz: Intent of bill is to let general practitioner to have geriatric experience through education and you are looking to expand the specialty of anything else.

Rep. Kerzman: Correct.

OPPOSITION:

Duane Houdek, Executive Secretary of the Board of Medical Examiners: See Testimony #2.

Bruce Levi, representing the ND Medical Association: See Testimony #3

Rep. Conrad: (Inaudible). Has this concern been assessed in your association, (inaudible0 and the community (inaudible).

Bruce Levi: I think there has been considerable discussion within the 20/20 group that's been working on some of the future workforce needs. In process of developing our own report on physician workforce news that addresses of not only geriatrics, but a number of other specialties as well as challenges in rural areas.

Rep. Conrad: They have accomplished something then.

Chairman Weisz closed the hearing.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1374

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: February 2, 2009

Recorder Job Number: 8409 5 min. 6 sec.

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz: Any discussions or motion on bill?

Representative Hofstad motioned for a DO NOT PASS.

Representative Uglem seconded.

Representative Hofstad: It truly is a mandate for physicians and I think it is over reaching.

Roll Call Vote: 13 yes, 0, no, 0 absent

Bill Carrier: Representative Nathe.

Date: 2-2-09

Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1374

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken ☐ Do Pass ☒ Do Not Pass ☐ Amended

Motion Made By Rep. Hofstad Seconded By Rep. Uglem

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ	√		REP. TOM CONKLIN	√	
VICE-CHAIR VONNIE PIETSCH	√		REP. KARI L CONRAD	√	
REP. CHUCK DAMSCHEN	√		REP. RICHARD HOLMAN	√	
REP. ROBERT FRANTSVOG	√		REP. ROBERT KILICHOWSKI	√	
REP. CURT HOFSTAD	√		REP. LOUISE POTTER	√	
REP. MICHAEL R. NATHE	√				
REP. TODD PORTER	√				
REP. GERRY UGLEM	√				

Total (Yes) 13 No 0

Absent 0

Bill Carrier Rep. Nathe

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1374: Human Services Committee (Rep. Weisz, Chairman) recommends **DO NOT PASS** (13 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1374 was placed on the Eleventh order on the calendar.

2009 TESTIMONY

HB 1374

HB 1374

Mr. Chairman,

Members of the House Human Service Committee:

This proposed legislation HB 1374 came through the "Silver Hair" assembly. We were asked to present it to the North Dakota Legislature for its consideration.

I felt with North Dakota's graying population that there was merit in assuring that our medical physicians were up to speed in the latest geriatric practices.

It has been pointed out to me that there are several areas of this proposed legislation that may need more defining.

First, I am not sure that the intent was to make all physicians required to have continuing geriatric medical education. There may very well be some specialized medical practices that would be exempt.

Along with that, should the legislation set some parameters on the amount of continuing education requirements or just leave that up to the board.

Thank you for your consideration.

Rep. James Kerzman

NORTH DAKOTA STATE BOARD OF MEDICAL EXAMINERS

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HOUSE BILL 1374

House Human Services Committee
January 28, 2009

Testimony in opposition to HB 1374
North Dakota State Board of Medical Examiners
Duane Houdek, Executive Secretary

Chairman Weisz, members of the committee, my name is Duane Houdek, executive secretary of the Board of Medical Examiners. The Board is the state entity responsible for licensing physicians and regulating the practice of medicine in North Dakota. That includes establishment and enforcement of rules governing continuing medical education.

On behalf of the Board, I am testifying in opposition to HB 1374.

Now matter how worthy the goal of increasing geriatric knowledge among physicians may seem–imposing an educational mandate on medical licensure is not the way to address the issue.

When the Board licenses a physician, we look very carefully at the medical education received, rejecting some medical schools as inadequate. We require postgraduate training or residencies in programs that are properly accredited. We have detailed standards regarding the passage of national medical examinations. We do comprehensive background checks, including fingerprinting and FBI checks, inquiries about possible substance abuse, malpractice issues. In short, we check and verify anything that could adversely affect the North Dakota public's health or safety.

