To improve the health, independence, and quality of life of all older people, every older American should receive high-quality, patient-centered care (American Geriatrics Society, 2010). Currently disconnects exist between the expanding healthcare needs of older adults, the educational institutions responsible for training healthcare providers, and the entities paying for the training (U.S. Department of Health and Human Services Council on Graduate Medical Education [COGME], 2010; Kovner, Mezey, and Harrington, 2002).

Older adults with multiple chronic health problems frequently receive care from multiple healthcare providers with minimal, if any, contact between providers. This lack of coordination can result in adverse or simply unpleasant side effects for the older person, as treatment for one condition aggravates or leads to another problem. With appropriate coordinated medical care and social support, older Americans are more likely to remain safely in their own homes as they age, as well as to maintain their social activities. Appropriate care optimizes functional autonomy and quality of life (Boult, 2010). However, the current healthcare system fails to provide well-coordinated, high-quality chronic care (Institute of Medicine, 2008; Salsberg and Grover, 2006; Eleazer and Brummel-Smith, 2009). In addition, many healthcare professionals do not see older adults as having needs distinct from younger adults (Holtzen et al., 1993).

The professional healthcare workforce required to care for an aging America is an interdisciplinary workforce made up of physicians, nurses, social workers, pharmacists, psychologists, psychiatrists, nutritionists, dentists, dietitians, and physical therapists. This article reviews several health professions’ current state of readiness to address the care of a rapidly expanding older population.

Physicians

Geriatricians and geriatric psychiatrists

There are currently 7,029 geriatricians certified by the American Board of Family Medicine and the American Board of Internal Medicine, and 418 certified by the American Osteopathic Board of Family Medicine and Internal Medicine (American Geriatrics Society and the Association of Directors of Academic...
Geriatric Center’s Geriatric Workforce Policy Studies Center [GWPSC], 2010). In the United States, the mean number of geriatricians per 10,000 adults ages 75 and older is only 3.7 (GWPSC, 2010). As of December 2009, 2,732 physician directors have received the certified medical director (CMD) designation from the American Medical Directors Association. Among CMDs, 1,101 also are board certified in geriatric medicine (personal communication, Alicia Willey, American Medical Directors Certification Program).

There are currently 148 geriatric medicine fellowship training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). These programs are training 296 fellows annually; 273 first-year and twenty-three advanced fellows, of which 66 percent are medical students who graduated from schools outside of the United States. In 2009, there were 216 (44 percent) unfilled training slots in these training programs (Brotherton and Etzel, 2010). In 2007–2008

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the American Osteopathic Association recognized seven programs (Freeman and Lischka, 2009). These programs trained only three fellows.

There are currently 1,705 certified geriatric psychiatrists. In the United States, the mean number of geriatric psychiatrists per 10,000 adults ages 75 and older is only 0.9 (GWPSC, 2010). There are currently fifty-eight geriatric psychiatry ACGME fellowship programs training fifty-five fellows. Fifty-six percent of the fellows are graduates of foreign medical schools. In 2009, sixty-six geriatric psychiatry fellowship slots went unfilled (Brotherton and Etzel, 2010). A median of twenty-three days in geriatric psychiatry training is required in psychiatry residency four-year programs. These programs have an average of 2.8 certified geriatric psychiatrists available to teach an average of twenty-eight residents (Warshaw et al., 2010).

Primary care physicians

Presently, 12.7 percent of America’s physicians are family physicians, and 10.9 percent are general internists (COGME, 2010). In 2008, during the three-year residency training program, a median of twelve days of dedicated clinical training in geriatrics was required in family medicine, and twenty days in internal medicine residency programs (GWPSC, 2010).

Nurses

Forty-five percent of America’s registered nurses (RN) are prepared in associate degree (AD) nursing programs (U.S. Department of Health and Human Services, Health Resources and Services Administration, 2010) followed by four-year Bachelor of Science (BS) degree programs, with a few nurses trained via diploma (hospital-based) or military training. A 2005 survey of baccalaureate curricula reported 92 percent of BS nursing programs integrated geriatrics into one or more courses with the most geriatric content presented in medical-surgical nursing (adult health) and fundamental courses (Berman, 2005). Similar findings were reported from a recent study conducted to determine students’ curricula and clinical experiences in AD programs (Ironside et al., 2010). Rarely is geriatric content more than 25 percent of a course, with the highest percentage occurring in courses focused on adult health, fundamentals, and mental health. Most programs used nursing homes as a clinical site for teaching older adult care, generally in the first year of training.

