Atmosphere Unsettled around Workforce Trends

BY HOWARD GLECKMAN

Delivering well-integrated health and personal care requires many resources: creativity, technology and rapidly evolving medical science. But none of these assets matter without skilled and motivated people. Primary care physicians, nurses, nurse practitioners, physician assistants and direct care workers such as home health aides and certified nursing assistants (CNAs) are all essential to quality care. Yet, as demand for these workers grows, the supply is stagnant or even shrinking. Low pay, diminished professional status, high stress and perceived lack of respect are discouraging good people from taking these jobs. Patients and their families will eventually pay the price for care that is less than it should be.

The shortage is especially troubling as health systems shift their focus from acute to chronic care and as patients age. As these systems deliver a growing share of their services to those with chronic disease, it will be critical that they have staff with the special skills necessary to serve this population.

To manage their illness, these patients will need specialists. But they will also need accessible, high-quality family medicine, and, for too many patients, that care is not available.

The lack of primary care in the U.S. has been well-documented. The Association of American Medical Colleges estimates that demand for primary care physicians exceeds supply by about 9,000. By 2025, that gap will increase to 65,000.[1]

The dearth of family practice doctors, nurses and paraprofessionals is especially serious in rural states. For instance, in Mississippi, Louisiana and New Mexico, more than 30 percent of the population lives in areas designated as primary care shortage areas, according to the federal Department of Health and Human Services.[2] Overall, 65 million Americans live in communities without enough primary care physicians.

Throughout the nation, however, these shortages are especially severe in geriatrics — a scarcity that will become critical as 77 million Baby Boomers age. In a landmark 2008 report, the Institute of Medicine described the problem this way: "The sheer volume of older adult patients threatens to overwhelm the number of physicians and

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other professionals who will be available, unless more is done to ensure an adequate supply."[3]

Both industry and government have recognized the consequences of these shortages and, in fits and starts, have taken steps to address them.

For example, the 2010 Patient Protection and Affordable Care Act includes new financial incentives for family practice physicians, geriatricians and other health providers. One initiative, the expansion of patient-centered medical homes, may increase compensation for primary care doctors. It is also aimed at expanding the use of practice teams to both improve access for patients and reduce time burdens on physicians.

However, the Affordable Care Act also will provide insurance coverage for an estimated 32 million currently uninsured — and that will dramatically increase demand for primary care and exacerbate shortages of health professionals. After Massachusetts made near-universal health insurance available in 2006, the time new patients had to wait for an appointment with an internist nearly doubled, to 31 days.[4]

Health systems are adjusting by creating new models for delivering primary care, such as community health centers and expanding the role of nurse practitioners and physician assistants. In nursing homes, the culture change and Green House movements are aimed at improving the work environment for both aides and nurses. Hospitals are refocusing both training and their care models to help nurses, physician assistants and aides take better care of chronically ill, elderly patients.

That said, at least two countervailing trends may somewhat reduce these pressures on the supply of health workers.

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The first is provider consolidation. Demand for some specialists may ease as nursing facilities and hospitals close or merge and as health systems respond to pressure from payers to do more with less.

Similarly, technology also may ease future workforce demands. For instance, the growing use of devices for monitoring health status and even delivering care may reduce the need for some front-line workers and some nurses. Improved information technology may allow workers to be used more efficiently by, for instance, reducing the need for manual medication reconciliation.

Still, caring for growing numbers of patients — many with chronic disease — will remain a fundamentally hands-on job. While technology and consolidation may slow the trend a bit, overall long-term growth in demand for both health professionals and direct care workers is likely to rise far faster than these jobs can be filled. The challenge for health systems will be finding workers with the skills and commitment to care for the rapidly growing population of those who need help.

FRUSTRATION WITH PRIMARY CARE

For decades, family practice doctors and internists (who make up the bulk of primary care doctors) were the backbone of the American medical system. Today, however, they face a practice environment that is changing at warp speed. Among those challenges: growing consumer demands for specialty care, an increasingly outdated payment system and a small-practice business model that may no longer meet the demands of 21st century medicine.