That has been our mission since 1890 when this legislative body first created the Board and gave it the responsibility to regulate the practice of medicine: to protect the public by making sure physicians are safe and competent.

We do not license specialties. We do not try to manipulate the licensing process to favor one qualified, safe, competent physician over another. That is not, nor should it ever be, our role.

And so, a law that requires us to withhold a license from an otherwise safe, competent physician is not consistent with the mission you have given us, no matter how desirable the immediate goal may seem. It would, on the whole, not be positive for medicine in North Dakota for us to do so.

Yesterday, I sat through a hearing before this committee in which proponents of a bill argued that North Dakota has a shortage of psychiatrists. That patients, and especially children, have difficulty gaining access to needed psychiatric care in rural, and some urban, parts of our state..

Please consider this bill in that context. If Dickinson, or one of the other cities mentioned, was finally successful in recruiting a child psychiatrist, a graduate at the top of her class, a star--would you really want us to deny a license to that otherwise qualified, much needed physician because of the lack of a course in geriatrics? What constituency would we be serving then?

Take a less extreme example: If Stanley or Hillsboro had a primary care physician, a safe, competent, qualified physician, would you want us to refuse to renew his license because he failed to take an annual refresher course in geriatrics?

In addition to what I believe is the wrong approach, this bill is simply too broad in its application. Why would we require this geriatrics course of a pediatric physiatrist, who treats only children with cerebral palsy or muscular dystrophy? Or the child or adolescent psychiatrist? Or a pathologist?

Many of our hospitals utilize tele-radiologists, and to protect North Dakota citizens, we require anyone who reads a film for someone living in the state to have a North Dakota license, whether they are sitting in St. Paul or Australia when they do so. Are we to require them to have an annual refresher course in a subject that has no application to their job? Are we to tell our North Dakota hospitals they can't use this doctor who refuses?

As legislators, you know better than anyone, today it is a course in geriatrics–a worthwhile goal; tomorrow, a course in understanding mental health issues; the next day, a course about the warning signs of teen suicide. All worthwhile; none properly attached as a separate condition of licensure.

My last boss used to tell us–frequently, and with some vigor–"O.K., I understand the problem, you don't need to restate it. Now, let's hear some possible solutions." I know you are also in the business of solutions.

In that regard, please let me refer you to a study conducted by the American Geriatric Society in 2005, and funded by the Robert Wood Johnson Foundation, on the topic of increasing knowledge of geriatrics among primary care physicians. I have attached a relevant part of that study.

Those experts did not recommend licensing mandates such as the one you have before you today. Rather, they recommend providing incentives to medical schools to increase geriatric training. I know the UND medical school is looking at filling an endowed chair in geriatrics. Helping them with that and helping to extend its reach could greatly enhance physicians' knowledge of the subject.

Examining the payment mechanism within the payor system you partly control–medicaid–to ensure that rural, primary care gets adequately compensated to encourage more physicians to practice there, could have a significant impact, and is also consistent with these recommendations.

With respect to those who have suggested this bill, I submit that these sorts of measures could further their goals, without the adverse impact this bill would have on the medical licensure process and the overall practice of medicine in the state.

Thank you. I would be glad to try to answer questions of the committee.

knowledge base and therapeutic options expand. To this end, medicine and science must continue to develop improved approaches to the delivery of health care, as well as new technologies and pharmaceutical agents. A coherent, relevant geriatrics research agenda needs to be developed and continually refined, and the products of geriatrics research must be systematically evaluated for their clinical benefits and advantages over existing treatments. This agenda should include research focused on the needs of frail older persons and those with multiple illnesses. Research on prevention of frailty, disability, geriatric syndromes, models of care, and decision making about high-technology procedures and devices are examples of important topics for future research. Older persons, particularly those who have multiple morbidities and those from ethnic minorities, need to be included in clinical trials of new therapies. For those innovations that offer clear benefits, systematic efforts must be mounted to facilitate dissemination, adoption, and adaptation.