Only 43 percent of nursing schools reported having full-time faculty for geriatrics, and only 32 percent reported having part-time faculty with expertise in geriatrics obtained at the master’s level. Three identified areas to foster
geriatric competence among nursing students include the need for standards for teaching geriatrics in AD programs; faculty development; and innovative clinical models emphasizing the complexities of caring for older adults occurring in non-acute, community-based sites where students encounter older adults living independently (Ironside et al., 2010).

**Advanced practice nurses**

In 2008, an estimated 4,963 (1.9 percent) of advanced practice nurses (APN) were certified in gerontological nursing (U.S. Department of Health and Human Services, Health Resources and Services Administration, 2010). APNs can be either nurse practitioners (NP) or clinical nurse specialists. Other certified APNs caring for older adults include adult NPs, 27,113 (10.6 percent); family NPs, 52,039 (20.4 percent); women’s healthcare, 13,198 (5.2 percent); and psychiatric-mental health, 11,163 (4.4 percent). It is estimated that the focus of study for 21,535 APNs (8.6 percent of all advanced practice nurses), was geriatrics-gerontology (U.S. Department of Health and Human Services, Health Resources and Services Administration, 2010).

From 1993 through 2009, the American Academy of Nurse Practitioners (AANP) has awarded 28,925 certifications as family NPs, adult NPs, and gerontological NPs. All three certifications test knowledge in geriatric and frail-elderly primary care (AANP, 2010a). Thirteen percent of all NPs (N=135,000) have long-term-care privileges. Three percent of all NPs are certified in gerontology, have been in this field an average of 11.6 years, and have an average age of 52 years (AANP, 2010b). A 2008 national study of the characteristics of gerontological NPs found only half were working full-time as gerontological NPs. Although the role was established more than thirty years ago, 56 percent of the respondents indicated they were the first gerontological NP in their current position (Kennedy-Malone, Penney, and Fleming, 2008).

In 2009, twenty-eight nursing schools offered master’s level gerontological clinical nurse specialist (CNS) degrees, down from thirty-six in 2007 (Fang, Htut, and Bednash, 2008; Fang, Tracy, and Bednash, 2010). In these schools, fifty students were enrolled in CNS programs, compared to 124 in 2007. These fifty students accounted for 1.3 percent of the 3,879 students in master’s level CNS programs. While there was a decrease in the number of programs offering CNS degrees in gerontology, there was a slight increase in NP programs. In 2009, sixty-two schools compared to sixty in 2007 were training 519 students (1.6 percent of the 33,201 NP students) compared to 431 (1.6 percent of 26,989 students) in 2007. Additionally, in 2009 there were twenty-nine NP dual-track programs in gerontology (i.e., family NP-gerontological NP specialties) (Fang, Tracy, and Bednash, 2010). There was a decrease from fifty-two in 2007 to forty-nine in 2009 for post-master’s NP gerontological programs (Fang, Htut, and Bednash, 2008; Fang, Tracy, and Bednash, 2010).

**Geropsychiatric nursing**

A July 2004 national survey of all 339 graduate nursing programs (N=206/339) found that fifteen programs had a geropsychiatric nurse subspecialty. Sixty programs had a psychiatric mental health nursing graduate program, but only 38 percent (N=23) included some geropsychiatric nursing content, while more than half (N=116) reported integration of this content in a non-psychiatric nurse-practitioner program. The greatest numbers of APNs educated in the mental health needs of older adults are prepared in non-psychiatric nurse practitioners programs (Kurlowicz et al., 2007). A more recent survey found ninety-six NP programs in adult psychiatric and mental health (sixty-five) and family psychiatric and mental health (thirty-one) training 1,166 students. One dual-track program was focused specifically on gerontological NP-adult
psychiatry and mental health NP (Fang, Tracy, and Bednash, 2010).

**Psychologists**

According to the American Psychological Association (APA), 70 percent of practicing psychologists provide some services (8.5 percent of their time) to older adults (Anderson, 2009; Michalski, Mulvey, and Kohout, 2010). A representative sample of practitioner members of APA found that most respondents lacked formal training in geropsychology and perceived themselves as needing additional training (Qualls et al., 2002). In APA membership data, 9,547 members (out of 150,000) indicated an involvement in geropsychology, with 34.4 percent in independent practice, followed by 15.8 percent in university settings. Slightly more than half (54 percent) of the members involved in geropsychology identified themselves as practitioners. Of the 9,547 members, 7,706 were working in a health service provider subfield, 337 specifically worked in geropsychology and the remaining members worked in clinical settings, counseling psychology, clinical neuropsychology, or other settings.