The proverbial eight-minute office visit, driven in part by low payment rates by Medicare and private insurers, is a large part of the problem. Add to that growing administrative costs, high medical malpractice insurance premiums and increasing consumerism by patients, and many practicing physicians report high levels of frustration and loss of autonomy.

More troubling for the future, medical students appear to show little interest in primary care specialties. In a 2007 survey, only 7 percent of fourth-year medical students said they would practice adult primary care.[5]

Perhaps the biggest challenge in recruiting primary care physicians is changing the way they are paid. For example, the basic Medicare payment system for doctors (known as the Sustainable Growth Rate or SGR) has been in flux since 1997. Each year, doctors are threatened with an ever-deeper pay cut — most recently, more than 20 percent. Each year, at the last possible moment, Congress grants

a reprieve but fails to address the basic flaws in this system.

Doctors respond in two ways. Those in the fee-for-service Medicare system have made up for the increasingly poor compensation of hands-on office visits by ordering a growing volume of tests and imaging, both of which are more generously reimbursed. As a result, Medicare's cost of imaging more than doubled from 2000 to 2006 to more than $14 billion, with all of the growth coming from physician offices and independent imaging centers.[6]

But medical students also "vote with their feet" and choose other, higher-paying specialties. An experienced dermatologist, for instance, earns on average twice as much as an internist.[7]

Medical school graduates, of course, choose their specialty based on many other factors besides money, including prestige and what might be called a level of comfort with their patients. Unfortunately, among students, primary care medicine and geriatrics score low in both areas.[8]

David Greer, MD, dean emeritus of the Brown University School of Medicine and a former geriatrician, pointed to yet another reason why physicians shy away from seniors and others with chronic disease. "Doctors don't like patients who don't get better," he said.[9]

The Affordable Care Acts takes an important step to improve compensation for family-practice physicians by creating "patient-centered medical homes" and Accountable Care Organizations (ACOs) — both of which at least hold the promise of increasing incomes. Doctors who serve at medical homes, for instance, coordinate care among specialties for chronically ill patients in exchange for additional compensation.

Aides are more likely than coal miners to be injured on the job.

NURSES FILLING THE GAP

As the ranks of primary care physicians continue to fall short of growing demand, it is likely that more family medicine will be provided by registered nurses (RNs), nurse practitioners (NPs), and physician assistants (PAs).

In at least 16 states, advanced practice nurses have broad authority to provide medical care, including prescribing medications and ordering tests, without physician oversight. Given the growing cost pressures of traditional care, it is likely other states will follow suit. The question is whether there will be enough RNs, NPs and PAs to handle the growing workload.

The long-standing concern about an overall nursing shortage seems to have abated somewhat

in the wake of the recent recession. "The economy is slow, and nursing schools are filled," said Tara Cortes, executive director of the Hartford Institute for Geriatric Nursing.

In recent years, nursing employment has grown by about 5 percent annually. As a result of the boomlet in new graduates, new forecasts suggest some long-term improvement in the supply of nurses.

Boomers have fewer children than their parents, and they are more likely to be divorced or never married.

However, from 2001 to 2008, nearly 80 percent of newly employed nurses were over 50 — an ominous trend for those worried about the future.[10] Researchers such as Peter Buerhaus of the Vanderbilt University School of Nursing project that the U.S. will face a shortage of 260,000 nurses by 2025, about 10 percent fewer than it will need.

In addition, relatively few nurses are taking the additional training needed to get advanced practice certifications in key specialties. For example, just 1 percent of RNs have geriatric certification.

Most worrisome, nurse educators say that young nurses, especially, tend to approach their work as a job rather than as caring for a patient. They show a very different, more task-oriented mindset than their more experienced colleagues. To some degree, this may be the result of staff shortages and resulting high caseloads.

MORE AUTONOMY FOR AIDES

While physicians and nurses serve a key role in delivering medical care to the chronically ill, CNAs, home health aides and other front-line workers provide critically important hands-on services to patients in hospitals, those living with chronic disease at home or in nursing facilities, or those recovering from acute episodes.