Obstacles

Currently, too few geriatricians are trained in research (e.g., in 2003 a total of only 62 fellows in the second year and beyond were in training).[28] Moreover, most formally trained geriatricians do not focus on research. For example, only 11% of geriatricians trained in fellowships from 1990 to 1998 report spending more than half of their time on research.[34]

In addition, the funding for research on aging through the NIA and AHRQ has been inadequate to substantially expand the knowledge base to meet the health needs of the growing older population. Many high-quality proposals for aging research cannot be awarded because of insufficient funding. The funding issue is exacerbated by the general stagnation of the NIH budget following a period of dramatic growth. For instance, the NIA received $1.025 billion for fiscal year 2004, compared with an estimated $1.056 billion budgeted for 2005. This 3% increase only approximates the general inflation rate and will not permit the expansion of health research needed for the impending surge in the older population. Budget projections for the NIA are even more concerning, with anticipated appropriations that increase at less than the rate of inflation and will result in reduced support for aging research. Hence, sustained federal salary support for geriatrics research is tentative, even for successful researchers. Furthermore, the NIA's research training support program (the K series) has gaps for research faculty support, especially at the earliest and most advanced levels of experience.

Strategies for Overcoming Obstacles

To advance the scientific basis for the care of older persons, the global medical research budgets for the NIH, including the NIA, and AHRQ need to be increased. It is critical to invest in research on aging now, in anticipation of the healthcare needs of the older population that will begin to burgeon within the next decade. Advocacy groups and professional organizations can facilitate increased funding of aging research through heightened public awareness, including among members of Congress, about the pressing need for new knowledge about the health and health care of the rapidly expanding older population.

In addition, all NIH institutes need to pay increasing attention to the health problems that affect older persons. Mechanisms need to be developed to provide support for geriatrics research faculty at all levels of experience. Foundations should be encouraged to continue to fund programs that support subspecialists and surgical and related medical specialists who conduct aging research.

The NIA, other branches of the NIH, the VA, AHRQ, private foundations, professional organizations, and industry should focus on setting an agenda and providing funding for geriatrics and aging research to improve the health of older persons. This agenda must include funding for research on new models of healthcare delivery for an aging population, including community participatory research. Most important, priorities should be set and areas of focus for each partner should be identified, to ensure that the entire agenda can be covered and duplication is minimized.

GOAL: TO INCREASE THE NUMBER OF HEALTHCARE PROFESSIONALS WHO EMPLOY THE PRINCIPLES OF GERIATRIC MEDICINE IN CARING FOR OLDER PERSONS

Requisites

In the future, as now, physicians and other healthcare professionals who are not geriatricians will provide the majority of health care for older people.[35] Although some professionals will seek continuing education in geriatrics, most will have had no formal training or will have received geriatrics training only within the context of core training in their medical or other health professional school, residency, or subspecialty training. This nongeriatrician workforce should have the requisite attitudes, knowledge, skills, and resources and sufficient reimbursement that they welcome older patients into their practices and enjoy caring for them. Hence, geriatrics competency must be imparted during core training to create a prepared workforce, and geriatrics should be an area of focus in continuing professional development for primary care providers.

Obstacles

Interest in primary care disciplines, especially general internal medicine and family medicine, has been steadily declining. In large part, this has been due to lifestyle issues and a payment system that discourages continuous physician-patient relationships and the commitment to non-face-to-face time between visits that is required to manage chronic illness successfully. As a result, the adequacy of the workforce of physicians to provide primary care for older persons is threatened.

In addition, the ability of academic geriatricians to train healthcare professionals is in jeopardy. A paucity of academic geriatricians remains, and most educators in geriatric medicine are dependent upon clinical income, as academic institutions have generally been unable to provide adequate support for teaching geriatrics. The costs of graduate medical education have been supported in large part by CMS, and these funds have been administered through hospitals. As a result, in some programs, little or none of the medical education funds directly support geriatrics education. Geriatrics academic programs may therefore be

caught in a bind of being asked to provide an ever-increasing amount of teaching but not being compensated for time spent teaching.

