

Chapter 9

Personnel and Training

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Personnel and Training

Long-term care is the fastest growing segment of the health services industry in the United States (73). To keep pace with a growing population of elderly Americans the United States will require a 50-percent increase in the number of health care providers by the year 2010, according to the 1981 White House Conference on Aging. Some 2.6 million older persons—almost double the current number—will be in nursing homes by 2030 (87). Noninstitutional long-term care needs have not been estimated.

Attracting and retaining skilled, knowledgeable personnel will continue to be critical to the delivery of quality long-term care. Facilities face several fundamental problems in that regard:

- An inadequate number of health professionals opts for employment in long-term care facilities and programs.
- Professional, paraprofessional, and nonprofessional staff frequently lack prior training and experience in caring for the elderly, chronically ill, and mentally ill served by these facilities and programs.
- The staff turnover rate in long-term care facilities and programs is extremely high (63).

These problems are integrally related. Health professionals' lack of interest for work in long-term care is attributed, in part, to an educational process that stresses acute rather than chronic care and that provides little experience with and information about caring for mentally ill or elderly patients (21,30,40,59). Lack of preemployment

training and experience contribute to the high staff turnover experienced by most long-term care programs. Professional, paraprofessional, and nonprofessional employees, whose education has not equipped them with the knowledge and skills to care for long-term care patients, become dissatisfied with work in these settings (63). In addition, the salaries and benefits offered by long-term care facilities and programs are rarely competitive with those available in hospitals and other acute care settings (45,77).

Efforts to project the number of personnel needed to care for demented patients in the United States must consider:

- the Nation's changing demographics,
- the types of services needed, and
- the individuals best qualified to deliver these services.

A brief description of several models of care sets the stage for this chapter's discussion of the various professionals, paraprofessionals, and nonprofessionals who provide services to individuals with dementia, and the overriding issues concerning the education of these personnel. An understanding of the role played by each enables projections of the numbers needed and the training they will require to provide quality care. Educational, institutional, and governmental efforts to prepare individuals for this work and to address the fundamental personnel problems experienced by programs serving individuals with dementia are presented throughout the chapter.

MODELS OF CARE

Selecting an appropriate "model of care" is an important starting point in evaluating the groups and numbers of personnel needed to serve a population. The needs of long-term care patients differ from those of acute care patients. Considerations of personnel needs must account for these differences and determine which individuals are best suited to deliver care. Projections must also take into account the full range of care settings

available, and the staffing arrangement appropriate to each.

Three models of care useful in characterizing the delivery of health services are the medical, nursing, and multidisciplinary team approaches to care.

1. The **medical model** of care is the customary basis for estimating personnel needs in

health care. The model emphasizes acute rather than chronic care, diagnostic and treatment services rather than social and rehabilitative services, and the role of the physician over that of other health and social service professionals (48).

2. The **nursing model** focuses on the chronically ill, emphasizing their need for rehabilitative and personal care (e.g., feeding and bathing) services rather than intensive medical care. Nurses function as the primary service providers, working to promote, maintain, and, where possible, restore maximum function and independence in a patient's activities of daily living. In addition, nurses help with events and decisions that confront the patient and family over time (64).
3. The **multidisciplinary team** approach stresses the range of health and social services personnel appropriate to certain care situations. The model suggests that providing quality care to some groups of patients requires the skills and knowledge of a wide variety of professionals and paraprofessionals.

Dementia and the Multidisciplinary Team

The complexity of dementing illnesses makes the team approach to care an appropriate one for individuals with these illnesses. Their unique care needs stem from their combination of medical problems, self-care deficits, cognitive impairments, and social difficulties. Their care requires the skills and knowledge of individuals trained in long-term care, mental illness, and, in most cases, geriatrics. A variety of medical specialists, nurses and nurse's aides, social workers, and rehabilitative and recreational therapists may each contribute components necessary for quality care of persons with dementia.

Although most acute and long-term care facilities rely on a variety of professional, paraprofessional, and nonprofessional personnel, the multidisciplinary team approach, as an actual care strategy, requires both philosophical and formal acknowledgment of the importance of each member's role in the delivery of quality care. Actual training in the theory and practice of the team approach is important for its effective application.

While such training may be a component of on-the-job training or orientation, its incorporation into the formal education of health care and social service providers could enhance their ability to apply this approach.

The Team Approach as a Component of Education

Programs that train health and social service professionals frequently fail to acknowledge that no single group is equipped to meet the diverse needs of most patients. Programs fail to emphasize the valuable knowledge and resources available through professionals in other disciplines. An emphasis, during the educational process, on the role of each professional in conjunction with those in other fields—providing students with experience in working with individuals in a variety of disciplines—might enhance their ability and willingness to do so. Although a few programs have begun to teach this team approach, the majority still focus almost exclusively on a single professional discipline.

One program that attempts to prepare health professionals to apply the team approach is the Veterans Administration's Interdisciplinary Team Training in Geriatrics (described later in this chapter). The program provides clinical experience in geriatrics to students in 40 health-related disciplines from academic institutions throughout the United States (26). In addition to gaining skills and knowledge related to geriatric care, students learn to function as part of a team of caregivers.

Another effort to encourage interdisciplinary cooperation is made through 20 Geriatric Education Centers (GECs) sponsored by the Bureau of Health Professions (BHP) within the Health Resources and Services Administration of the Department of Health and Human Services (also described later). The first four GECs opened in fiscal year 1983; BHP established 16 more with fiscal year 1985 appropriations (83). The centers aim to disseminate interdisciplinary and discipline-specific information in geriatrics to students of the health and allied health professions. GECs offer training modules for faculty in nursing, medicine, dentistry, social work, psychology, rehabilitation, pharmacy, and long-term care administration in

order to aid faculty efforts to establish or augment geriatric education programs at their own institutions.

Multidisciplinary Care in Programs and Facilities

Although most facilities and programs providing long-term care services rely on a variety of health, allied health, and social service personnel, few make a formal commitment to training staff in the theory and practice of multidisciplinary care. Orientation sessions, inservice training programs, and regular team meetings are among the means through which individual facilities and programs instruct staff in the value of and approaches to interdisciplinary cooperation.

Orientation and Inservice Training of Team Members

Facilities and programs that acknowledge a formal commitment to multidisciplinary team care stress the importance of training sessions that incorporate its principles and methods. Orientation and inservice sessions that include all levels of personnel—from physicians to nurse's aides to maintenance and dietary staff—offer opportunities to present information about the patients and the philosophy of the program and to foster mutual respect among staff.

Through these sessions, individuals whose role includes a supervisory function maybe apprised of the facility's commitment to treating each employee as an integral member of the care team. In addition, the sessions allow programs to convey to all staff information fundamental to serving their patients. Even housekeeping and maintenance staff, for instance, must know of the tendency for wandering behavior among persons with dementia so as to avoid an inappropriate and potentially harmful response on their part. Technical information regarding skills and treatment procedures may be reviewed separately with the groups of staff responsible for implementing them.

An overriding problem for programs and facilities seeking to train health and social service professionals about caring for patients with dementia is the absence of teaching resources. Several facilities and universities have recognized and

attempted to respond to that need; the Alzheimer's Disease and Related Disorders Association (ADRDA) and the American Health Care Association have published a manual to train nursing home staff about dementia (32).

Another such effort was made by the Hillhaven Corp., a leader in the development of special care units for dementia patients. Hillhaven emphasizes the importance of orientation and monthly inservice training for all staff members. Orientation includes a minimum of 8 hours classroom and 16 hours experiential learning (e.g., role playing and observation). The training manual developed for Hillhaven (60) presents information on the biological, physiological, and social aspects of dementia. Each chapter suggests a lesson plan, including classroom and experiential sessions (15 to 30 minutes each), and possible continuing education activities. Topics include causes of memory loss in the elderly, issues involving the family, and day-to-day nursing care. Tests before and after the training monitor how well the staff integrates the material.

Team Meetings

Facilities that purposefully implement the team approach say that staff meetings are an important way to foster involvement of all levels of personnel in institutional and patient management. Weekly meetings to assess patient status and needs, for instance, include all personnel involved in patient care. Including nurse's aides and other paraprofessionals in these sessions shows an important recognition of their critical role in the delivery of quality care. Of all facility personnel, nurse's aides spend the greatest number of patient contact hours and provide the highest percentage of direct care. Soliciting their input can provide valuable information and may alleviate the intense job dissatisfaction and rapid turnover prevalent among aides in more hierarchical facilities (a problem discussed later in this chapter).

Members of the Multidisciplinary Team

Staff size and composition vary with the number of persons served, the nature of the program, financial resources and management strategy of the program, and State and Federal requirements. The following categories of personnel, however,

indicate the range of individuals who may act as team members in a multidisciplinary approach to care (19):

- **management:**
 - board of directors, and
 - administrator;
- **medical staff:**
 - medical director,
 - attending physician,
 - psychiatrist (consultant),
 - neurologist (consultant), and
 - dentist (consultant);
- **nursing staff:**
 - director of nursing,
 - registered nurse,
 - licensed nurse practitioner,
 - nurse's aide, and
 - nurse specialist (e.g., gerontological nurse practitioner);
- **extended care providers:**
 - social worker,
 - physical therapist,
 - occupational therapist,
 - speech therapist,
 - psychologist (consultant),
 - nutritionist (consultant), and
 - pharmacist (consultant);
- **life enrichment personnel:**
 - activities director, and
 - training coordinator.

Budgetary constraints prohibit most facilities and programs from employing such an extensive range of personnel. The majority rely heavily on professionals employed on a contractual or fee-for-service basis (19).

The various groups of professionals and paraprofessionals frequently employed by long-term care facilities and programs are briefly described here, although greater detail about the roles and educational preparation of each is provided later in this chapter.

- **Physicians:** Aside from the medical director, required for Federal reimbursement of programs, few long-term care facilities employ a full- or part-time physician. Patients needing medical attention must be visited by their personal physician or temporarily transferred to an acute care facility.
- **Nurses and nurse's aides:** The vast majority of full-time employees in most long-term care facilities are registered or licensed practical nurses (RNs and LPNs) and nurse's aides. RNs and LPNs accounted for 22 percent of the full-time staff in U.S. nursing homes in a 1977 survey; nurse's aides, for 68 percent. The shortage of nurses in long-term care, however, is severe (39,73,87).
- **Medical and nursing specialists** The expertise of medical and nursing specialists (e.g., geropsychiatrists, neurologists, and geriatric nurse practitioners) makes their role in the diagnosis and management of individuals with dementia valuable. Few facilities, however, retain these professionals as part of the permanent staff due to such factors as scarcity and expense.
- **Social workers:** Facilities and programs that serve persons with dementia may employ a social worker on a full-time, part-time, or consultant basis. Their skills in individual and group counseling and their knowledge of local and national resources make them valuable participants in planning and administration of patient care.
- **Recreational and rehabilitative therapists** A variety of therapists (e.g., physical, occupational, exercise, art, and speech) may work with patients to enhance mobility and fine motor and communication skills. Although few facilities employ therapists from each of these disciplines, many employ one or more specialists on a part-time basis.
- **Pharmacists and nutritionists:** Inpatient facilities may employ experts in pharmacology and nutrition on a contractual basis. These specialists assess individual patient needs and facility programs related to diet and the use of drugs.
- **psychologists:** Psychologists may provide many direct and indirect services to patients in long-term care settings. Few programs retain a full-time psychologist, although many employ these professionals on a consultant basis. A trained psychologist may assist in developing and evaluating strategies to address behavioral problems manifested by persons with dementia. Psychologists may also provide inservice training for staff and may work

with families on how to communicate with and care for persons with dementia.

- **Administrators:** Administrators of facilities and programs caring for persons with dementia play a major role in planning and delivery

of care. Their decisions regarding allocation of resources, organizational structure, and program priorities are critical to the quality of service delivered.

ISSUES IN EDUCATION FOR HEALTH AND SOCIAL SERVICE PROFESSIONS

Three factors are important in stimulating interest in caring for specific groups of patients and for work in particular care settings: 1) factual information, 2) clinical experience, and 3) positive faculty role models. The limited interest of many health and social service personnel in geriatrics and long-term care is frequently attributed to the failure of educational programs to address these topics—the emphasis on the role of the professional in acute rather than long-term care situations and the absence of efforts to address negative attitudes toward the elderly (66).

The 1970s marked the beginning of an infusion of material related to care of the elderly and chronically ill into programs for health and social service professionals. The extent to which information about that or any subject or population is included in academic and training programs, however, remains a matter of institutional choice. Variability of institutional priorities and resources results in wide differences in the quality and quantity of educational exposure students receive to any subject area.

Credentialing

Mechanisms to ensure that particular subjects are addressed in the education and training of health and social service professionals include:

1. the establishment of Federal or State requirements in designated subjects and skills for personnel employed by facilities that provide particular services;
2. the inclusion of specific curricular requirements in the accreditation criteria for academic programs; and
3. the incorporation of material related to particular topics on licensure examinations.

No concerted effort has been made to date, however, to ensure knowledge about and experience with dementia patients among personnel employed by facilities and programs serving them.

