

**LIVING LONGER, GROWING STRONGER:
THE VITAL ROLE OF GERIATRIC MEDICINE**
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Mr. Chairman and members of the Committee, my name is Susan Klein and I represent the Bureau of Health Professions at the Health Resources and Services Administration, an agency within the Department of Health and Human Services.

We, too, heard the roar of 76 million baby boomers charging toward the next century and advanced age. We began what the editor of the American Society on Aging's newsletter called the "Human Genome Project to lay the coming labor shortages in healthcare before the country, proffer recommendations on what needs to be done and take action to remedy the shortfalls." We call it the Geriatric Education Futures Project (GEFP). What I would like to discuss with you today are the GEFP, two significant challenges in geriatric education successfully being met and one sleeping giant that we must awake.

The Geriatric Education Futures Project

The impetus for the Futures Project came from precipitously changing demographics in the country. Seven national studies within a five year period highlighted 3 major problems:

- (1) few clinicians with even minimal geriatrics training,
- (2) a severe shortage in the numbers of health care faculty capable of teaching geriatrics, and most importantly,
- (3) the absence of an Agenda for Action to respond to the geriatric education requirements necessary in a radically changed health care environment.

So, the goal of the Geriatric Education Futures Project was to promote and improve geriatric education in the health professions and thereby respond to a national health care need.

Under the creative leadership of Ms. Bernice A. Parlak, Chief of the Geriatric Initiatives Branch, the Geriatric Education Futures Project began. The GEFP is not a series of reports that gathers dust. Nor is it merely a project that "The Government" does. Rather, it is a 3-phased, ongoing, living event whose implementation involves all stakeholders in geriatric education.

- The first phase of the Futures Project was development of the *A National Agenda for Geriatric Education: White Papers*. Sixty recognized leaders in geriatrics and related fields submitted eleven papers representing diverse and sometimes opposing positions. Their task was to come to consensus on where the field was in geriatric education, where it needed to be and what realistic actions could be taken to get there. Five cross-cutting topics germane to all health professionals and six discipline specific issues were the focus of the Papers:
 - managed care,
 - long term care,
 - case management,

- interdisciplinary education, and
- ethnogeriatrics [the nexus of health, aging and ethnicity],

The White Papers are "action-oriented." Each one (1) presented a critical review of the state of the art of geriatric education in its topic area, (2) projected a future responsive to societal need [a vision to meet the projected need]; and (3) provided specific policy recommendations to achieve the preferred future. Each recommendation listed required actions, responsible agents (Such as associations, agencies, and organizations) and *measurable*, expected outcomes.

Phase two, the invitational National Forum on Geriatric Education and Training, was held in the Spring of 1995. Over 100 experts in geriatric education, funding agents, providers, consumers, health professions educators and policy makers came together to explore the parameters that define the needs in geriatric education. They assessed the outcomes of programmatic approaches to date, examined funding strategies and identified the factors that limit or enhance the education and training of health care professionals in geriatrics and gerontology. The results were gratifying:

- Over 3,000 copies of the *National Agenda for Geriatric Education: White Papers* have been distributed in the U.S. and other countries. Several associations, including the American Public Health Association and the Association for Gerontology in Higher Education have officially adopted its recommendations as their organization's educational goals in geriatrics.
- The 1997 publication supported by AARP Andrus Foundation and other foundations, *Aging Education and Training: Priorities for Grantmaking Foundations*, extensively quotes the *National Agenda* and its findings to grantmaking foundations to increase their commitment to aging education and training.
- All HRSA funded Geriatric Education Centers [or GECs, presently 30 of the 4] GECs in existence] have acknowledged that the *White Papers* are the standard of geriatric education for health care professionals.
- Perhaps, most important, the White Papers expressed a consensus among various geriatric organizations. You will note today that Dr. Murphy's testimony here represents a unified body of opinions among the experts. I am proud to say that our efforts have contributed to this unity of opinion.

Phase three of the Geriatric Education Futures Initiative developed national innovative educational collaboratives and continues catalytic activities directed toward the implementation of a national agenda for action in geriatric education.