Strategies to Overcome Obstacles

Core training in medical school and postgraduate training must include substantial geriatrics training to ensure competency in caring for older persons. Beginning in medical school, trainees also should have ample experience with healthier older persons in community settings, which can improve attitudes toward geriatric patients.[36,37] During residency training, internists and family physicians should receive training in the comprehensive care of older persons with multiple and complex illnesses.

To meet these large teaching demands, geriatricians will need to partner with other teachers. Most often, geriatricians will lead other faculty, including general internists, family physicians, surgeons, and related specialists, to develop, implement, and teach the geriatrics curriculum to medical students and residents. At some institutions where local expertise and interest among nongeriatrician faculty is great enough, these physicians, rather than geriatricians, will lead geriatrics curriculums in their disciplines. In these instances, geriatricians will be invaluable as collaborators who have additional expertise to contribute. Funding for medical education should be included in the budget of the healthcare system and should remunerate the time spent teaching geriatrics.

At the level of the practicing physician, geriatric medicine should collaborate with general internal medicine and family medicine to ensure that primary care specialties remain viable and increasingly attractive as career choices. Within these specialties, physicians must be given incentives to provide high-quality geriatric care.

GOAL: TO RECRUIT PHYSICIANS AND OTHER HEALTH PROFESSIONALS INTO CAREERS IN GERIATRIC MEDICINE

Requisites

The ability of geriatric medicine to meet its mission is critically dependent upon having a sufficient workforce of geriatricians. As noted below in the section "Future Roles of Geriatricians," geriatricians will be needed as leaders in clinical, educational, research, and administrative roles to accomplish these goals. Accordingly, recruitment efforts must focus on expanding the numbers of geriatricians, not merely replacing those who have left the field.

Obstacles

Recruitment into the field remains a major challenge to the growth of geriatrics and to achieving the goals of geriatric medicine. Currently, many physicians-in-training are reluctant to go into geriatrics because of concerns that the lifestyle will be too onerous, the pay will be too low, the systems needed to support physicians to "do the right thing" will be lacking, and the funds available to support research and educational efforts will be inadequate.

Strategies for Overcoming Obstacles

Although meeting the projected needs for clinical geriatricians may not be a realistic goal, the high demand for geriatricians' services in academic and other healthcare settings justifies a substantial effort to increase the number of physicians entering geriatrics. If more young doctors are to be attracted to the discipline, trainees must envision a bright future as geriatricians. They must have role models who enjoy their work and feel satisfied with their lifestyle and remuneration. Whether they plan to focus on clinical care, research, education, or administration, trainees must feel confident that their skills and the services they can provide will be valued for the next 40 years. Geriatricians and their professional organizations must make concerted efforts to recruit professionals-in-training into geriatrics by promoting the positive aspects of this personally and professionally rewarding field.

Given the current low recruitment rates, measures to "jump-start" recruitment into the field are justified and are urgently needed. These measures should include loan repayment; ample support for advanced fellowships (beyond the 1 year required for certification) to train geriatricians to be leaders in research, administration, and education; and plentiful career development awards. Certifying bodies and the Accreditation Council for Graduate Medical Education should explore pathways that increase the attractiveness of geriatrics fellowship training.

GOAL: TO UNITE PROFESSIONAL AND LAY GROUPS TO INFLUENCE PUBLIC POLICY TO CONTINUALLY IMPROVE THE HEALTH AND HEALTH CARE OF SENIORS

Requisites

Major advances in the treatment of acquired immune deficiency syndrome, cancer, and heart disease have been achieved through increased recognition of their importance by the general public and through partnerships between professional and lay organizations. These partnerships have influenced policy, funding for research, and the provision of health care to those afflicted. Geriatric medicine needs the same prominence and influence to achieve its mission and goals.