- **Regulatory requirements:** States and the Federal Government impose few requirements for the training of professionals and paraprofessionals employed by programs and facilities that provide long-term care. They rely on the educational process to provide adequate training in subjects and skills related to patient care. This system fails to account for qualitative and quantitative differences in educational programs that can translate into vastly different levels of preparation among individuals with the same professional title.
- **Accreditation criteria:** Accreditation is one mechanism through which academic training in specific subjects can be standardized for students of particular health or social service professions. At present, however, accreditation committees make few specific curricular requirements. They focus instead on general requirements regarding the overall structure and management of the academic facility. Decisions regarding program requirements, curricular content and format, and allocation of resources are left to individual academic institutions,
- **Professional licensure:** The licensing process is a means of ensuring that professionals seeking employment in particular sectors have a certain degree of related expertise. Licensure examinations and requirements are established and administered primarily by States or professional organizations. State Boards of Nursing, for instance, give examinations developed by the National League of

Nursing; and the American Medical Association's National Board of Medical Examiners develops exams for physician certification. The degree to which certification examinations test for knowledge and skills in areas related to dementia (e.g., geriatrics, long-term care, and mental health) varies among the professions and areas of specialization. Testing specifically about dementia, however, ranges from little to none. Through inclusion of questions testing for knowledge about aging and dementing illnesses, boards that oversee licensure and certification of health and social service professionals may help emphasize the importance of teaching about these subjects.

Resources for Teaching About Dementia

Efforts to educate students and practicing professional and paraprofessional staff about dementing disorders are hindered by a lack of teaching resources, as mentioned earlier. Academic institutions, patient care facilities, and community programs note their need for faculty, textual material, and quality clinical opportunities to provide training in the diagnosis and care of dementia patients.

Recent attention to questions about diagnosis and treatment of persons with dementia has dramatically increased the amount of related written material. While textbooks for health and social service professionals have begun to address the subject, many programs rely on journal articles to provide the latest information about diagnostic and treatment strategies for dementia patients. Journals offer the benefit of exposing students to a variety of perspectives, to current theories about the diseases, and to innovative ideas regarding methods of treatment and care. The transience of the information in periodicals, however, complicates the task of curriculum planning and teaching about dementing illnesses. The absence of a discrete body of information regarding techniques for diagnosis, treatment, and care compounds the difficulties of teaching about the diseases, and may inhibit schools' ability and willingness to formally incorporate teaching about dementia into their curricula.

Opportunities for practical experience with persons with dementia are important in training health and social service professionals and paraprofessionals to work with them. Recognition of the nursing home as an excellent setting for students to gain clinical experience in working with the elderly led to the development of the "teaching nursing home" concept. Universities, particularly those with strong academic programs in geriatrics, have increasingly incorporated clinical rotations and practicum in these facilities as a core part of the curricula for students of health and allied health professions. However, the quality of the facility is critical to determining the quality of students' experience with, understanding of, and interest in working with dementia patients. Geographic factors and absolute numbers of students may make access to facilities with quality programs difficult for academic institutions.

A supply of faculty knowledgeable about and interested in working with dementia patients is critical to teaching students about dementing disorders. The shortage of faculty with expertise in such areas as geriatrics, geropsychiatry, and long-term care is critical. A recent report by the Department of Health and Human Services' Ad Hoc Committee on Enhancement of Training in Geriatrics and Gerontology estimated that only 5 to 25 percent of the numbers of required trained faculty are available to teach geriatrics in health and allied health schools (see table 9-1) (71). In addition, about 450 faculty members with combined expertise in mental health and aging are needed

Table 9-1.—Number of Faculty Members Needed To Teach Geriatrics by 2000^a

Profession	Number needed
Medical schools—physicians ^b	1,300
Nursing schools	1,300
Social work schools	1,000
Pharmacy schools	300
Clinical psychology programs	450

^aFigures represent the minimum number of faculty members with a Primary commitment to teaching about geriatrics that would be required by the various health and allied health professions. In most cases, the estimates assume a need for three faculty members with expertise in geriatrics for graduate-level programs and two for undergraduate programs.

^bA 1980 Rand Corp. study of physicians' role in geriatrics estimated a need for 1,350 physician faculty members to teach medical school about aging. Of these, 900 would be geriatricians and 450 would be geropsychiatrists. The numbers were based on a minimum of three faculty members in each school, with additional faculty members to guide medical residency programs (41).

SOURCE: Adapted from U.S. Department of Health and Human Services, National Institute on Aging, *Report on Education and Training in Geriatrics and Gerontology*, Administrative Document, 1984.

for schools of medicine, nursing, and social work (76).

Fellowships and training grants are effective ways to augment the population of teachers and researchers in a specialized area. The opportunity for physicians to pursue postresidency fellowships in geriatrics, for instance, has increased the number interested in and qualified to pursue research and teach in field of geriatric medicine.

Continuing education is another important way to enhance the knowledge and skills of practicing professionals and paraprofessionals. Its impact on the quality of practice may be more immediate than that of curricular modification at the undergraduate and graduate level (17). It is particularly important in the health professions, where knowledge and understanding of diseases, diagnostic and treatment techniques, and approaches to care are rarely static.

Federal Funding of Education

Much of the impetus for developing programs for preparing health and social service professionals in geriatrics and long-term care has come through Federal funding of education. Title VII of the Public Health Service Act provides institutional and student support for schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, and health care administration. Title VIII provides similar support for nursing schools and students. The initial intent of the legislation in 1963 was to respond to reported shortages of health personnel at that time. The program sought to increase enrollment and to ensure the financial viability of health profession schools.

By 1974, the aggregate supply of health personnel had improved significantly. The remaining problem in the supply of health professionals was reportedly one of geographic and specialty maldistribution (78). Congress had revised the program to address these personnel shortages. One effort included the establishment of 11 Area Health Education Centers (AHECs) in 1972. Identifying geriatrics as a field in which trained professionals was in critically short supply, one AHEC was designated to address that gap in 1977. The remaining AHECs are established on a geographical basis rather than topical need.

The Administration has recently sought termination of support for health professional education. Budget proposals in fiscal years 1986 and 1987 recommended no funding for Title VII and Title VIII programs. The Administration contends that Federal subsidy of health professions education is no longer warranted because of the steadily increasing supply and the projected surpluses of professionals (37,56). Geographic and specialty maldistribution are not considered a priority for Federal policy, but would be left to market forces and State and local programs. The Administration's proposal does not address the question of distribution problems in the health professions.

Congressional and academic opponents of the Administration's position point out that the programs no longer seek a universal increase in the number of health professionals. At present, both Title VII and Title VIII are highly specific in their intent to address the shortage of health professionals in particular geographic areas and sectors of health care (e.g., family and internal medicine, or nursing administration) (56). They contend that the loss of funds will impede efforts to address problems of distribution of health professionals.

Support for Medicine and Related Professions

In October 1985, Congress enacted legislation extending primary care training authorities under Title VII of the public Health Service Act and requiring the Secretary of Health and Human Services to give priority to applicants who demonstrate a commitment to family medicine, general internal medicine, and general pediatrics in their medical education training programs. Public Law 99-129 also extended the Area Health Education Centers program designed to provide training for health professionals in geographically underserved areas and professionally underrepresented sectors of health care. In addition, the law set aside funds for geriatric training programs for health professionals.

Support for Nursing

The 99th Congress also acted to defend nursing education programs from the Administration's proposed cuts. The Administration's fiscal year 1987 budget sought to terminate funding for Ti-

tle VIII nurse training, reasoning that the present supply of nurses is adequate to meet the Nation's health care needs.

An Institute of Medicine study done in 1982 found, however, that although the number of generalist registered nurses may have increased sufficiently, nursing shortages persist in certain geographic areas and in particular health care settings and nursing specialties (39). (The undersupply of professional nurses in long-term care is described later in this chapter.) In addition, observers note that the demand for nurses with advanced degrees continues to exceed schools' ability to prepare advanced level nurses to work as educators,

administrators, and supervisors (61,67). The Administration's fiscal year 1987 budget would eliminate funding for advanced nurse training programs and nurse practitioner programs.

The Nurse Education Act of 1985 (Public Law 99-92), signed in July 1985, reauthorized the program for nursing special education projects. The legislation emphasized the need for programs that prepare nurses in a variety of settings—acute care, long-term care, ambulatory, and noninstitutional—and for programs that seek to improve the specialty and geographic distribution of nurses in the United States.

PROFESSIONALS AND PARAPROFESSIONALS IN LONG-TERM CARE

This section describes the groups of professionals and paraprofessionals who play a primary role in diagnosis, treatment, and care of persons with dementia in long-term care facilities and noninstitutional programs. It identifies factors that contribute to the difficulties programs and facilities experience in attracting and retaining qualified personnel, and describes various educational, institutional, and governmental efforts to address the problem. The major role played by family members in caring for dementia patients is described in chapter 4.

Nurses

Although the number of nurses working in long-term care has risen significantly since 1972, it has not kept pace with the increase in the number of patients. Between 1972 and 1980, the percentage of nurses working in long-term care facilities rose by 42 percent, and the number employed by home health agencies by 200 percent (11). At present, however, the 18,000 nursing homes in the United States employ a total of 60,000 registered nurses, an average of just over three per facility (22). Because of their central role in providing long-term care, the shortage of nurses and their short job tenure impede the delivery of quality care to the many persons served by these facilities and programs. The average nursing home

resident receives 12 minutes of registered nursing care per day in a skilled nursing facility (SNF) and 7 minutes per day in an intermediate care facility (ICF) (28).

The Health Care Financing Administration predicts that by 1990 there will be a shortfall of 75,000 nurses in nursing homes alone (73). Moreover, the shortage of long-term care nurses may severely limit the potential of home health, adult day, and respite services to offer alternatives to nursing home care for the chronically ill.

Nurses employed by facilities and programs providing long-term care services frequently lack educational training and experience in caring for the chronically ill. That lack is attributed, in part, to an educational process that stresses acute rather than chronic care and that provides little experience with and information about caring for mentally ill or elderly patients.

Several additional factors exacerbate the shortage of nurses in gerontologic and long-term care:

- the growth of the over-75 population, whose high incidence of chronic illness and severe functional impairments creates an increased demand for long-term care services;
- noncompetitive salaries, limited opportunities for career advancement, and unfavorable work conditions for nurses in nursing homes and other long-term care facilities;

- the expansion of nursing roles and functions in long-term care of elderly and chronically ill patients;
- the growth of agencies and programs (e.g., home health and adult day care) providing noninstitutional long-term care;
- decreased enrollment in nurse training programs;
- limited material related to geriatrics and chronic care in basic nursing curricula;
- the limited number of programs providing training in gerontological nursing and long-term care, and low enrollment in these programs; and
- reduced funding to support institutional development and student education in gerontological nursing and related areas (59).

The shortage of professional nurses desiring employment in long-term care may have similar consequences for both inpatient facilities (e.g., nursing homes) and alternative care programs (e.g., adult day care, home health care, and respite care) that serve these individuals. Each may be forced to rely on nurse's aides and other paraprofessionals to function as the primary care providers. Although many day-to-day patient care tasks may be fulfilled by these paraprofessionals, given adequate training and preparation, evidence indicates that they are frequently granted responsibility for procedures that should be performed by professional health care staff (e.g., preparation and administration of intravenous medication, blood transfusion, or insertion of nasogastric tube) (16).

Nurses' Roles in Long-Term Care

The limited number of professional nurses on staff results in increased responsibility for those working in facilities and programs offering long-term care services. For example, in addition to delivering direct patient care, an RN at a nursing home may act as staff supervisor and patient discharge planner, conduct therapeutic socialization groups, coordinate the volunteer program, and conduct staff inservice education programs. Although that approach attempts to gain maximum utilization of a scant resource, the difficulty of fulfilling too broad a range of responsibilities may diminish a nurse's effectiveness, detract from the quality of care, and contribute to the job dissatis-

faction and short job tenure prevalent among registered nurses in this field (19,59,63).

An increasingly important role of nurses, in both institutional and noninstitutional settings, is supervising and training paraprofessional staff and keeping administrative records. Many nurses, particularly in long-term care facilities, spend the majority of their time performing administrative duties rather than indirect patient care. Most basic nursing programs, however, fail to provide training in these duties. The 1985 Invitational Conference on Issues and Strategies in Geriatric Education noted the importance of case management skills and of supervisory and teaching skills for nursing students, given their burgeoning role in long-term care, and encouraged the integration of these skills into basic nurse training programs (14).

Documenting compliance with regulatory requirements for long-term care facilities and programs consumes a vast amount of nursing time. Registered nurses assume primary responsibility for administrative detail and paperwork, leaving direct patient care to nurse's aides, orderlies, and volunteers. Studies indicate that nurse administrators give cost containment a higher priority than quality assurance in their efforts to comply with regulations (42). (The effectiveness of regulatory requirements as a means of assuring the delivery of quality care is described further in ch. 10.)

Recent studies of long-term care facilities and programs in the United States cite the lack of consistent, professional leadership as a major cause of problems related to employee motivation and turnover. Directors of nursing, one study revealed, tend to regard their positions as temporary—few had held their position for longer than 1 year. Instability in facility leadership exacerbates problems of staff turnover and proves damaging to staff morale. Nursing staff show little respect for or responsiveness to a continually changing leadership (42).