- One collaborative, in process, is a second generation initiative. It follows the HRSA, PEW and Institute of Health Care Improvement (IHI) project to develop a model Interdisciplinary Professional Education Collaborative.

This second generation collaborative is among three Divisions within the BHPr responsible from five different sections of the Public Health Service Act, and IHI. It's purpose is to find effective educational methods to prepare new health care professionals with quality improvement knowledge, skills, and competencies for integrated professional work aimed at meeting and improving individual and community health needs and making services more cost effective. A good example is the Oregon GEC which is improving the health and health care services to the population age 65+ by increasing the number of immunizations for influenza and pneumonia. According to local statistics, there is a 19% rate

of immunization rate for influenza. Death rate for community pneumonia is high; one estimate is 14%. Students are involved in the design and conduct of the intervention, so that they can learn Quality Improvement techniques and learn about preventive care of the elderly. This project is expected to significantly impact public health. This and one other GEC, are participants in the Community-based Quality Improvement Education Program for the Health Professions sponsored by the Bureau of Health Professions (BHPPr) and the Institute for Healthcare Improvement.

Other examples of collaboratives include:

Iowa GEC Consortium. A state wide consortium to enhance interdisciplinary geriatric education and explore collaborative opportunities such as conferences, curriculum development, and grant initiatives was developed utilizing the White Papers. This consortium successfully submitted an application for GEC funding.

Best Practices Sourcebook

An interdisciplinary collaborative effort:

- University of Maryland School of Social Work
- Association for Gerontology Education in Social Work
- National Association of Social Work
- Council on Social Work Education
- California GEC
- National Coalition on Mental Health and Aging
- West Los Angeles Veterans Affairs Medical Center, Geriatric Research, Education and Clinical Center
- Western Maryland Area Health Education Center
- Bureau of Health Professions, HRSA

The collaborative will compile, review, synthesize, write and disseminate a Sourcebook of best practices of models and strategies for gerontological interdisciplinary teams with guidelines for incorporation into professional education programs. The Sourcebook's contents will include best practice models, strategies, outcomes of four focus groups, literature and Internet searches, and letters to key personnel conducting federally funded geriatric team training programs.

Interdisciplinary Training Programs for Professionals Caring for People with Disabilities

Partners include:

- Office of Disability, Aging, and Long-Term Care Policy, Assistant Secretary for Planning and Evaluation, Department of Health and Human Services
- George Washington University Health Policy Center

This is an exploratory study to review the literature on interdisciplinary training and a description of several training programs which are focusing on the elderly and is in response to the Interdisciplinary Education White Paper.

Planning Grant on Interdisciplinary Geriatric Team Training

Partners include:

- University of Colorado Schools of Dentistry, Medicine, Nursing
- UCHSC Center on Aging
- Aura Regional Medical Clinic
- University of Denver School of Social Work
- Total Long Term Care
- Senior Life
- Colorado Access

This planning grant is the implementation of the Interdisciplinary White Paper recommendations. The grant was one of only three Hartford Foundation grants awarded. Numerous GECs have used the White Papers as the basis for GITT applications.

Development of Joint DDS/MSG Program

Partners include:

- School of Dentistry, University of Southern California
- School of Gerontology, University of Southern California

These two schools have joined together in developing a degree program which will result in the awarding of joint doctorate of dentistry and masters in gerontology degrees. This is believed to be the first joint DDS/MSG degree program in the U.S.

National Agenda on Geriatric Education: Interdisciplinary Education,

- Half-day Institute. 23rd Annual Meeting, Association for Gerontology in Higher Education, Boston, MA - February 20, 1997.
- Monograph: *A National Agenda for Geriatric Education: Interdisciplinary Education White Paper - The AGHE Institute Response and Strategies*

A GEFP collaborative sponsored by the AGHE Education Committee, the Bureau of Health Professions, HRSA and the Oklahoma GEC. One of the largest attendance pre-workshop institutes held by AGHE.

Why are these collaborative efforts so important? Because they represent joint efforts among disciplines which have never worked together in the past. These participants have risen above the petty turf battles which so often stymie collaborative approaches among the various health professions. HRSA has been able to use relatively low levels of funding in an incredibly cost-effective manner because of this unity. We have been able to bring these groups together to form partnerships which will grow and bear fruit in the future with minimal levels of funding.