Obstacles

Despite the "graying" of America, the culture is predominantly youth oriented. In fact, much of the cultural and economic emphasis is on antiaging products aimed at preserving the appearance of youth and offering the hope of immortality. The mass media have propagated images that lead to expectations of a nation of superhero older persons. This distorted vision is a distraction from the more common reality of aging with chronic diseases, often multiple, that are the focus of much of geriatric medicine.

In addition, the contribution of the geriatrician who orchestrates the health care of frail older persons has received less attention than the care of specific diseases that affect older persons. Although patients and families who have received geriatric care have been extremely grateful and have gained a clear understanding of the worth of this approach, it has been difficult to communicate the added

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Testimony in Opposition to HB 1374
House Human Services Committee
January 29, 2009

Good morning Chairman Weisz and Committee Members. I'm Bruce Levi representing the North Dakota Medical Association.

This past year, the Institute for Medicine (IOM) released a report, *Retooling for an Aging America: Building the Health Care Workforce* (April 2008) that says the nation faces an impending health care crisis as the number of older patients with more complex health needs increasingly outpaces the number of health care providers with the knowledge and skills to adequately care for them. As the nation's baby boomers turn 65 and older and are living longer lives, fundamental changes in the health care system need to take place, and greater financial resources need to be committed to ensure they can receive high-quality care. Right now, the nation is not prepared to meet the social and health care needs of elderly people.

The IOM report says that as the population of seniors grows to comprise approximately 20 percent of the U.S. population, they will face a health care workforce that is too small and critically unprepared to meet their health needs. The committee concluded that if our aging family members and friends are to continue to live robustly and in the best possible health, we need bold initiatives designed to:

-explore ways to broaden the duties and responsibilities of workers at various levels of training;

-better prepare informal caregivers to tend to the needs of aging family members and friends; and

-develop new models of health care delivery and payment as old ways sponsored by federal programs such as Medicare prove to be ineffective and inefficient.

The North Dakota Medical Association agrees with the ND Board of Medical Examiners in opposition to HB No. 1374. While the bill sponsors effort to improve care to our elderly people is laudable, a "one size fits all" approach to continuing medical education (CME) is not an effective solution.

The North Dakota Medical Association conducts a voluntary accreditation program for North Dakota institutions and organizations providing continuing medical education programs for physicians (Altru Health System, MeritCare, Trinity Health). In turn, NDMA is required to comply with the Accreditation Council for Continuing Medical Education, a national organization that serves as the body recognizing institutions and organizations offering continuing medical education accreditation. As part of those national requirements, providers of CME are required to incorporate into CME activities "the educational needs (knowledge, competence, or performance) that underlie the professional practice gaps of their own learners." In other words, any CME course must relate to the actual "practice gaps" of physicians who attend that course. This recognizes the real world in terms of the diversity of physician specialty, practice setting, and patient need.

The ND Board of Medical Examiners raises practical concerns. A mandatory geriatrics course for physicians would not accomplish the sought after results suggested by the IOM report. Practical solutions for North Dakota have been suggested. The UND School of Medicine & Health Sciences proposed, and the ND State Board of Higher Education endorsed, a budget request not included in the executive budget for two additional faculty positions in geriatrics to expand our training in the field of geriatrics. This initiative to develop a geriatrics program was spearheaded by the UNDSMHS after an extraordinarily generous bequest from the late Eva Gilbertson has provided over $5 million to the UNDSMHS to initiate a Geriatrics Training and Care Center that will be centered at MeritCare in Fargo. To develop this program, two additional full-time faculty members were requested to establish an enhanced geriatrics training and care delivery program. The Geriatrics Training and Care Center is an excellent example of what can be done to address the growing elderly population in our state and address the concerns raised in the IOM report. HB No. 1374 will not provide the kind of geriatric training necessary to meet our future needs. We urge the committee to become informed of and support the UNDSMHS proposal included as an optional budget request when the higher education appropriation bill (SB No. 2003) comes over to the House.

We urge a "Do Not Pass" on HB No. 1374.