Salaries and Benefits

Noncompetitive salaries, limited opportunities for career advancement, and unfavorable work conditions are seen as significant factors in the

undesirability of nursing positions in long-term care facilities and programs. One survey found that staff nurses in nursing homes earned an average of 20 percent less than hospital nurses (45). A comparison of benefits received by nurses employed in different settings revealed that only 9 percent of nursing home nurses received paid vacations and sick leave and that only 11 percent had retirement programs or were provided with health or life insurance plans. The situation is similar for nurses employed by respite, adult day care, and home health programs. By contrast, of hospital nurses surveyed, all received paid vacations and holidays, and almost all had employer-provided health insurance and retirement plans (77).

Nursing Education

Several categories of nurses are licensed to practice. The licensure requirements and scope of responsibility of each category vary with the extent and nature of their educational training.

Registered nurses are professional nurses licensed by individual State boards of nursing. By virtue of their training, RNs are certified to assume nursing roles and duties that other nursing personnel (e.g., LPNs and nurse's aides) are not. Students can prepare for RN licensure in three ways:

1. Baccalaureate programs, offered in 4-year colleges and universities, require 2 years of pre-professional and 2 years of professional study. Graduates receive a baccalaureate degree in nursing, and are eligible to take the State nursing board examination for registered nurses.
2. Diploma programs, offered in hospital schools of nursing, confer a diploma in nursing after successful completion of 2 to 3 years of post-high school study. Graduates of these programs do not receive an academic degree, but are qualified to take the State nursing board examination for registered nurses.
3. Associate degree programs, usually offered in 2-year community technical or vocational colleges, lead to an associate degree in nursing and qualify graduates to take the State nursing board examination for registered nurses.

Recent surveys confirm the low interest among RNs for work in long-term care facilities: Ninety percent of graduates from each of the three types of RN training programs take positions in hospitals; only a small portion opt for nursing home employment (52). The survey did not report on the selection of noninstitutional long-term care nursing positions. Baccalaureate program graduates showed nursing home jobs to be their least preferred employment choice (3.9 percent); diploma and associate degree graduates marked them as the next to least preferred.

A recent Institute of Medicine study found that employment profiles of RNs generally followed that pattern (see table 9-2) (39). The survey was based on responses of nurses aged 35 to 37, an age at which the National League for Nursing believes the career preferences for these professionals are best measured.

Licensed practical nurses are technical nurses licensed by individual State boards of nursing. Most LPNs train in vocational, technical, or community colleges (39). The programs range from 11 to 24 months in length, with the first 2 to 3 months spent in the classroom and the remainder divided between classroom (40 percent) and clinical (60 percent) learning.

Although no national standards differentiate the patient care tasks of LPNs from those of RNs, a recent study identified 78 nursing tasks performed in long-term care facilities. The study asked nurse educators to evaluate which groups of nursing personnel (LPNs, RNs, nurse's aides) were qual-

Table 9.2.—Registered Nurses Aged 35 to 37 in Selected Types of Employment^a

Type of employment	Degree program		
	Baccalaureate	Diploma	Associate
Hospital	45.4	47.5	67.4
Nursing home	3.9	7.3	6.7
Public and community (health, student, and occupational health).	15.4	9.0	6.1
Nursing education	4.3	1.2	0.6
All others,	6.4	10.0	7.5
Not employed in nursing	24.6	25.0	11.7

^aAccording to highest levels of educational preparation, November 1980

SOURCE: Institute of Medicine, *Nursing and Nursing Education Public Policies and Private Actions* (Washington, DC: National Academy Press, 1983)

Table 9_3.—Distribution of Nursing Task Responsibilities (in percent)

Task	Nurse's			Task	Nurse's		
	aide	LPN	RN		aide	LPN	RN
Administer cardiopulmonary resuscitation.	1.3 ^a	35.7	28.7	Irrigate vagina (douche)	35.0 ^a	28.9	5.6
Administer cough and deep breathing exercises	27.8	28.9	10.6	Make patient's bed: occupied.	76.6	6.1	1.0
Administer gavage feedings	2.8 ^a	44.8	23.8	Make patient's bed: unoccupied.	87.2	3.0	1.5
Administer oxygen therapy	11.9 ^a	40.0	15.0	Measure intake and output	63.0	15.5	2.0
Administer oxygen treatment	11.6 ^a	38.8	19.0	Place patient in correct alignment.	51.9	14.8	3.7
Apply cold treatments	23.8	39.9	5.7	Practice range of motion exercises with patient	44.4	15.0	2.2
Apply elastic bandages	29.7	37.9	5.1	Prepare and give injections	0.0 ^b	49.7	6.7
Apply elastic stockings	44.7	27.9	3.6	Prepare and give intravenous medications	1.4 ^a	20.7 ^a	64.1
Apply heat treatments	18.3	46.1	6.3	Prepare and give oral medications	4.2 ^a	46.9	5.2
Apply restraints	58.9	15.3	3.7	Prepare and give rectal medication	7.3 ^a	41.7	5.2
Apply sterile dressings/bandages,	9.5 ^a	50.5	9.5	Prepare and give topical medication	9.3 ^a	41.5	5.7
Assist patient dressing/undressing	81.0	4.5	3.0	Provide oral hygiene	80.3	4.4	1.5
Assist patient in/out of bed	80.0	4.5	2.5	Provide perineal care	72.0	9.5	2.0
Assist patient using bedpan	82.4	4.8	2.1	Provide skin care to comatose or paralyzed patients	61.5	13.2	3.3
Assist patient using bedside commode,	83.7	3.7	2.1	Record intake of food/fluids	51.0	14.6	2.5
Assist patient using urinal	88.3	3.3	2.7	Record output (feces, urine, vomitus, etc.)	51.3	15.2	55.1
Assist patient walking	73.4	6.5	2.5	Record patients's height/weight.	58.2	11.4	2.5
Bathing patient: bed	80.9	8.0	0.5	Remove/clean inner cannula of tracheotomy	1.5a	35.3	33.1
Bathing patient: shower	86.5	3.6	1.0	Record temperature, pulse, respiration, and blood pressure	39.7	19.1	5.0
Bathing patient: tub	86.2	3.1	1.0	Regulate blood transfusion	0.0 ^b	22.8 ^a	49.0
Care for decubitus ulcers (bedsores)	15.1	43.8	5.2	Regulate intravenous flow	2.2 ^a	33.3	36.2
Care for patient in isolation.	34.7	28.7	7.8	Remove fecal impaction	33.2 ^a	29.5	4.7
Check for fecal impaction	39.2	25.8	5.2	Rub patient's back	73.2	4.6	1.5
Collect stool specimen	53.6	16.5	4.1	Serve food trays	75.6	3.5	2.0
Collect urine specimen	56.2	16.3	3.0	Start blood transfusion	4.2 ^a	3.4 ^a	83.2
Comb patient's hair.	83.8	3.5	1.5	Start intravenous fluids	0.0 ^b	4.7 ^a	85.8
Count apical pulse.	30.3 ^a	23.4	5.5	Suction patient's nose.	25.0 ^a	30.6	13.7
Count radial pulse	39.9	17.2	5.6	Suction patient's throat.	11.3a	44.4	13.1
Count respirations	44.4	16.7	4.0	Suction patient's tracheotomy	2.1 ^a	39.2	29.4
Cut patient's finger/toe nails	60.4	17.2	3.6	Take blood pressure	41.2	17.1	3.0
Discontinue blood transfusion	3.7 ^a	38.8	34.3	Take temperatures axillary	54.4	15.0	4.1
Discontinue intravenous fluids	10.6 ^a	38.3	22.7	Take temperatures orally	55.4	12.4	3.0
Empty/record drainage from tubes	51.2	17.7	9.1	Take temperatures rectally	54.5	15.8	2.5
Engage in OT with patients	55.8	12.8	7.7	Transport patient in wheelchair.	70.7	4.5	2.0
Feed patients	68.1	5.9	2.0	Transport patient on stretcher	62.6	12.3	1.8
Give enemas	47.7	26.1	2.0	Test urine for sugar/acetone	56.2	17.0	3.6
Insert naso-gastric tubes	0.0 ^b	26.2 ^a	49.0	Turn patient	71.1	4.6	20.5
Insert urinary catheter.	0.5 ^a	51.1	11.3	Weight/measure patient	67.0	9.9	3.4
Irrigate colostomy	5.4 ^a	46.4	16.3				
Irrigate urinary bladder	4.6 ^a	48.6	13.9				

^aSignifies a task for which employee has not received preemployment training

SOURCE: K W Beaver, "Task Analysis of Nursing Personnel Long-Term Care Facilities in Utah," Ph D dissertation, Brigham Young University 1978

ified to perform each task, and surveyed nursing personnel in 79 reputable long-term care facilities as to their performance of these tasks (see table 9-3). While nurse educators deemed LPNs qualified to perform 74 of the 78 tasks, LPNs surveyed revealed that they routinely perform all 78 tasks (16). (The four tasks nurse educators deemed inappropriate for LPNs to perform were insertion of nasogastric tubes, preparation and administration of intravenous medication, regulation of blood transfusions, and starting blood transfusions or intravenous fluids,)

Nurse specialists are those who have completed graduate education or fulfilled certification requirements in a particular area of nursing. Such opportunities are generally available only to certified RNs (more specifically, to RNs who have obtained their licenses through a baccalaureate degree program).

The American Nurses Association (ANA) and 12 nurse specialty associations offer specialty certification to RNs who meet their eligibility requirements. Requirements may be practical and/or aca -

demic. The American Board of Urologic Allied Health Professionals is the only organization that permits LPNs to apply for specialty certification (39).

Although no specialty association exists for nurses in gerontological practice, the ANA offers a certificate in gerontological nursing to those with 2 years practical experience, and certifies as "gerontological nurse practitioner" those who complete a formal practitioner program outlined in ANA's "Guidelines for Nurse Practitioner Programs" (see description that follows). As of 1985, 49 of 131 institutions with accredited nursing master's programs offered master's training in geriatric nursing. Three offered graduate training in geropsychiatric nursing (53).

Other fields in which the ANA offers specialty certification (e.g., adult clinical specialist, psychiatric and mental health nurse, and adult and family nurse practitioner) address the care of mentally ill, aged, and long-term care patients, and may therefore include information about and experience with individuals with dementia.

Nurse practitioners (NPs) are a subgroup of nurse specialists. They are registered nurses who complete an academic program (approximately 1 year) to obtain skills and knowledge that permit them to collaborate with physicians,

This category of health professional is a new one, but it is developing rapidly. As of 1985, eight accredited programs provided training for geriatric nurse practitioners (GNPs) (53). Several other practitioner programs (e.g., family and adult nurse

practitioner, and psychiatric nurse practitioner) include content relevant to serving geriatric and long-term care patients. As of March 1985, the ANA had certified 466 GNPs. By comparison, it certified 4,363 family nurse practitioners and 3,770 adult nurse practitioners (12).

Evaluations of the role NPs might play and the effectiveness of the physician/NP team have been favorable (39). The Congressional Budget Office reports that these professionals are about one-third to one-half as costly as physicians per hour of work, and that they spend more time with each patient (70).

One assessment of present and future personnel needs in caring for the elderly evaluated the role of the geriatric nurse practitioner. The study projected that with moderate delegation of responsibility by physicians to GNPs and physician assistants, the number of primary care physicians needed to care for the elderly in 2010 could be reduced by 25 percent. With maximum delegation to GNPs, the number could drop by 44 percent (See table 9-4) (41). These figures are based on current levels of utilization and assume a role for geriatric specialists and medical subspecialists (e.g., surgeon, cardiologist, or gastroenterologist) in addition to primary care physicians. The study projected a need for 12,000 to 20,000 GNPs by the year 2010. Only 466 GNPs were registered by the ANA as of March 1985 (12).

State law and reimbursement regulations are two influences on the role NPs may play in the delivery of primary care, the tasks they may per-

Table 9.4.—Physician and Nonphysician Personnel (in FTEs) Needed in 2010 to Care for Elderly Population, By System of Delegation*

Mode of practice	Moderate delegation					Maximum delegation				
	GS	MS	PCP	GNP/PA	SW	GS	MS	PCP	GNP/PA	SW
Status quo	520	1,109	26,914	11,622	3,766	391	1,109	19,852	19,479	7,532
Consultative	11,702	8,330	21,156	12,169	3,941	8,618	8,330	15,692	20,398	7,882
Primary care	18,205	8,330	17,026	12,169	3,941	13,329	8,330	12,739	20,398	7,882

KEY: FTE full-time equivalent; GS geriatric specialist; MS medical subspecialist; PCP primary care physician; GNP/PA general nurse practitioner/physician assistant; SW social worker.

abased on current utilization levels. cMaximum delegation: Nonhospital care Hospital care
 dModerate delegation: Nonhospital care Hospital care
 650/0 MD 90% MD @0/0 MD 80% MD
 25% GNP/PA 10% GNP/PA 40% GNP/PA 200/0 GNP/PA
 10 %/0 Sw 0% Sw 20 %/0 Sw 0%/0 Sw

SOURCE: Adapted from R.L. Kane, D.H. Solomon, J.C Beck, et al., *Geriatrics in the United States: Manpower Projections and Training Considerations* (Santa Monica, CA: Rand Corp., 1960).

form, and the degree to which they must be supervised by a physician. With the evolution of NP training programs, some States amended physician and nurse practice acts to allow NPs to perform some medical procedures previously reserved for physicians. Other activities (e.g., drug prescription, and certain diagnostic procedures) may be done by NPs only under physician supervision, as defined by the State. Under Medicaid and Medicare regulations, certain services are unreimbursable unless supervised or performed by a physician. In this way, the regulations define the role NPs play in patient care and influence the willingness of health care institutions to employ these professionals (62)85).