There are no certification programs in geropsychology. However, at APA’s August 2010 meeting, the APA recognized professional geropsychology as a specialty area (personal communication, Gregory Hinrichsen, Albert Einstein College of Medicine, August 18, 2010; Hinrichsen, 2010).

**Physical Therapists**

From 1992 through June 2009, 1,006 physical therapists have been certified in geriatrics by the American Physical Therapy Association (APTA). To maintain the geriatric certified specialist (GCS) designation, individuals must re-certify every ten years (APTA, 2010b). As of October 2010, there are six APTA credentialed residencies in geriatrics (APTA, 2010a). A physical therapist who completes a residency in a credential program in geriatrics is automatically eligible to sit for the GCS exam (Hartley, 2010). Otherwise, the physical therapist needs evidence of 2,000 hours of direct patient care in the specialty area within the last ten years, 25 percent (500 hours) of which must have occurred within the last three years (APTA, 2010b).

The Section on Geriatrics (SOG) of the APTA was formed in 1978 to address the needs of the physical therapy practitioner working with the aging client, including therapists, assistants, and students. As of October 2010, there were 5,246 members: 4,632 physical therapists, 453 physical therapists assistants, and 161 students (APTA, 2010a).

In 2009, the SOG implemented the Certified Exercise Expert for Aging Adults (CEEAA) educational certification program and developed the Physical Therapists as Exercise Experts with Aging Adults curriculum guidelines. Currently more than 160 physical therapists are CEEAA-certified (GeriNotes, 2010). In July 2010, the SOG held the Exercise and Physical Activity in Aging Conference. Attended by more than 300 physical therapy professionals, this event focused on geriatric physical therapy research, education, and clinical practice (Exercise and Physical Activity in Aging Conference, 2010).

**Pharmacists**

Started in 1997 by the American Society of Consultant Pharmacists (ASCP), the Commission for Certification in Geriatric Pharmacy (CCGP) has established a national voluntary certification program for pharmacists (see the ASCP website, www.ascp.org). There are currently 1,210 certified geriatric pharmacists in the United States (personal communication, Tom Despite efforts over the past twenty years, there are still not enough healthcare professionals to care for older adults.
Clark, executive director, Commission for Certification in Geriatric Pharmacy, October 2010)—a small amount given the 269,900 staffed pharmacy positions reported by the U.S. Department of Labor (Bureau of Labor Statistics, 2010).

The most recent survey (2006) that was conducted by the American Association of Colleges of Pharmacy geriatric special interest group, and completed by 42 percent of the eight colleges and schools of pharmacy in the United States, found only 43 percent of the respondents had an elective course in geriatrics (Odegard et al., 2007; Delafuente, Mort, and Wizer, 2006; D’Antonio et al., 2008). However, all respondents indicated that an advanced pharmacy practice experience in geriatrics or in long-term care was available for students (Gray, Elliott, and Semla, 2009). Few pharmacy schools have a required geriatrics course or module, or integrate geriatrics into other coursework. The quantity and success of integration is unknown, but less than half of all pharmacy schools have a full-time geriatric pharmacy specialist (Delafuente, 2009).

Advanced training is available through fellowships and postgraduate year two (PG-Y2) residency programs specializing in geriatrics. At present there are twelve specialty residencies in geriatrics accredited by the American Society of Health System Pharmacists (ASHP), and seven of these are at Veterans Administration sites (ASHP, 2010). The pressure of having to repay student loans often drives young practitioners to seek jobs in the community instead of pursuing a PG-Y2 geriatrics residency. No loan-forgiveness incentive exists for pharmacists who undertake advanced training in geriatrics, a barrier mentioned in the Institute of Medicine report that applies to all healthcare professions (Traynor, 2008).

Social Workers

The minimum education requirement to qualify as a social worker is a bachelor's degree in social work (BSW). A master's degree in social work (MSW) is typically required for positions in health settings and is required for clinical work. There are nearly 150 MSW programs in the country (National Association of Social Workers [NASW], 2010a). While there is no specific certification available for geriatrics social workers, they can be credentialed via the NASW. The MSW-prepared individuals meeting set criteria can be credentialed as an advanced social worker in gerontology (ASW-G) or as a clinical social worker in gerontology (CSW-G). The BSW-prepared individuals can be credentialed as a social worker in gerontology (SW-G). Currently there are 358 social workers credentialed: 98 ASW-G, 42 CSW-G, and 218 SW-G (NASW, 2010a).

In 2006, 12 percent of licensed social workers (38,400) identified their practice areas as “aging” (NASW, 2006). A 2009 study on compensation of social workers reported that those certified in geriatrics tend to earn less than the median practitioner does overall (NASW, 2010b).