The Bureau of Labor Statistics estimates there are about 3 million direct care workers in the U.S. Today, more than half work in hospitals, skilled nursing facilities or other institutions. But by 2016, two-thirds will be employed in private homes or other community settings, according to the Paraprofessional Health Care Institute. Nearly all are women, and about one-quarter are foreign-born.

Home health aides make only about $10 per hour, while other direct care workers such as companions or homemakers earn even less. Home care workers rarely get benefits such as vacation pay, sick days, health insurance or retirement. Those working in nursing homes or hospitals are more likely to receive benefits, but their wages are somewhat lower. Overall, one-third, or 1 million workers, has no health insurance. Another 20 percent rely on Medicaid.[11]

Because so many work part time, the average annual income for a health aide is only about $17,000.[12] That is below the poverty level for a single mother with two children and barely half the median income. Not only is the pay low, but the work is physically and emotionally demanding. Injury rates for aides are among the highest of any occupation in the U.S. Aides are more likely than coal miners to be injured on the job.

With pay and benefits low and the risk of injury high, it is not easy to find aides who combine skills and compassion. One, 23-year-old Andrea McClain, describes what she thinks make a good aide: "Being able to communicate, being able to understand what a client wants. But you need to listen to them. Sometimes you think you know what they want, but you need to wait for them to ask."

While money and benefits surely matter, the

best aides often say they choose this difficult occupation because of their love of the work — and for their patients. Many cared for parents or siblings before training as aides.

When asked about keys to job satisfaction, many point to respect, or the lack of it, Aides say they often feel the sting of disrespect from clients and their family members. "I'm an aide, not a maid," direct care workers like to say. They feel disrespect from their agencies, as well as from the nurses they work with.

In a self-produced video, aides at the Home Care Associates, a Philadelphia-based, employee-owned home health agency, candidly described how others see them. People, they said, call us "toy nurses." Or "the girl."

The problem is severe in nursing homes, as well, where annual turnover can top 80 percent.

However, new operating models of nursing facilities, driven in part by the culture change movement, are based on giving aides greater levels of responsibility and flexibility. For example, the Green House model designed by William Thomas, MD, is built on a more collegial, less hierarchical design where aides (called *shahbazim*) are given considerable autonomy.

Early evidence suggests that nursing home quality improves where aides are given responsibility. One study found that a collegial organization was a far more important determinant of nursing home quality than wages.[13]

Still, far more needs to be done to increase the number of skilled and motivated aides. Better training, greater opportunities for promotion and better benefits may be key. So may reforming immigration laws, recognizing that increasing numbers of aides will come from abroad.

The growing trend toward seniors aging in place will make delivery of medical and personal services more complex and labor-intensive.

Increasing wages and benefits is a huge challenge, particularly in an environment where Medicare and Medicaid are cutting reimbursements. However, it may be possible to find ways for these workers to share in the potential benefits of risk-sharing arrangements such as ACOs. Importantly, by making subsidized health insurance available to low-wage workers, the Accountable Care Act may provide medical coverage for many front-line workers who have, until now, gone without.

THE SPECIAL CHALLENGE OF GERIATRICS

Perhaps no specialty will be under greater pressure than geriatrics. Demand for providers is exploding as a result of a remarkable confluence of demographic, social, economic, medical and political trends. Even as a rapidly aging population is likely to need more care for more time, their own families will be less able to provide such assistance.

Not only are 77 million Baby Boomers aging, but these Boomers have fewer children than their parents, and they are more likely to be divorced or never married. Their daughters, who can be expected to be their primary caregivers, will be more likely to work, leaving less time for care giving. Adult children are more likely to live in a distant city. And those Boomers are likely to live many more years with chronic disease.

Dramatic changes in Medicare and Medicaid payment systems will encourage the use of lower-cost service providers in lieu of doctors for much routine care.