A Nursing Home Demonstration Project at the University of Utah tested the use of NPs as primary caregivers to long-term care patients. Their responsibilities included:

- definition of observational boundaries or “progress benchmarks” to be used by staff in recognizing and reporting significant change in a patient’s condition;
- instruction of nursing staff to foster understanding, skills, knowledge, and values fundamental to quality long-term care;
- evaluation of patient progress;
- assessment of need for, administration of, and interpretation of diagnostic procedures (e.g., hematocrit and urine tests, blood sampling and blood chemistry work-ups, and radiographic studies);
- determination of need for therapy, further assessment, or referral;
- education of patient and family about diagnosis and care plans; and
- 24-hour emergency availability (55).

Nursing Curricula

The importance of cognitive knowledge and clinical experience in determining career preferences is well documented. A greater emphasis on geriatrics and long-term care in nursing education, therefore, is seen as critical to addressing the nursing shortage in these fields (18).

Since the mid-1970s efforts to include geriatric content into basic (RN and LPN) nursing programs have grown. The Nurse Training Act of

1975 (public Law 94-63) and its amendments emphasize the problems of providing health care for the elderly and the need for staff development through education. Through the Bureau of Health Professionals’ Division of Nursing, the legislation supports efforts to integrate geriatrics into the curricula of both basic and advanced degree nursing programs (75).

The majority of entry-level programs, however, still include little theoretical or clinical content in geriatrics and long-term care (43). Moreover, because much of the impetus to incorporate geriatrics into basic nursing curricula and to establish programs for advanced training in geriatric nursing has come through federally funded grants and contracts, reduced funding for nursing programs in fiscal years 1986 and 1987 may curtail future progress.

Nursing programs are under no obligation to teach these subjects. Curricular content in nursing programs remains a matter of institutional choice. The National League of Nursing, the accrediting body for academic nursing programs, does not issue written quantitative or minimum curricular requirements (39). Funding constraints and access to resources, faculty, and clinical training sites contribute to the broad disparity in the quality and quantity of material related to geriatrics, mental health, and long-term care in both undergraduate and graduate nursing programs.

Several modifications in standard nursing curricula could facilitate students’ preparation for and interest in gerontological and long-term care nursing:

- **Differentiation of acute and chronic illness:** Current nursing education focuses heavily on the acute care patient. Fundamental differences in treatment and prognosis make it necessary to distinguish between acutely and chronically ill persons. An approach that incorporates assessment and management of functional and rehabilitative restrictions of the chronically ill would broaden nursing students’ understanding of these patients’ care needs.
- **Assessment skills:** Expanding the range of assessment skills taught to nursing students may enhance their ability to contribute to the

diagnosis and care of chronically ill patients. In addition to standard assessment of physical status, nurses who work with the chronically ill may be asked to assess the patient's self-care abilities, cognitive skills, living environment, and social interactions. Particularly in long-term care settings, nurses maybe the most appropriate professional to perform a comprehensive assessment of patient status.

- **Case-management:** Because of the wide range of professionals and agencies that can play a role in caring for the chronically ill, it may be useful for nursing programs to prepare nurses to work with patients and families in locating appropriate services and identifying the optimal setting for care.
- **Patient/family education:** Nurses working with the chronically ill may teach patients and families how to perform daily activities and how to modify the physical environment to enhance the patient comfort, safety, or ability to cope. These skills are often omitted from programs that emphasize disease processes and medical regimens.
- **Training and supervising paraprofessionals:** Because much of the daily care for chronically ill persons in nursing homes is provided by paraprofessional staff, nurses are increasingly expected to train and supervise these employees. To ensure the maintenance of quality care, nurse training programs should include skills necessary for training and supervising paraprofessional and nonprofessional staff.
- **working within a multidisciplinary team:** As described earlier, the model of care that emphasizes a multidisciplinary team approach to care is different from the physician-based model used in most acute care settings. Clinical exposure to settings where nurses participate in the team approach is important in preparing nursing students for that role.
- **Administrative and supervisory skills:** Finally, because nurses are increasingly expected to supervise and train paraprofessional staff and to assume primarily responsibility for administrative detail and paperwork, these skills should be integrated into basic nurse training programs.

Incorporation of material related to geriatrics and long-term care is fundamental to preparing nurses for work in this increasingly prominent field. The knowledge and skills nursing students acquire in studying and working with elderly and chronically ill persons are an important basis for their ability to work with patients with a dementing disorder. Information about and experience with mentally ill patients may further enhance nurses' capacity to work with individuals who have dementia.

There is no single point in the course of nurse training at which it is "correct" to teach about dementing disorders. The subject maybe addressed in a course about aging and disorders prevalent among the aged; it may be incorporated into a unit on psychiatric disturbances or necrologic impairments; it maybe described along with other chronic degenerative diseases. However, several topics related to the diagnosis, treatment, and care of dementia patients could be incorporated productively into one or more segments of the required nursing curriculum. These include:

- a list and definitions of dementing disorders;
- assessment techniques (physical, emotional, functional, psychosocial, intellectual);
- common behaviors of persons with dementia (disorientation, wandering, incontinence, drug reactions, aggressiveness);
- interview techniques;
- sensory stimulation and assistance with activities of daily living;
- role of therapeutic techniques (physical, psychological, medical, speech, recreational, occupational);
- clinical progression;
- role of the family;
- environment modification;
- management with minimal restraints (chemical and physical); and
- need for consistent, continual orientation cues (20).

Nurse% Aides

Nurse's aides spend more time with patients and provide more direct patient care than any other group of personnel in long-term care facilities. Re-

cent estimates suggest that 80 to 90 percent of care in nursing homes is given by aides (3,29). This important group of employees, however, also has the lowest level of educational and preemployment training (see table 9-5) and the highest rate of turnover (34,35). Annual turnover rate among nurse's aides averages 75 percent (3).

Lack of preemployment preparation and in-service training, low wages, and the absence of employee benefits, recognition, and opportunities for advancement all contribute to the intense job dissatisfaction and rapid turnover among nurse's aides. A survey of aides at 40 nursing homes in the Detroit area (34) found that:

- only 49 percent were high school graduates;
- only 11 percent had been taught anything concerning geriatrics, gerontology, or problems of the aged;
- 51 percent had received no formal orientation or in-service training (most had been trained by another aide);
- most facilities provided no pay differential in accordance with level of academic achievement or relevant job experience;
- few facilities offered opportunities for career advancement based on experience gained or training pursued during employment;
- monetary rewards and employment benefits (e.g., sick days, paid vacation time, or health insurance) were negligible or nonexistent;
- only 35 percent received pay increases based on seniority; and
- of the aides whose tenure exceeded 5 years, half had received no salary increase and had

been at minimum wage since their initial employment.

In the task analysis study of 78 nursing duties described earlier, nurse's aides were found to routinely perform nursing tasks for which nurse educators deem them unqualified (see table 9-4) (16). Although a panel of nurse educators identified 27 tasks for which they deemed aides insufficiently trained, nursing staff of long-term care facilities reported that aides routinely perform 74 of the 78 tasks. For example, facilities indicated that it is not uncommon for nurse's aides to administer oxygen, discontinue intravenous fluids, or give medication, each of which the nurse educators deemed aides insufficiently trained to perform.

Most States have legislative requirements for a specific number of hours of orientation and in-service education for nurse's aides, but the quality and quantity of the training are often limited (1). State requirements regarding preservice education and experience are far less specific for these employees than for administrators and professional staff in long-term care facilities. Because nurse's aides provide the vast majority of direct care in these facilities, the absence of specific training requirements is of particular concern.

Owing in part to the high turnover rate, nursing home administrators are often reluctant to provide the resources, particularly release time and funds, for quality continuing education programs for aides.

Federal Efforts To Improve Training

The Nurse Training Act of 1975, mentioned earlier in conjunction with efforts to incorporate geriatrics into nursing curricula, supports efforts to provide training to paraprofessionals and nurse's aides.

Seeking to upgrade the skills of the paraprofessionals who care for the elderly in nursing homes, the Bureau of Health Professionals' Division of Nursing funded seven basic training programs for nursing home aides and orderlies. Among these, Westbrook College instituted a geriatric nurse assistant program to train students in the basic skills necessary for geriatric nursing care in long-term care facilities, to create a deeper understanding

Table 9-5.—Preemployment Requirements for Nurse's Aides^a

Requirement	Yes		No		No response	
	Number	%	Number	%	Number	%
High school graduate	2	12.50	12	75.00	2	12.50
Prior training program	8	50.00	7	43.75	1	6.25
Nurse's aide experience	6	37.50	9	56.25	1	6.25
Written application	14	87.50	0		2	12.5
Personal interview	16	100.00	0		0	
Letters of reference	5	31.25	10	62.50	1	6.25

^aBased on survey of 40 nursing home directors

SOURCE: M. O. Hogstel, "Auxiliary Nursing Personnel: Management of Personnel in Long-Term Care," M. O. Hogstel (ed.) (Bowie, MD: Robert J. Brady Co., 1983)

and awareness of the physical, emotional, social, and religious needs of the elderly. And the Miami Jewish Home and Hospital for the Aged established a regional geriatric training program to upgrade the skills of licensed professional (or vocational) nurses, nurse's aides, and other paraprofessional nursing personnel.

State Efforts To Improve Training

Efforts to improve the training of nursing home personnel are also increasing at the State level. Seventeen States now require training of geriatric nurse's aides (9). To date, however, no State requires that preparatory classes for these individuals include information about dementia and caring for persons with dementia.

The Maryland State Office on Aging designed and administered a project to prepare administrators and nurses in long-term care facilities to train paraprofessional and nonprofessional staff. The project aimed to help these professionals assess the learning needs of their staff and to construct, execute, and evaluate teaching and learning experiences. The group concluded that:

- The morale of paraprofessional and non-professional staff members improves when their practice is based on knowledge rather than on tradition or belief.
- Increased knowledge of gerontology is important for facilitating the evolution of new roles in care for the elderly.
- Certification and recognition are important incentives for and expressions of commitment to the importance of formal learning about gerontology for long-term care positions.
- Readily accessible films, books, and other resource materials are important stimuli and supplementary learning tools (8).

The State of Virginia requires that geriatric nurse's aides receive vocational education prior to employment. For a program to be approved, it must meet State requirements. These include a list of minimum competencies to be incorporated into the training program curriculum. Although teaching about dementing diseases is not specifically required, the topic may be addressed under several subjects that are required (e.g., disorientation; physical, psychological, and sociological

changes of aging; and major disorders of the nervous system). Programs are also required to train students to perform a wide range of nursing tasks and to assist patients in activities of daily living, although there is no requirement for training to perform these tasks with an individual with dementia (81).

Physicians

Although it is difficult to assess the actual number of physicians who provide care for chronically ill patients in and out of health care institutions, it has historically been a field of medicine with low appeal. The number of physicians who provide care for nursing home patients is one reflection of this situation.

Few nursing homes in the United States maintain a full-time resident physician, and the number of physicians who report visiting nursing homes over the course of a year is small. In 1981 only 14 percent of physicians reported visiting patients in a nursing home. That percentage is much lower than the 48 percent of physicians who are family practitioners and internists—those most responsible for nursing home visits by physicians—indicating that few physicians continue to provide care once their patients are admitted to nursing homes (58). Even among physicians declaring geriatrics to be their primary specialty, few report doing any work in nursing homes (49).

Work With the Chronically Ill

Several factors have been cited as contributing to physicians' apparent reluctance to work with the chronically ill, particularly with elderly chronically ill patients:

- **Education:** An educational process that stresses acute rather than chronic care and provides little experience with and information about caring for mentally ill or elderly patients contributes to the lack of interest physicians show for working with these patients.
- **Inadequate financial reimbursement:** Medicaid and Medicare reimbursement rates may be too low to offset the costs and inconvenience of travel to facilities in which long-

term care patients reside (not only nursing homes, but also alternative care settings and individual residences). Administrative difficulties in obtaining reimbursement may create further disincentive.

- **Regulatory disincentives:** Certain regulatory requirements may influence physicians' willingness to serve patients residing in long-term care facilities. (Medicare requires one visit per month for patients in SNFs, although State requirements vary. Medicaid requirements call for one visit every 30 days for the first 90 days in an SNF, and every 60 days in ICFs.)
- **Geographical inconvenience:** The geographic isolation of many long-term care facilities adds to the time and inconvenience of physician visits.
- **Ageism:** Societal bias against the elderly and lack of interest in their needs is often cited as a factor contributing to physicians' attitudes toward working with older patients.
- **Lack of professional recognition:** Working with the chronically ill, for whom there may be no treatment or cure, provides little opportunity for the physician to gain recognition as a competent "healer."
- **Therapeutic nihilism:** Physicians express the frustration and lack of professional fulfillment associated with working with patients for whom there is no cure and no treatment that can significantly alleviate symptoms or impede progression of the illness.