INSTITUTE OF MEDICINE

REPORT BRIEF • APRIL 2008

RETOOLING FOR AN AGING AMERICA: BUILDING THE HEALTH CARE WORKFORCE

The number of older adults in the United States will almost double between 2005 and 2030, and the nation is not prepared to meet their social and health care needs. The baby boomer generation starts to turn 65 in 2011, which will create multiple challenges for the health care system. For one, the majority of older adults suffer from at least one chronic condition and rely on health care services far more than other segments of the population. Additionally, this generation of older adults will be the most diverse the nation has ever seen with more education, increased longevity, more widely dispersed families, and more racial and ethnic diversity, making their needs much different than previous generations. Another problem is the dramatic shortage of all types of health care workers, especially those in long-term care settings. Finally, the overall health care workforce is inadequately trained to care for older adults.

In 2007, the Institute of Medicine (IOM) charged the ad hoc Committee on the Future Health Care Workforce for Older Americans to determine the health care needs of Americans over 65 years of age and to assess those needs through an analysis of the forces that shape the health care workforce, including education and training, models of care, and public and private programs. The committee concludes that the definition of the health care workforce must be expanded to include everyone involved in a patient's care: health care professionals, direct-care workers, informal caregivers (usually family and friends), and patients themselves. All of these individuals must have the essential data, knowledge, and tools to provide high-quality health care. The committee proposes a concurrent three-prong approach:

- Enhance the geriatric competence of the entire workforce
- Increase the recruitment and retention of geriatric specialists and caregivers
- Improve the way care is delivered

The committee concludes that the definition of the health care workforce must be expanded to include everyone involved in a patient's care: health care professionals, direct-care workers, informal caregivers and patients themselves.

ENHANCING GERIATRIC COMPETENCE

In general, the health care workforce receives very little geriatric training and is not prepared to deliver the best possible care to older patients. Since virtually all health professionals care for older adults to some degree, geriatric competence needs to be improved through significant enhancements in edu-

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cational curricula and training programs. The committee recommends that health care professionals should be required to demonstrate their competence in the care of older adults as a criterion of licensure and certification.

Direct-care workers (nurse aides, home health aides, and personal care aides) are the primary providers of paid hands-on care to older adults, yet they are inadequately trained in geriatric care. The committee also recommends that training standards for these workers should be strengthened by increasing existing federal training requirements and establishing state-based standards.

Finally, both patients and informal caregivers need to be better integrated into the health care team. By learning self-management skills, patients can improve their health and reduce their need for formal care. In addition, informal caregivers play a large role in the delivery of increasingly complex health care services to older adults. The committee recommends that public, private, and community organizations provide funding and ensure that training opportunities are available for informal caregivers.

Geriatric specialists are needed in all professions not only for their clinical expertise, but also because they will be responsible to train the entire workforce in geriatric principles.

INCREASING RECRUITMENT AND RETENTION

Geriatric specialists are needed in all professions not only for their clinical expertise, but also because they will be responsible to train the entire workforce in geriatric principles. However only a small percentage of professional health care providers specialize in geriatrics, in part due to the high cost associated with the extra years of training as well as the relatively low pay. The committee recommends that financial incentives be provided to increase the number of geriatric specialists in every health profession. These incentives should include an increase in payments for their clinical services, the development of awards to increase the number of faculty in geriatrics, and the establishment of programs that would provide loan forgiveness, scholarships, and direct financial incentives for professionals who become geriatric specialists.

Direct-care workers typically have high levels of turnover and job dissatisfaction due to low pay, poor working conditions, high rates of on-the-job injury, and few opportunities for advancement. To help improve the quality of these jobs, more needs to be done to improve job desirability, including improved supervisory relationships and greater opportunities for career growth. To overcome huge financial disincentives, the committee recommends that state Medicaid programs increase pay for direct careworkers and provide access to fringe benefits.