Discussion

The following elements emerged during this review of information regarding the workforce that is prepared to care for older adults:

- There are insufficient numbers of prepared faculty;
- There is a lack of value placed on geriatrics where curriculum decisions are made;
- Those working with older adults earn a lower income, despite added education and training;
- There is a need for competencies to guide care so that all healthcare providers are skilled in caring for older adults; and,
- There is a need for a “business case” in care delivery that shows how and why these competencies produce safer, quality, and value-based care that is also economically effective.

When a training site has just one faculty member experienced in geriatrics, it is difficult to build a viable program. Faculty development is the single most necessary precursor to the
successful implementation and maintenance of geriatric curricular enhancements. Unless faculty members foster positive attitudes toward aging, expand their geriatric and gerontology knowledge base, and are able to integrate geriatric content into the curriculum, progress cannot be made (Latimer and Thornlow, 2006).

The educational experience strongly shapes career choices. During clinical training, medical students have their first glimpse of “real world” medical practice, where they are exposed to a disproportionate number of specialists. Most medical schools have faculty anchored to a large hospital that attracts unusually complex patients not representative of the general population (COGME, 2010). Hospitals tend to use the non-targeted direct and indirect educational subsidies to support subspecialty residencies, rather than primary care or geriatric programs (Mullan, 2009). Academic leaders may oppose using scarce resources to support geriatrician leaders rather than to enhance other areas they feel are more important to their missions, strategic plans, or budgets (Boult, 2008).

Similar to the field of medicine, nursing faculty in AD programs state that the “lack of value placed on geriatrics at the level where decisions are made” is an important impediment to enhancing geriatric content and experiences in their programs (Ironside et al., 2010). Several private foundations have strongly supported healthcare professions to develop competencies to care for older adults. For example, the John A. Hartford Foundation funds nursing, social work, and medicine centers of excellence in geriatrics. Many other professions are developing or have competencies in place regarding appropriate care for older people. Continuing education will play a critical role in preparing an adequate number of healthcare professionals to serve older adults (Qualls et al., 2002). It is important that these geriatric competencies emphasize interdisciplinary practice so that the care of older adults does not remain compartmentalized (Mezey et al., 2008).

In June 2008, the American Geriatrics Society convened the coalition, Partnership for Health in Aging (PHA). The coalition’s mission was to develop a set of eldercare core competencies, which could be endorsed by all health professional disciplines, by February 2009. Workgroup members represented ten healthcare disciplines: dentistry, medicine, nursing, nutrition, occupational therapy, pharmacy, physical therapy, physician assistants, psychology, and social work. The workgroup drafted a set of baseline competencies, which were ultimately endorsed by twenty-eight professional organizations (Barr, 2010; PHA, 2010).

The recent Initiative on the Future of Nursing study, supported by the Robert Wood Johnson Foundation and conducted by the Institute of Medicine, also emphasized that effective workforce planning and policy making require better data collection and an improved information structure (Institute of Medicine, 2010). The Affordable Care Act established a National Healthcare Workforce Commission to evaluate and make recommendations for the nation’s healthcare workforce. It is essential that this new commission ensures an appropriate focus on the priority area of older adult care, especially for those experiencing complex care needs (General Accounting Office, 2010).

Conclusion

Despite considerable effort over the past twenty years, there are still not enough healthcare professionals with the preparation and knowledge to provide optimal care to older adults. The 2008 Institute of Medicine report, Retooling for an Aging America, documented this dilemma and will guide future federal

When a training site has just one faculty member experienced in geriatrics, it is difficult to build a viable care program.
government responses. If the high-technology, event-based approaches to care continue without geriatrics and gerontology expertise and input, the costs of care for this vulnerable population will continue escalating to financially unsustainable levels (Fried and Hall, 2008; Kaiser Family Foundation, 2008). Education must focus on caring for the entire person rather than a specific disease state (Ironside et al., 2010).

The ultimate health and well-being of older Americans is a broad issue needing system-wide support by all committed to serving the growing demographic of aging Americans. We must recognize it is a compelling and powerful personal commitment that can benefit those whose lives we are entrusted to care for, including our own families and friends, now and in the future.

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References


**Aging with Dignity through the Affordable Care Act**

Bruce Chernof, Guest Editor

The Spring 2011 issue of *Generations* will illustrate the many ways that the Affordable Care Act provides a framework to help today’s and tomorrow’s elders age with dignity. Articles will discuss key elements of health reform with particular emphasis on long-term care, including long-term care reform, improvements to Medicare, the role of states in Medicaid expansion, measuring meaningful change, and a look into tomorrow’s healthcare system.

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