Although the relative importance of each factor has not been established, a recent survey of 4,000 physicians in 15 specialties sought to identify factors that influence willingness to provide care for nursing home patients (see table 9-6) (51). The study did not consider the impact of educational and sociological factors on physicians' decisions, but did evaluate the importance of logistical and practical considerations of providing nursing home care.

Because regulatory requirements and reimbursement rates, particularly for Medicaid, vary by State, it is difficult to generalize about their influence on physicians' willingness to serve patients in long-term care facilities. Nevertheless, nationally applied regulations may have an effect.

Table 9-6.—Characteristics of Physicians Who Visit Nursing Homes^a (‰ distribution)

Characteristics	Visits per week		
	None	1-4	5+
Board-certified	51.8	281	201
Noncertified	537	19.6	267
U.S. medical school graduate	53.5	28.8	237
Foreign medical graduate	51.3	14.8	339
60 years +	47.1	17.1	35.8
Less than 60	56.7	24.4	19.0
Accepts Medicaid	52.5	22.3	25.6
Does not accept Medicaid	55.2	207	24.6
Practice location:			
Large metropolitan	575	191	234
Small metropolitan	51	23.1	178
Nonmetropolitan	428	237	335
Region:			
Northeast	61.7	206	17.7
North Central	45.9	271	27.0
South	53.3	207	26.0
West	50.3	186	31.1

^aBased on a survey of 4000 physicians with office-based practices. The findings therefore may not be representative of all U.S. physicians. Fifteen medical specialties were resampled.

SOURCE: J. B. Mitchell, "Physician Visits to Nursing Homes," *The Gerontologist* 22:45-48, 1982.

Federal reimbursement programs are structured to avoid excessive payment for what are termed "gang visits" by physicians to nursing facilities—visits during which a physician sees many patients over a brief period and claims reimbursement for each, as if each were a separate call. Medicare reimbursement standards recommend comparing a nursing home visit during which several patients are seen to a routine office visit, whereas a visit during which only one patient is seen be considered a house call. Carriers are advised to assume that multiple patients are visited (i.e., reimburse at the lower rate) unless there is distinct evidence to the contrary. Reimbursement at the level of a routine office visit fails to account for costs in travel and time that such visits entail. Thus, reimbursement standards may create a disincentive for physicians to visit patients in nursing homes.

The impact of such regulations on physicians' reluctance to care for these patients is hard to assess. Surveys indicate, however, that physicians who do visit nursing home patients have high case loads there (an average of 11 patient visits per week), constituting over 7 percent of their weekly patient sessions (51). (Other types of visits include those to office, hospital, emergency room, clinic, and private residence.) It is unclear whether that finding reflects instances in which Medicare re-

striations do not apply (e.g., non-Medicare patients in nursing home) or indicates an acceptance of these conditions by physicians working with nursing home residents.

Time spent on nursing home visits does appear to be relevant. Physicians who visit nursing homes report that, including travel time, the average visit takes twice as long (36 rather than 18 minutes) as an office visit (5 I). The additional time and inconvenience may contribute to physicians' reluctance to care for patients in these facilities.

Educational and sociological factors may influence physicians' professional preferences to an even greater degree than the logistical and practical considerations just described. It is through the educational process that students come to regard particular aspects of medical practice as rewarding, and to recognize those areas of medicine that are professionally and societally esteemed.

As noted, physicians' lack of interest in long-term care is attributed in part to an educational process that emphasizes acute rather than chronic care (23,30). The incurability and slow progression of chronic diseases are a source of frustration to physicians whose training stresses dramatic intervention, treatment, and cure. Working with the chronically ill, for whom there are few split-second decisions or heroic cures, is less gratifying for professionals trained in this manner (23).

Several modifications in medical education may enable schools to address that imbalance and thereby prepare professionals who find satisfaction in serving both chronically and acutely ill patients.

- Greater information about and experience with the chronically ill might enhance students' understanding of the different perspective and skills that are required in caring for these patients.
- Physicians who are knowledgeable about and competent in chronic care may serve as important role models and stimulate students' interest in and respect for the physician's role in long-term care.
- An orientation that does not equate "successful treatment" with "cure" could enable health

care professionals in training to recognize the different expectations that must accompany care for chronically ill patients.

- The value of enhancing the functional capacity and quality of life of patients for whom no cure is possible is an important aspect of chronic care to be conveyed to medical students.

Because dementing diseases are chronic and degenerative in nature, modifications of this sort may be critical to stimulating physicians' interest in working with these patients. In that regard, knowledge about and experience with chronically ill patients—particularly elderly and mentally ill patients—may be of equal importance to lectures and classroom discussion about dementing illnesses.

Didactic Content Related to Dementia.—During the first two years of medical school—the pre-clinical years—students spend the majority of their academic time in lectures, seminars, and laboratories. The basic medical sciences (e.g., anatomy, physiology, pathology, neurology, immunology, and biochemistry) are conveyed to first- and second-year students using standard didactic teaching methods.

The absence of content related to aging and to geriatric medicine is widely cited as a critical gap in medical education, contributing to physicians' low level of interest in and knowledge about working with older patients. The 1970s marked the beginning of a dramatic increase in the number of schools that incorporated such material into their curricula. A 1983 survey indicated that 91 percent of U.S. medical schools have incorporated some geriatric material into their curriculum (see table 9-7). Seventy-two percent had some required time for geriatric education; 19 percent offered only elective time for geriatrics. (Of 127 accredited medical schools, 114 schools were surveyed and 100 responded (15).)

Continued efforts to include information about aging and medical care of older persons are important for many reasons. Whether geriatrics should be introduced as a separate, required subject or integrated into other core courses remains subject to debate, but teaching medical students

Table 9-7.—Inclusion of Geriatrics in Medical School Curriculum (percentage)^a

Geriatrics in curriculum	1978	1983
Required curriculum	64	72
Elective curriculum only	36	19
No geriatrics	NR	9

NR: Not reported.

^aBased on survey of 81 medical schools in 1978 and 101 medical schools in 1983.SOURCE: P.P. Barry and R.J. Ham, "Geriatric Education: What the Medical Schools Are Doing Now," *Journal of the American Geriatric Society* 33:133-135, 1985.**Table 9-8.—Schools With Geriatric Curriculum: Percentage of Time Each Year of Medical School^a**

Year in school	Required course	Elective course
First	49	21
Second	55	17
Third	9	19
Fourth	3	84

Many schools have curriculum time in more than 1 year.

^aBased on 1983 survey of 100 medical schools.SOURCE: P.P. Barry and R.J. Ham, "Geriatric Education: What the Medical Schools Are Doing Now," *Journal of the American Geriatric Society* 33:133-135, 1985.

about dementing disorders does not necessarily require a discrete course about geriatrics.

As with nurse training, there is no "correct" time for teaching medical students about dementing disorders (see table 9-8). Although a course about aging and diseases prevalent among the elderly is an appropriate place for describing the various dementing disorders associated with chronic organic brain degeneration, various aspects of the diseases may be described in any number of courses throughout the curriculum. Physiological aspects, for instance, may be described in a neurology course. Assessment techniques may be discussed in a class about psychiatry. Topics such as community resources and the role of the family may be broached during the study of patient management considerations.

Clinical Experience With Dementia Patients.

—The clinical (third and fourth) years of medical education are characterized by practical experience (rotations) in diagnosis, treatment, and care of patients. The elderly and mentally ill are two groups whose specific care needs are frequently overlooked in designing this component.

Because many of the illnesses suffered by older persons are chronic rather than acute, the oppor-

tunity to care for older patients provides students with a different set of experiences. Students gain an understanding of the different role, knowledge, and skills required in caring for the chronically ill. Management of the long-term care patient, for example, may require the physician to head an interdisciplinary team comprising a wide range of health and social service workers. As coordinator, the physician must be able to prescribe drugs as well as services, assess physical as well as emotional needs, and determine the availability and propriety of resources. (Table 9-9 identifies some of the skills relevant to geriatric care that students might be expected to master.)

Table 9-9.—Skills Relevant to Geriatric Care To Be Mastered by Medical Students

- Interview and take an accurate medical history of an elderly patient including functional (e.g., the patient's ability to perform daily activities) and psychosocial (e.g., motivation, morale, family and social interaction, household composition, or productivity) factors.
- Conduct and record a complete physical examination of an elderly patient, including assessment of normal physical signs of aging and of functional ability (e.g., ability to perform daily activities, or mental status testing).
- Distinguish "normal" from pathologic aging (e.g., with respect to cognitive function, psychomotor performance, human sexuality, personality adjustment, and illness behavior).
- Demonstrate clinical decisionmaking skills, accounting for altered clinical presentation of disease in the elderly, multiple illness complexes, patient lifestyle, cost-benefit factors, and prognosis.
- Apply knowledge of clinical pharmacology in elderly patients (interactions and side effects of specific drugs; patient drug use patterns).
- Apply knowledge of rehabilitative medicine in managing the problems of elderly patients (underlying principles, facilities and programs, plan development, and outcome prediction).
- Identify available social resources and programs in planning the care of an elderly patient (financial, health, and social supports, including natural support systems).
- Coordinate and provide for a continuum of care (delivery of integrated care to elderly persons at differing levels of health and social services, such as hospitals, nursing homes, day care centers, and patient's home).
- Participate as part of an interdisciplinary health care team in coordinating assessment and management of elderly patients.
- Provide personalized and empathetic care to patients and their families.

SOURCE: J. C. Beck and S. Vivell, "Development of Geriatrics in the United States," *Geriatric Medicine*, vol. 2, C.K. Cassell and J.R. Walsh (eds.) (New York: Springer-Verlag Publishing, 1985).

In addition to the benefits of enhanced knowledge and training gained through caring for the chronically ill, many argue that exposure to these patients heightens students' interest in caring for them. Until recently, medical schools made little effort to provide students with experience with these patients; any experience gained was likely to be incidental. Facilities in which large numbers of elderly or mentally ill persons reside (e.g., nursing homes) came to be considered undesirable working environments.

The most recent data show that of the 127 American medical schools, 99 have required courses that cover geriatrics, including eight that exclusively focus on geriatrics (70). The clinical settings in which students work with the elderly (hospital, nursing home, outpatient clinic, or patient's home) vary according to the affiliations of the particular school. (Table 9-10 indicates the number of schools offering clinical rotations in each of several types of settings.)

The "teaching nursing home," mentioned earlier, is one innovative approach that allows students to gain experience in caring for chronically ill elderly people. Similar in principle to the teaching hospital, it affords medical students and graduates the opportunity to work with patients in a long-term care facility. The National Institute on Aging and the Robert Wood Johnson Foundation both sponsor projects to develop teaching nursing homes in the United States (74,83).

Graduate Medical Education.—For most students, the 4 years of medical school are followed

Table 9.10.-Medical Schools Using Various Training Sites (percentage)

Training sites ^a	Schools
Nursing home	74
Hospital (university or community)	64
Outpatient clinic	63
Veterans Administration hospital	46
Patient's home	43
Other community sites	33
Family practice center	31
Congregate housing	26
Private practice	23
Day care	19

^aMost schools use more than one site.

SOURCE: P.P. Barry and R.J. Ham, "Geriatric Education: What the Medical Schools Are Doing Now," *Journal of the American Geriatric Society* 33:133-135, 1985.

by a period of internship and residency, during which they gain the additional training necessary to become certified in some branch of medicine. Even those who choose to practice primary care medicine (e.g., internists and family physicians) generally complete a residency program.

The accreditation of residency programs and the certification of physicians completing residency programs provide two avenues for ensuring that physicians in particular medical specialties gain knowledge and experience in the diagnosis and treatment of dementia patients.

Accreditation of a residency program is the process by which the Accreditation Council for Graduate Medical Education (ACGME) grants public recognition to a program providing advanced preparation for physicians in a particular medical specialty. Programs are evaluated by a Residency Review Committee (RRC). Each RRC comprises representatives from the American Medical Association's Council on Medical Education and from professional associations representing that medical specialty (e.g., American Board of Psychiatry and Neurology, or American Board of Internal Medicine) (2).

Certification is the process by which a specialty board grants recognition to an individual physician who has completed a residency program in a particular medical specialty and who has passed an examination of competence in that specialty. Examinations are developed by medical specialty boards within the professional association representing that specialty (2).

Inclusion of material related to dementia is particularly relevant for residents in such specialties as psychiatry, neurology, family medicine, internal medicine, and geriatrics. RRCs for these fields could insist that curricula for residency programs in these specialties include content related to care of persons with dementia. Medical specialty boards in the professional associations representing these medical specialties could design certification examinations that test for knowledge related to diagnosis and treatment of persons with dementia.

At present, no formal board of geriatric medicine exists. Geriatrics is subsumed by other medical specialties, particularly family and internal medicine. Both the American Board of Family Prac -

tice and the American Board of Internal Medicine are working to develop examinations that will enable physicians certified in these areas of practice to pursue added qualifications in geriatric medicine (6).