Challenges

We are addressing two challenges:

Cross-cultural competency in geriatric care must be incorporated into all levels of healthcare. education. The aging population is becoming culturally more diverse. As many as one in four older adults will be a member of a minority ethnic group by the year 2030. "Both between and within each of the major ethnic categories, including those classified as white, vast differences are found in factors which affect the

health and health care of older adults. Differences include patterns of health beliefs and health care utilization, health risks, patterns of interdependence with family members, ethical decision making priorities, and in some cases, response to treatment" (Ethnogeriatrics White Paper). The nexus of the fields of aging, health and ethnicity is known as ethnogeriatrics . Ethnogeriatrics has emerged from the GECs as a most significant contribution to the field

The new Ethnogeriatric Collaborative is a collaborative of 41 Geriatric Education Centers whose goals are to develop a Core Model Curriculum in Ethnogeriatrics for Geriatric Education Centers and a data base of GEC produced and other ethnogeriatric curriculum. Already the Stanford GEC has a resource base of over 3,000 resources for training in ethnogeriatrics. It is anticipated that following the completion of these goals the core curriculum will be applied to specific ethnic subgroups.

Interdisciplinary geriatric education and training must be required for health care professionals. Geriatric health care of the old-old is by nature interdisciplinary. Multiple chronic health problems, interacting with social, emotional and environmental concerns complicate acute, episodic health problems so that only an interdisciplinary team can adequately address the complex nature of the problems. The IHI collaborative mentioned above and the activities of the GECs are prime examples of such training.

The Sleeping Giant

The accompanying chart shows that 6.7 million health care professionals do not have geriatric education or training and the proposed targets for education and training for GECs next year. However, we do have the ability to address this problem, if we do it now. This potential pool of talent is actually a "sleeping giant" which can attack the problem of health care for the elderly if awakened.

The GECs have done a yeoman's job in reducing the number down from over 7 million in the past 14 years. They are recognized as *the* national resource for geriatric education in the country. However, the rapidly growing numbers of older adults will precipitate an acute need for these 6.7 million workers. This number includes 15,000 faculty from all disciplines, 3,750 of which should be minority faculty. They must receive sufficient education and training to incorporate geriatrics into the curriculum of health professions schools.

These "unmet need" numbers are extrapolated from varied and inconsistent figures. There is no workforce data base that has adequate geriatric education information. Medicine and nursing are the only professions with some reliable figures. These datum are limited and reliant on individual interest and available research funds. Unfortunately the 200+ allied and associated health professions have no data available at all from which projections can be made.

A workforce analysis of geriatric workforce needs for health professions faculty, clinicians and researchers is required to benchmark the actual deficit. Such indicators as the demographic imperative of a rapidly aging population, the attendance at GEC educational activities, the opinion of leading experts in the field and the growing anecdotal data of iatrogenic health problems due to health care providers' lack of geriatric expertise are indeed strong evidence for the need. However, in an era rightfully demanding accountability, benchmarks and performance outcome measures, the lack of hard data is disturbing. There is an urgent need to wake this giant of health care professionals to the important and unique characteristics of geriatric care. We must measure its size so that, as a nation, we are prepared to provide it with adequate education and training.

Summary

The shortage of health care professionals to care for the older adults of today and tomorrow is quite serious. The Geriatric Education Centers and Faculty Fellowships in Geriatric Medicine, Psychiatry and Dentistry have had a significant impact upon the need. They are indeed, national leaders in geriatric education. Yet, the projected need continues to outweigh the resources of these programs. The approach to geriatric competency among the health professionals of today and tomorrow is a larger issue than any one profession, association, state, or national government agency can resolve. Only through collaboration and cooperation among all key stakeholders can we hope to attain a future of caring, cost effective, efficient health care of older adults that will allow them to "live longer and grow stronger." *A National Agenda for Geriatric Education* has been that vehicle. The seeds of cooperation have been planted and are beginning to blossom.