IMPROVING MODELS OF CARE

The health care system today often fails to provide high-quality care to older adults, and services are often delivered by many different providers without coordination. The committee envisions the following key principles for the care of older adults in the future:

- The health needs of the older population need to be addressed comprehensively.
- Services need to be provided efficiently.
- Older persons need to be encouraged to be active partners in their own care.

Many innovative models of care show promise to improve the quality of care delivered to older adults or to reduce costs. However the diffusion of these models has been minimal, often due to the fact that current financing systems do not provide payment for features such as patient education, care coordination, and interdisciplinary

care. The committee recommends that more be done to improve the dissemination of models of care that have been shown to be effective and efficient for older adults. Since no single model of care will be sufficient to meet the needs of all older adults, the committee also recommends that Congress and public and private foundations significantly increase support for research and programs that promote the development of new models of care in areas where few models are currently being tested, such as preventive and palliative care.

More research is also needed regarding the effective use of the workforce to care for older persons—that is, how to increase both the size and the capabilities of the existing workforce and how those strategies might affect patient outcomes. In part, this will require an expansion of the roles of many members of the health care workforce, including technicians, direct-care workers, informal caregivers, and the patients themselves. As individual roles are broadened, the following elements need to be considered:

- Development of an evidence base regarding new provider designations
- Measurement of additional competence to attain these designations
- Greater professional recognition and salary, commensurate with these responsibilities

Finally, the committee recommends that federal agencies provide support for the development of technological advancements that could enhance individuals' capacity to provide care for older patients. This includes the use of assistive technologies that may reduce the need for formal care and improve the safety of care and caregiving. Health information technologies and remote monitoring technologies improve communication among all caregivers and enable health professionals to be more efficient.

The nation needs to move quickly and efficiently to make certain that the health care workforce increases in size and has the proper education and training to handle the needs of a new generation of older Americans.

CONCLUSION

This report serves as a call for fundamental reform in the way the workforce is trained and used to care for older adults. In order to deliver high-quality care to older adults, the development of a health care workforce that is sufficient in both size and skill is essential. While the impending demands on the health care system have been recognized for decades, little has been done to prepare for the years ahead. The nation needs to move quickly and efficiently to make certain that the health care workforce increases in size and has the proper education and training to handle the needs of a new generation of older Americans.

FOR MORE INFORMATION . . .

Copies of *Retooling for an Aging America: Building the Health Care Workforce* are available from the National Academies Press, 500 Fifth Street, N.W., Lockbox 285, Washington, DC 20055; (800) 624-6242 or (202) 334-3313 (in the Washington metropolitan area); Internet, www.nap.edu. The full text of this report is available at www.nap.edu.

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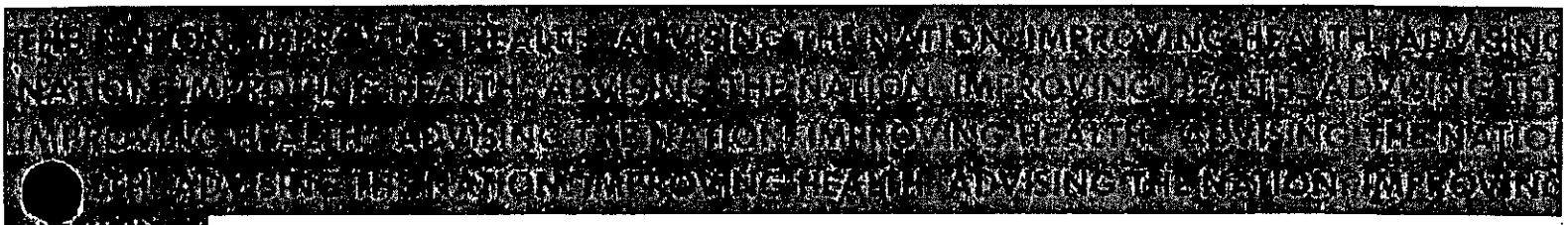

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COMMITTEE ON THE FUTURE HEALTH CARE WORKFORCE FOR OLDER AMERICANS

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