Under a grant from Pfizer Pharmaceuticals, the American Geriatrics Society (AGS) is developing curriculum guidelines for postresidency training in geriatric medicine. The AGS Geriatric Curriculum Development Committee will forward its recommendations to the ACGME's Internal Medicine Residency Review Committee. If the RRC approves the guidelines, it will recommend their inclusion in the ACGME's next *Directory of Residency Training Programs* (7).

Although a limited number of residency programs in geriatrics has become available in the United States since 1972, few physicians pursue graduate training in geriatrics. Because no formal board of geriatric medicine exists, physicians completing a geriatric residency program cannot obtain formal certification similar to that available in other medical specialties. The absence of opportunities for professional recognition may significantly influence individuals' willingness to pursue training in geriatrics after medical school. The debate about designating geriatrics as a separate area of medical expertise or whether competence in geriatric care should be required of all physicians is widely discussed in the literature.

Postgraduate Medical Education. -Opportunities for geriatric fellowships are increasing. One of the first fellowship programs in geriatric medicine was instituted by the Veterans Administration in July 1978 (26,86). Candidates must be certified in internal medicine, family medicine, or psychiatry.

The Federal Council for Internal Medicine has suggested that such advanced training may generate teachers and researchers in geriatric medicine and care, and may also develop expertise in physicians who wish to become medical directors for long-term care facilities or consultants to those caring for elderly patients with complex medical or psychosocial problems (27).

Social Workers

Social workers' skills in individual and group counseling and their knowledge of local and national resources make them valuable partners in planning and administering care for persons with dementia. They may participate in:

- client intake interviews,
- preadmission counseling of client and family,
- postadmission counseling and followup services for patient and family,
- financial needs assessment,
- utilization of and referral to community resources,
- coordination of volunteer programs,
- case management, and
- discharge planning (19).

Social workers may provide consultative services to other members of the health care team, and in some facilities may act as team leader. In identifying and meeting the psychosocial needs of patients and families, social workers may become involved in client advocacy inside and outside of long-term care facilities (19).

A social worker may also serve as case manager for individuals with dementia and their families. Community referral programs, as well as programs and facilities providing services, may employ a social worker for that purpose. As case manager, a social worker may help patient and family locate appropriate services, identify sources of funding, and monitor services delivered. In consultation with the appropriate health care staff, a social worker may also help identify the optimal setting for care and evaluate the effectiveness of services delivered.

Although social service staff may hold any variety of undergraduate or graduate degrees, this assessment focuses on the educational preparation of those with a master's degree in social work. A master's degree generally requires a minimum of 2 years postgraduate work. During the first year, students complete core courses in social work practice. The foundation material aims to provide students with fundamental knowledge, skills, and guidelines for practice that can be ap -

plied across practice settings, population groups, and problems. Course content includes material related to human behavior and the social environment, social welfare policy and services, special population groups, values and ethics, social work practice, and research methods.

On completion of the fundamental course work, students select a field of concentration (see table 9-11). Common concentrations are in:

- children and youth services,
- family services,
- gerontology,
- health,
 - . mental health, and
 - . social and economic development,

Within these fields, many programs allow students to select a mode of practice (e.g., clinical, administration, programming and supervision, or research) in which to specialize. Through a combination of classroom and experiential learning, students gain knowledge and skills specific to their area of concentration and mode of practice.

In September 1983, the Council on Social Work Education (CSWE) was awarded a 14-month grant by the Administration on Aging to promote the development, adoption, and infusion of geronto-

logical curricula and teaching materials into social work programs. The project was intended to expand the number of social workers equipped to plan and deliver services to the elderly (46). CSWE surveyed all 89 graduate social work education programs regarding their course offerings in gerontology; the information was reviewed and updated in late 1983 and early 1984 (25).

Gerontological social work programs generally require a course in social policy related to aging (e.g., housing, transportation, or medical assistance) and in direct service to the elderly (e.g., skills, knowledge, and resources needed in serving the elderly). Students select additional courses that combine their concentration in gerontology and the mode of practice that they have chosen. Clinicians, for example, might take a course in clinical social work with the aged and their families, while administrators might take a course in senior center administration or administrative issues in financing health care for the elderly.

A large portion of the social work student's academic time—about 3 days per week—is devoted to work experience. Many gerontological programs stress the importance of experience with diverse segments of the elderly population in a variety of settings—those who are relatively healthy and independent, those who are homebound, those in acute care settings and long-term care facilities, and those who are terminally ill. These programs may require students to rotate through a variety of practice settings, including a senior center, nursing home, a hospital outpatient department, and a State, county, or city office on aging. Students learn to evaluate, assess, and manage service, to establish treatment plans, and to counsel older adults and their families,

The curriculum of the gerontological social work program at Syracuse University illustrates the degree to which the core courses and field opportunities may provide information about and exposure to dementia patients:

Processes of Aging: covers organic brain syndromes including comparison with acute dementias, strategies for management, and theories of causation.

Direct Service to the Elderly: 1 class session of 14 devoted to dementia. Texts and journals are the written source materials used.

Table 9-11.—Concentrations Chosen By Master of Social Work Students^a

Concentration	Percent
Gerontology	2.5
Alcohol, drug, or substance abuse	1.2
Child welfare	4.4
Community planning	1.4
Corrections, criminal justice	1.2
Family services	6.5
Group services	0.6
Health	7.2
Industrial social work	0.8
Mental health/community mental health	11.6
Mental retardation	0.7
Public assistance/public welfare	1.0
Rehabilitation	0.5
School social work	1.5
Other fields of practice of social problems	5.0
Combinations	2.0
Not yet determined	21.4
None	30.7

^aBased on 1983-84 survey of 21,569 students enrolled in U.S. master of social work programs.

SOURCE: Council on Social Work Education, "Statistics on Social Work Education," Washington, DC, 1984.

Field Practice: 16 hours per week. Settings include long-term care facilities, psychiatric and general hospitals, senior centers, and State and local agencies on aging. Each may involve students in services for elderly individuals with dementia (68).

other social work concentrations may also include course material and field experience related to the care of individuals with dementia. Students concentrating in mental health, for instance, take courses in chronic mental illness, psychopathology, social policy related to the mentally ill, and group methods in clinical social work or family therapy. Field work in such settings as psychiatric hospitals, community mental health centers, and psychiatric departments of general hospitals may involve them in caring for persons with chronic dementias.

Rehabilitative and Recreational Therapists

Facilities and programs that provide care for persons with dementia may employ one or more rehabilitative or recreational therapists on a part-time or consultant basis. Individuals with training in any number of specialties—occupational, physical, exercise, art, music, or speech therapy—may enrich the quality of care provided. Programs note the positive impact that physical and creative outlets have for persons with dementia—diminishing problematic behavioral tendencies such as wandering, agitation, and aggression:

Exercise Therapy: The opportunity for physical exertion proves particularly important to persons with dementia, many of whom are still quite physically able. Programs note that simple, daily exercise periods significantly diminish patients' restlessness, agitation, and wandering behaviors. In addition, exercises offer a time for group recreation, and help maintain patients' mobility and fitness. Exercise programs may be led by an individual with training in movement therapy. Alternatively, a movement therapist may teach staff how to facilitate an exercise program.

Art Therapy: Art therapy may enhance a program for persons with dementia, offering the opportunity for creative expression, and enabling individuals to gain satisfaction through tangible accomplishment. While a facility may institute an arts and crafts program without the services of a designated art therapist, a specialist's ability to

gain insights into patients' personalities and needs from their creative endeavors may assist staff to serve these individuals better.

Physical Therapy: Larger facilities, particularly nursing homes, may employ a physical therapist to assist individuals with specific mobility problems. For instance, physical rehabilitation may be necessary for a person with dementia who has suffered a hip fracture.

Occupational Therapy: A certified occupational therapist (OT) or certified occupational therapy assistant (COTA), like an art therapist, may contribute to program quality by providing creative and productive projects for persons with dementia. In addition, an individual trained in occupational therapy may design reality orientation programs and sensory stimulation activities for persons with dementia. These programs may be conducted by an OT, a COTA, or another member of the staff trained by one of these specialists.

Speech Therapy: Swallowing difficulties are a common and potentially fatal problem among persons with dementia. The skills of a speech therapist may be particularly important for these individuals.

It is critical that those who provide rehabilitative or recreational therapy for persons with dementia understand the nature of dementing illnesses—the extent to which persons with dementia may profit from therapeutic techniques and from physical, creative, and emotional outlets despite their cognitive and physical deficits. Educational programs in different therapeutic specialties may address these issues to varying degrees, and students may gain clinical experience related to care of persons with dementia. It remains important, however, for facilities and programs employing a rehabilitative or recreational therapist to provide basic training to ensure the adequacy of a professional's knowledge about dementing disorders and skills in communicating with and managing those with dementia.

Psychologists

Psychologists can play an important role in multidisciplinary team care for persons with dementia. They can assist in developing and evaluating strategies that address behavioral difficulties frequently encountered with persons with dementia. Psychologists can provide inservice training

for staff and can help family members learn ways to communicate with and care for individuals with dementia more effectively.

Psychologists offer many direct and indirect services to those in long-term care settings. These can include:

Direct Services: As a staff member or consultant to a facility or program that provides care or refers individuals to appropriate care settings, a psychologist may assist in evaluating and planning individual care needs. Psychologists may perform the initial assessment of a patient's cognitive, intellectual, and behavioral functioning, in order to evaluate the extent of services required and the type of setting that would be appropriate (13). Those skilled in neuropsychological assessment can provide valuable information regarding diagnosis, nursing care, and rehabilitation approaches for older individuals (31,47).

Staff Training: A professional psychologist may provide quality inservice training to staff in long-term care facilities or in programs that provide care for persons with dementia. The need for such training has been emphasized and is evidenced by one national sample of nursing homes that indicated that only 4 percent of long-term care staff ever attended a course on mental or social problems (44). The psychologist can provide substantive information about aging, age-related psychosocial changes, psychopathology in older persons, and intervention techniques for improving patient care and functioning. In addition, this professional may provide insights on the role and function of the mental health specialist in long-term care settings. As a team care coordinator or consultant, the psychologist may further train long-term care staff in carrying out certain treatment processes and objectives (13).

Program Development: A psychologist in the long-term care setting may also assist in facility- or program-wide planning (e.g., milieu therapy or reality orientation), evaluation of existing programs, and policy formulation. The psychologist's knowledge and insights may help identify undefined or unmet needs of older individuals.

A survey done in 1979 of all accredited doctoral and internship programs in clinical and counseling psychology revealed a substantial increase in content related to aging (24). A previous study of 101 doctoral programs in clinical psychology found only one that offered formal training in the

psychology of aging (see table 9-12) (65). A greater number of programs offered training opportunities in the field of aging, though none had classes and practicum as part of the required curriculum. The 1979 survey found that:

- 4 of 104 responding doctoral programs in clinical psychology offer formal programs in the psychology of aging;
- 46 programs carried courses with some content directly applicable to clinical psychology of aging (e.g., neuropsychology, psychological assessment, or developmental psychology);
- 60 programs cited one or more geriatric practicum facilities with which they were associated; five programs required students to work in one of these settings; and
- 64 programs reported faculty interest in or knowledge about the clinical psychology of aging.

Issues related to persons with dementing disorders—assessment and care; the role of the family and role of health care staff caring for those with dementia—are likely to be addressed by advanced degree programs for psychologists specializing in aging, although no formal documentation exists,

Program and Facility Administrators

Administrators of facilities and programs caring for persons with dementia play a major role in planning and delivering care. Their decisions regarding the allocation of resources (e.g., the number and type of staff hired), organizational structure, and program priorities are critical determinants of the quality of services delivered. Therefore, their understanding of the nature of dementing illnesses and patients' needs is a key to the quality of care provided.

It is quite likely, however, that the administrator of a long-term care facility or program has no prior experience with or training related to the care of persons with dementia. Even those who have formal education in health care administration may have received no training on the nature of dementing disorders and patients' specific care needs. Programs that train health care administrators emphasize management skills and responsibilities. They often provide little or no in-

Table 9-12.—APA-Accredited Doctoral Clinical Programs and Internship Programs, 1975 and 1979

Program	1975		1979	
	Number	Percent ^a	Number	Percent ^a
Doctoral clinical:				
Accredited programs	101	—	120	—
Replies	76	75	104	87
Formal programs in clinical psychology and aging	1	1	4	4
Informal programs in clinical psychology and aging	N/A	N/A	15	14
Programs with at least 1 course in aging	25	33	46	44
Programs with 1+ practicum facility in aging	34	45	60	58
Programs with 1+ faculty interested/knowledgeable in aging	38	50	64	62
internship training:				
Accredited programs	118	—	169	—
Replies	97	82 ^b	138	82 ^b
Programs providing formal experience in aging	22	23	56	41
Programs with some contact in aging	42	43	33	24
Programs with staff interested/knowledgeable in aging	31	32	58	42

^aPercentages based on total number of replies received, except where otherwise rated (see note b)
^bpercentage of programs surveyed.

NOTE: N/A means not available

SOURCE: L.D. Cohen and S.G. Cooled, "Psychology Training Programs for Direct Services to the Aging (Status Report: 1980)." *Professional Psychology Research and Practice* 14:720-728, 1983.

formation about specific diseases and individual patient needs,

Formal preparation of nursing home administrators is just beginning to conform to traditional accreditation procedures (84). The Council on Post Secondary Accreditation's Commission on Health Irresponsible for accreditation of programs that train these administrators. The Association of University Programs in Health Administration is currently developing a proposal to examine the educational needs of nursing home administrators. The result may be a model curriculum that would eventually be reflected in educational programs and licensing examinations (84).