At the same time, the growing trend toward seniors aging in place will make delivery of medical and personal services more complex and labor-intensive. After all, providing care to 40 seniors scattered across dozens of suburban cul-de-sacs is far more challenging than serving the same number of elders living in one skilled nursing or assisted-living facility.

Despite the explosive growth in the senior population, the number of board-certified geriatric specialists is declining as these specialists retire more quickly than new ones are being trained. Today, while 33 million Americans are age 65 or older, only about 7,000 physicians are board-certified geriatricians, 20 percent fewer than a decade ago.

What can be done to make geriatrics a more attractive specialty?

- **Revise the Medicare payment system.** In

part, such reforms should recognize that it often takes more time for a physician to treat geriatric patients. Medicare should also pay for end-of-life counseling (a provision included in an early version of the Affordable Care Act but dropped in the face of allegations that these discussions represented "death panels").

Medical education should also concentrate on improving communication skills for new doctors, many of whom struggle to talk to older patients.

■ **Rethink medical training.** Medical schools should do a better job introducing students to the specialty and help change the mindset that considers symptom management secondary to curative treatment. Medical education should also concentrate on improving communication skills for new doctors, many of whom struggle to talk to older patients.

■ **As shortages of geriatricians grow, their role will increasingly be supplemented by others.** Nurses, for instance, are the key medical professionals in nursing facilities, where physician contact with residents is extremely limited. Yet fewer than half of nursing schools offer geriatric programs, and Tara Cortes of the Hartford Institute estimated that only about 1 percent of RNs hold a geriatric certificate.

To fill the gap, nurses will be joined by physician assistants and nurse practitioners, among others. The 2008 Institute of Medicine report shows only 1 percent of pharmacists and fewer than 4 percent of social workers are geriatric specialists.[14]

Dealing with elderly patients calls for very different skills than caring for younger adults. Elderly patients are more likely to be treated for multiple chronic diseases than an isolated acute event. They respond to medication differently. Those in hospitals are more prone to delirium and confusion, and may be higher fall risks. Those suffering from dementia require even higher levels of care.

The good news is that more schools and hospitals are offering geriatric training programs for both nurses and nurse practitioners. For instance, NICHE (Nurses Improving Care for Healthsystem Elders), a joint venture of the Hartford Institute and the New York University School of Nursing, has built partnerships with more than 300 U.S. hospitals, helping to develop protocols for both assessment and management of older patients.

At the same time, hospitals are changing the way they care for geriatric patients. Some are setting up special units for this population. Holy Cross Hospital in Silver Spring, Md., pioneered a separate emergency room for seniors. Other hospitals are creating designated medical units, sometimes called Acute Care for Elders (ACE) units, for older patients. Still others, especially those with high populations of seniors, are adapting these care methods throughout the hospital. All of these models require skilled geriatric nurses, but the hospitals provide a higher-performing and more satisfying work environment.

Until recently, NICHE has focused on hospital care. However, as post-acute and post-operative care begins to move from hospitals to nursing homes, NICHE is beginning to provide training and assessment tools to nurses in these settings as well.

Much of the burden of providing this care will fall to front-line workers such as home health aides and CNAs. However, demand for nurses, nurse practitioners and physician assistants will also increase as shortages of appropriately trained physicians grow. At the same time, dramatic changes in Medicare and Medicaid payment systems will encourage the use of lower-cost service providers in lieu of doctors for much routine care.

We can continue down the current road and face the crisis of care the Institute of Medicine warned about in 2008.

INCENTIVES, RESOURCES ARE KEY

Medical science has made it possible for patients to live many years with multiple chronic diseases that require complex care. Yet, we have failed to create the financial and cultural incentives to encourage the right people to make careers providing that care.

In the end, our rapidly aging society will be faced with a choice. We can continue down the

current road and face the crisis of care the Institute of Medicine warned about in 2008. Or, we can find new ways to encourage health professionals and care workers to take on this challenging, but critically important, work. For the most part, we know what to do. We just need to commit ourselves and our resources to doing it.

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