A 1984 survey of State licensure requirements found that 11 jurisdictions require only a high school diploma, 19 require a baccalaureate degree, 15 require an associate degree, and 6 have no educational requirements for nursing home administrators (84). Requirements for directors of noninstitutional programs (e.g., respite or adult day care) are even less stringent than those for nursing home administrators. In Virginia, for instance, an individual need only be of sound physical and mental condition to operate a day care facility for persons with dementia (82).

The American College of Health Care Administrators (ACHCA), however, reports recent that States are now making educational requirements for nursing home administrators more rigorous.

ACHCA's 1985 survey found that 42 States require between 15 and 30 hours of continuing education per year for the periodic renewal of licenses (5).

A national licensure examination for nursing home administrators also exists. States establish their own pass/fail standards for the examination. Categories on the test include patient care, personnel management, financial management, marketing and public relations, laws and regulations, and resource management. Approximately one-quarter of the questions are in the category of patient care, addressing such topics as nursing, social, physician, and pharmaceutical services and recreational activities for long-term care patients. The National Association of Boards of Examiners for Nursing Home Administrators reports that the most recent examination contained at least one question about dementia (50).

Volunteers and Survey Staff

Many long-term care facilities and programs rely on volunteers to help provide services to their patients. Volunteers may assist staff in managing patients during mealtime or recreation periods, may help to transport patients within a facility, or may simply visit with patients in the facility or in their home. No Federal or State requirements govern the training of these volunteers. Nonetheless, it is critical for youngsters and adults whose volun-

teer work brings them in direct contact with persons with dementia to have a basic understanding of the nature of dementing disorders and training in appropriate communication with and response to behavioral problems exhibited by these persons. The facility or program using their services or a designated community resource may provide such basic training for volunteers.

Agencies that inspect long-term care facilities and programs are subject to few Federal or State regulations or requirements regarding staffing levels and qualifications. Among the States there are wide variations in the experience and educational background of surveyors and in the composition of survey teams. Nationally, about half the surveyors are nurses, one-fifth sanitarians, and most others engineers, administrators, and generalists (38).

FEDERAL AND STATE STAFFING REQUIREMENTS

States assume primary responsibility for enacting laws and promulgating standards for nursing homes, respite facilities, adult day care centers, and home health care programs. Medicaid and Medicare impose additional requirements on participating long-term care facilities.

Regulatory mechanisms that seek to ensure the delivery of quality care maybe classified as structural, procedural, or outcome-oriented (see ch. 10). Federal and State requirements for long-term care facilities and programs have been primarily structural-establishing standards regarding the physical plant, recordkeeping, and staffing of nursing facilities (1)38).

Classification of Staffing Requirements

Staffing requirements may be categorized broadly as either quantitative or qualitative. Quantitative requirements specify the number of personnel that must be on duty for a given number of residents or beds in a facility. Qualitative requirements specify the number of personnel that must be on duty for a given number of residents or beds in a facility. Qualitative requirements specify the types of personnel who must be em-

ployed, the patient care tasks that must be performed, and the professional qualifications of those who perform them. The degree to which either type of regulation can ensure the delivery of quality care, however, may be limited by the absence of training requirements for nursing home personnel.

Surveyor training is particularly important where measures of quality involve assessing actual care provided rather than simply reviewing facility records and structural features. Resident-focused evaluations, like those in the newly developed Patient Care and Services system, are described in chapter 10. Health Care Financing Administration data on surveyors indicate that many States are not adequately trained to conduct surveys that focus on resident care. In 1983, for example, eight States had only one or two licensed nurses on staff. In addition, Federal training programs have been cut back substantially in recent years due to budget constraints. A recent survey revealed that one-quarter of State surveyors had fewer than 10 hours of training, and that one-third of those had none (38).

Substantive and qualitative differences in the education and training of individuals with the same title result in vast differences in the degree to which they are prepared to work with particular groups of patients. without standards to define specific skills and subjects in which they must be trained-prior to or during employment-there may be little assurance that individuals are equipped to provide quality care.

Federal and State regulations do not address this issue. No Federal requirements for staff training apply to all nursing facilities, and only 22 States have defined training provisions. The required amount of time, format, and content of training vary substantially among States and most address training related primarily to health and safety precautions (e.g., fire prevention, evacuation procedures, sanitation). Requirements for training in specific subjects and skills related to patient care are left to the discretion of each facility (1). Fed-

eral standards on staff training are defined for facilities seeking participation in the Medicare program. Where these exist, they are similar to State regulations: they address training related to health and safety precautions, not subjects and skills related to patient care.

Quantitative Staffing Requirements

The degree to which quantitative requirements can ensure the delivery of quality care is controversial. Many contend that other characteristics of the labor force (e.g., staff training, staff mix, job satisfaction) may be at least as important as staff size in determining the quality of care delivered (1).

In a contract commissioned by the Health Care Financing Administration, Abt Associates, Inc., reviewed State laws on nursing home staffing, compared State and Federal requirements, and analyzed the effect of these requirements on actual staffing patterns. The study confirmed several points about quantitative requirements:

- There are no federally defined quantitative staffing requirements for nursing homes.
- Thirty-eight States have quantitative staffing requirements for SNFs; 24 for ICFs. The majority of these are stated as a staff-to-patient rather than a staff-to-bed ratio. The rules may or may not be supplemented by qualitative staffing requirements such as those specifying a particular mix of employees.
- In most cases quantitative staffing requirements appear to be the result of legislative or administrative compromise between consumer groups, the nursing home industry, and the State budget office, rather than a decision founded on firm evidence that a particular ratio assures quality care. To date, no evidence for such figures exists.
- In the majority of States, the State-defined minimum staffing requirement has been adopted by the State Medicaid program as the maximum staff level reimbursable by the program. The regulations in California, Massachusetts, New York, and Wisconsin are examples of that situation.

Qualitative Staffing Requirements

Although qualitative staffing requirements attempt to establish structural and procedural standards conducive to the delivery of quality care, they do not account for inadequacies in education and training of nursing home personnel, or for individual differences in competence and motivation. Mandatory staff training in specific subjects and skills may be of some value, but even these measures cannot compensate for differences among people. Thus quality assurance, as it relates to facility staffing, is particularly difficult to address through regulatory mechanisms.

The types of qualitative staffing requirements used by the States include:

- **Shift-specific requirements:** States may require personnel with particular professional qualifications to be on duty at certain times. Several, for instance, specify that an RN be on duty during each day shift, and that either an RN or an LPN be present during evening and night tours of duty (1). These provisions assume that the presence of staff with particular professional qualifications ensures the delivery of quality care.
- **Staff mix requirements:** States may outline “staff mix” requirements that specify the types of personnel a facility must employ. These may take into account such factors as facility classification (SNF or ICF), shift time (day or night), and number of persons served by the facility. Such provisions, again, may be of limited value where personnel are insufficiently knowledgeable about, or poorly motivated to provide, quality care.
- **Role-specific requirements:** States may require a particular level of academic achievement for personnel in specific roles within a facility. Thirty-seven States, for example, require that the Director of Nursing Services (DNS) of a skilled nursing facility be an RN. Ten States require the DNS to have specialty training (e.g., in geriatrics) in addition to RN licensure (1).
- **Task-specific requirements-patient care:** States that require the performance of particular tasks may or may not specify the level

of training required for personnel who will perform them. The Abt study indicates that where tasks related to patient care are required (e.g., bathing, or turning bed-ridden patients), States do not specify the qualifications or training necessary for staff performing them. Task-specific requirements may be of diminished value as a quality assurance mechanism without provisions that ensure training commensurate with responsibilities delegated.

- **Task-specific requirements-administrative:** Tasks for which States delegate responsibility to specific staff persons appear to be primarily administrative. Twenty-four States, for instance, specify tasks for which the DNS is responsible (e.g., hiring staff, coordinating staff activities, developing patient care plans, and providing inservice training and orientation for new staff). That can mean that a DNS is granted responsibilities for which he or she may lack prior training. The DNS of a nursing facility is a licensed nurse—either RN or LPN—but most nurse training programs include little or no training in managerial and administrative skills. Without an accompanying requirement that nurses supplement their basic education to acquire these skills before assuming a managerial role, States delegate responsibilities that the DNS may be ill-prepared to fulfill.
- **Substantive training requirements:** Nurse's aides are the only group for which any State requires training in subjects and skills related to patient care. (The only subjects in which nursing homes are required to train employees, however, are those related to safety and sanitation within the facility.) For other groups of employees, States rely on the accreditation and education process to provide adequate preparation for work with nursing home residents. Recognizing the vast role that nurse's aides play in direct patient care, and the absence of formal educational training—including high school—among a large percentage of these employees, 17 States have instituted mandatory job-training requirements for nurse's aides. The number of classroom and clinical teaching hours, the content, and the timing vary, but most require

that training be completed within the first 6 months of employment (9).

Actual v. Required Staffing Patterns

The Abt survey of actual staffing patterns in nursing facilities reveals that median staffing levels in virtually every State meet or exceed the State-defined minimum. Even States without quantitative staff requirements have median staffing levels that compare favorably with those elsewhere (1).

These findings do not appear to be the result of any discrepancy between requirements for facility licensure and those for participation in reimbursement programs, for, as noted earlier, most State Medicaid programs have adopted the State-defined minimum as the maximum staffing level reimbursable by the program (1).

Two factors may contribute to the disparity between the required and actual level of staffing in many facilities. First, Medicare and private pay financing mechanisms may have enabled facilities, at the time of the Abt study, to employ greater numbers and more highly trained staff than regulations required. Unlike Medicaid, the Medicare program does not define a maximum reimbursable staffing level. The cost reimbursement system, along with the elasticity of rates with private pay patients, may have allowed facilities to exceed State and Federal staffing requirements.

Second, technical considerations may dictate the need for a larger or more professional staff than requirements stipulate. State staffing requirements may be more the product of legislative compromise and administrative guesswork than a reflection of evidence that a particular staffing pattern can ensure quality care (1). Staffing patterns that exceed minimum requirements may therefore reflect institutional decisions about the actual number and mix of staff necessary to operate a facility.

Neither qualitative nor quantitative requirements are statistically significant in explaining actual median staffing levels in nursing facilities. Nursing homes apparently make their staffing decisions on the basis of technical and economic considerations rather than in response to regulations (1).

FEDERAL PROGRAMS FOR EDUCATION AND CURRICULUM DEVELOPMENT

An understanding of the principles and practices related to interdisciplinary health care, long-term care, geriatrics, and mental illness is an important component in the preparation of health and social service personnel who work with persons with dementia. Much of the impetus for including these topics in training programs for health and social service professionals has come through federally funded grants and contracts in education.

Recent efforts by the Administration to terminate funding for programs that train health care personnel have been mentioned throughout this chapter. These actions have been based on reports of the current supply and projected surpluses of health professionals. However, while Federal funding efforts have succeeded in increasing the aggregate supply of health care personnel, problems related to geographic and specialty distribution remain (39)57,78).

Since the mid-1970s, Congress has sought to redirect funding of education for health-related professions in order to address reported shortages of personnel in particular sectors of health care and particular regions of the country. Geriatrics and long-term care are among the fields where knowledgeable professionals are reported to be in critically short supply. Federal efforts to address this issue are described in this section. Because the Federal Government has been instrumental in initiating and supporting education in these fields, elimination of Federal funds could seriously impede continued efforts in that regard (59).

Administration on Aging

The Older Americans Act (OAA) of 1965 (42 U.S.C. 3001 et seq.) established the Administration on Aging (AOA) within the Department of Health, Education, and Welfare (now Department of Health and Human Services) as the coordinator of grants and contracts to the States for the development of new or improved programs for older persons. Title IV of the OAA addresses "Training, Research, and Discretionary Projects

and Programs" for the elderly. Administration of title IV is delegated to the Administration on Aging with assistance and cooperation, as necessary, from the Department of Education, the National Institutes of Health, and other appropriate agencies and departments of the Federal Government.

Part A of title IV—Education and Training—deals with the need to attract a greater number of qualified personnel to the field of aging and to upgrade the training of personnel working on this issue. It directs the AOA Commissioner to make grants and enter into contracts to achieve these purposes. Activities may include support and development of education, training, and curricula for practitioners in health and social service professions; inservice training for personnel in offices and agencies that administer programs related to aging; and dissemination of information about aging to the public (79).

Training Related to Care of Dementia Patients

A 1984 amendment to the OAA recognizes the increasing need for personnel knowledgeable about the treatment and care of persons with Alzheimer's disease and related disorders. It requires that:

In making grants and contracts under this part, the Commissioner shall give special consideration to the recruitment and training of personnel, volunteers, and those individuals preparing for employment in that part of the field of aging which relates to providing custodial and skilled care for older individuals who suffer from Alzheimer's Disease and other neurological and organic brain disorders of the Alzheimer's type and protruding family respite services with respect to such individuals.

A 1984 amendment to Part B requires the AOA Commissioner to make grants and contracts that address the needs of these persons.

In making grants and contracts under this section, the Commissioner shall give special consideration to projects designed to meet the supportive service needs of elderly victims of Alzheimer's

disease and other neurological and organic brain disorders of the Alzheimer's type and their families, including home health care for such victims, adult day health care for such victims, and homemaker aides, transportation, and in-home respite care for the families, particularly spouses, of such victims.

Training in Interdisciplinary Health Care Delivery

The Older Americans Act also directs the AOA Commissioner to make grants for the establishment and support of multidisciplinary centers of gerontology and gerontology centers of special emphasis. Language added to the law in 1984 requires, among other things, that the multidisciplinary centers shall:

- recruit and train personnel;
- conduct basic and applied research related to aging;
- stimulate the incorporation of information on aging into the teaching of biological, behavioral, and social sciences at colleges and universities;
- help to develop training programs in the field of aging at colleges and universities; and
- provide information and consultation to the public and voluntary organizations that serve the needs of older individuals in planning and developing services under other provisions of the OAA.

In accordance with these requirements, AOA supports nine Long-Term Care Gerontology Centers (80). A primary objective of these centers is the development of professional and paraprofessional staff for delivery of health care, personal care, and other services through career and continued education and training. Through research, education, and service activities involving university faculty members, agency planners, administrators, and practitioners, the centers assist local communities, States, and regions in developing and implementing more cost-effective and efficient long-term care policies, programs, and systems.

Several centers provide opportunities for professional training in geriatrics and long-term care. The Pacific Northwest Regional Center in Seattle, Washington, for example, has developed sev-

eral interdisciplinary training sites where students of medicine, nursing, social work, public health, pharmacy, dentistry, dietetics, and physical therapy work in teams to plan and deliver care to functionally impaired elderly individuals (4).

Alzheimer's disease has been of major interest to the Long-Term Care Gerontology Centers. Related activities at various centers include development, testing, and evaluation of approaches to delivery of service and care to Alzheimer patients; development of model support groups for families; and development of training models to assist service providers in working with caregivers (80).

Health Resources and Services Administration

The Health Professions Educational Assistance Act of 1976 (Public Law 94-484) and the Nurse Training Act of 1975 (Public Law 94-63) exemplify the genesis of legislative attention to the need for geriatric training among health professionals and paraprofessionals. The former authorized the Secretary of Health, Education, and Welfare to award grants and contracts for interdisciplinary training and for curriculum development for the "diagnosis, treatment, and prevention of diseases and related medical and behavioral problems of the aged" (54).

The Health Resources and Services Administration's Bureau of Health Manpower (now Bureau of Health Professions, or BHPr) was designated to administer the legislation. BHPr provides national leadership in coordinating, evaluating, and supporting the development and employment of U.S. health personnel. It assesses the supply and requirements of the Nation's health professions and develops and administers programs to meet those requirements; collects, analyzes, and disseminates information on the characteristics and capacities of health professions' education systems; and develops, tests, and demonstrates new approaches to the education and employment of health personnel within various patterns of health care delivery and financing systems. BHPr provides financial support to institutions and individuals for health education programs; it also admin-

isters Federal programs for development and deployment of targeted health personnel and for the institutional development, training, employment, and evaluation of such staff (80).

Geriatric Education Centers

Beginning in 1983, BHPr supported the development of regional geriatric education centers (80). In that year and in fiscal year 1984, four GECs were funded. A total of 20 GECs were funded for fiscal year 1985. GECs are intended to serve as prototypical resources in multidisciplinary training for health professionals in geriatric care. Each center offers training to a range of health professionals, including doctors, dentists, nurses, pharmacists, and social workers. The main functions of the GECs are to:

- conduct faculty training programs to prepare key resource persons in schools of the various health profession;
- serve as a clearinghouse for information on multidisciplinary geriatric education programs and instructional resources;
- provide educational services in support of geriatric training to academic centers, professional associations, and State and local health agencies;
- assist schools of the various health professions to select, install, implement, and evaluate appropriate geriatric course materials and curriculum improvements; and
- establish organized multidisciplinary units to provide a critical mass of resources for geriatric leadership and coordination (83).

Other BHPr Projects Supporting Study of Geriatrics

The Bureau of Health Professionals also funds:

- training grants to support geriatric activities for residents in family and internal medicine;
- projects to integrate geriatrics into programs for physician assistants;
- area health education centers programs seeking to develop didactic information and clinical experiences in geriatrics for students of dentistry, nursing, pharmacy, social work, and related areas;

- gerontological nursing concentrations in master's and doctoral nursing programs;
- training of geriatric nurse practitioners; and
- the development of continuing education gerontology training programs for nurse educators and practicing nurses (80).

Veterans Administration

In 1973 the Veterans Administration (VA) initiated an effort to encourage health care professionals to specialize in geriatric medicine.

Geriatric Research, Education, and Clinical Care Centers

Through an integrated approach, the VA's geriatric research, education, and clinical care centers (GRECCs) train practitioners, teachers, and researchers in the field of geriatrics. Fifteen centers have been authorized by Congress; 10 are operating. Each center focuses on the clinical treatment of a particular aspect of geriatrics that has implications for improved care and for the education of health professionals. Several focus primarily on neurological disorders and organic brain disease (80).

Physician Fellowships

VA supports 20 physician fellowships in geriatrics. Participants gain expertise in geriatrics and gerontology through clinical training at VA medical centers that have medical school affiliations. Each of the 10 GRECCs offers fellowship positions to postresidency physicians interested in geriatrics and long-term care. The VA geriatric fellowship program began in 1978 (33).

Interdisciplinary Team Training in Geriatrics

The VA Interdisciplinary Team Training in Geriatrics program provides clinical experience in geriatrics to students in health disciplines from academic institutions throughout the country. Approximately 50,000 students participated in 1985. VA provides funding support for about 2,400 to 2,500 of these students. Participants include master's students in psychology, social work, audiology and

speech therapy; residents in optometry and podiatry; clinical nurse specialists in geriatrics; and students of pharmacology and occupational therapy. Students gain knowledge and skills related to geriatric care and learn to function as part of a team of caregivers (80).

Training and Support for Nursing Students

The VA Health Professional Scholarship Program supports students enrolled in accredited baccalaureate nursing programs and accredited master's degree programs offering specialties needed by the agency. In fiscal year 1982, more than 25 percent of the awards to master's degree students were for geriatric/gerontological nursing. In return for the financial assistance, recipients provide a minimum of 2 years' service in a VA medical center (80).

VA also provides training for clinical nurse specialists in geriatrics. The program, established in 1981, enables master's-level nursing specialists to complete their clinical practicum at the VA medical center affiliated with their academic institution. In fiscal year 1983, VA supported 106 master's clinical nurse specialist students—40 in geriatrics, 53 in psychiatric mental health, and 13 in rehabilitation (80).

Continuing Education

VA provides funds to each of its medical centers to provide continuing education programs for its employees. The agency also funds programs for continuing education at the local, regional, and national level. A recently conducted regional program focused on Alzheimer's disease and other dementias (80).

National Institute of Mental Health

Through the Center for Studies of Mental Health of the Aging, the National Institute of Mental Health addresses training and personnel needs among the aging. Its related activities include:

- faculty development awards to prepare expert faculty in the field of geriatric mental health;

- postgraduate (fellowship) specialty training in geriatric mental health; and
- design of geriatric training models to provide training experience to the nonspecialist in geriatrics and to stimulate the development of model materials and curricula for the incorporation of geriatric mental health skills and knowledge in the general training of professionals in the four core mental health disciplines (psychiatry, psychology, social work, and nursing) (80).

Approximately 50 awards were made through these three programs in fiscal year 1983. Other activities identified for program support include continuing education in mental health and aging for clinicians already in practice, inservice, or setting-specific training in mental health and aging, and curriculum development addressing these and other needs (80).

Health Care Financing Administration

Some funding of geriatric education comes through the Medicare program, managed by the Health Care Financing Administration. The money is allotted to teaching hospitals—facilities in which graduate medical students gain clinical experience in patient care while working under the supervision of qualified physician-faculty—to compensate them for the costs incurred in patient care. The provisions do not specify reimbursement practices for facilities and programs other than hospitals (e.g., teaching nursing homes) that serve as clinical training sites for students of health professions. For the most part, services provided in long-term care facilities and programs are not reimbursable under Medicare. Thus, there would be no compensation for health professionals training in these settings.

Before the October 1983 Medicare revisions, hospitals were reimbursed retrospectively for patient care on a cost or charge basis. Under that system, direct and indirect costs of graduate medical education programs (residencies) were included in the reimbursement calculations. Under the new prospective payment system, reimbursement is allocated at fixed rates for each diagnostic category (diagnostic-related group). Educational

costs are considered separately. Both direct and indirect costs are identified,

When the prospective payment system was designed, Congress and the Administration identified several factors that generate increased financial burden for teaching hospitals, but that should be compensated. These include:

- direct educational costs (e.g., stipends for residents or salaries for physician supervisors);
- indirect educational costs (e.g., additional test ordered by, and additional services provided by residents as part of their learning experience);
- the greater load of severely ill patients attracted to teaching hospitals; and
- the greater level of charity care provided by teaching hospitals (368 teaching hospitals: 6.4 percent of all hospitals in the country—provided 49 percent of the hospital charity care in 1984 (10).

The Administration's budget proposals for 1986 and 1987 sought dramatic reductions in education payments through Medicare. The proposals were meant to freeze payments for direct medical education expenses and to halve the indirect medical education subsidy. Such financing mech-

anisms, the Administration hoped, would begin to discourage the trend toward specialized medicine.

In its action on the 1986 and 1987 budgets, however, Congress retained Medicare provisions for reimbursement of direct and indirect medical education costs incurred by teaching hospitals (72).

Although leaders in medical education agree that a greater supply of primary care physicians is important and that some policy incentive may be necessary to slow the trend toward specialization, they suggest less drastic measures than those proposed by the Administration. By defining a limited period during which graduate medical students could receive Federal funds, the program might encourage students to enter primary care rather than specialized medicine. Primary care residencies generally take 12 to 36 months, while more highly specialized fields (e.g., surgery and neurology) may require up to 7 years of residency training. Those who seek to discourage medical specialization contend that, because specialized medicine inflates the cost of medical care, the additional training costs of these programs should be borne by the trainees, institutions, and programs themselves (36).

ISSUES AND OPTIONS

The dementing disorders described in this assessment demarcate the differences between services needed by individuals with dementia and those needed by patients with acute conditions. Consideration of present and future personnel needs must account for these differences and determine which individuals are best suited to deliver care. Projections must consider the full range of care settings available, and the type of staffing arrangements appropriate to each.

Programs and facilities serving individuals with dementia and their families confront several fundamental problems in attracting and retaining knowledgeable and experienced personnel. Many of these problems—the limited number of health

and social service professionals interested in long-term care; the lack of prior training and experience related to care of elderly, chronically ill, and mentally ill patients; and the high staff turnover rates—may be related to issues in the education and training process.

Educational programs that prepare health and social service professionals and paraprofessionals continue to emphasize the role of working with individuals with acute rather than long-term care patients. In doing so, they establish a set of expectations that may diminish the appeal and satisfaction of working with chronic care patients. Positive faculty role models are an important way to convey interest in and raise the esteem of profes-

sionals in long-term care. In addition, students require substantive information about the clinical experience with chronically ill patients,

The absence of teaching resources is an overriding problem for programs and facilities seeking to train personnel in working with chronic care patients. Although there is an abundance of information related to the diagnosis and treatment of persons with dementia in recent journals for health and social professionals, the absence of a discrete, consensual body of information complicates the task of curriculum planning and teaching about dementia.

ISSUE 1: Should the Federal Government play a role in the coordination of institutions and programs that train health and social services professionals?

Option 1: *Do not get involved in the accreditation of academic institutions and programs that train health and social service professionals,*

Option 2: *Establish curricular requirements to be included as criteria for accreditation of academic programs and institutions preparing individuals for health and social service professions*

Under option 2, legislation could designate the number of hours, the format, and subjects to be incorporated into programs training personnel in these fields. In that way, Congress could ensure the inclusion of content related to the care of persons with dementia (e.g., long-term care, geriatrics, and mental health) in programs that train health and social service professionals.

ISSUE 2: Should the Federal Government establish standard definitions and licensure requirements for health and social service professionals?

Option 1: *Continue to allow individual States to establish definitions and licensure requirements for health and social service occupations.*

Option 2: *Direct the Department of Health and Human Services or another appropriate Federal agency to formalize defini-*

tions and licensure requirements for health and social service professions.

Option 2 would allow the Federal Government to ensure uniform standards for experience and training of individuals with a particular professional title. Licensure requirements could specify subjects and skills to be addressed and the number of hours of clinical and classroom training to be designated to each. In addition, requirements could specify particular topics to be addressed on standardized licensing examinations.

ISSUE 3: Should government establish qualitative personnel requirements for programs and facilities caring for persons with dementia?

Option 1: *Define the number and type of personnel to be employed by facilities and programs serving individuals who need long-term care.*

Option 2: *Allow personnel requirements to be defined by Federal and State reimbursement programs.*

Under option 1, requirements could be based on such criteria as the number of patients, type of facility (e.g., inpatient, home-care, adult day care), and illness classification of patients served. Under option 2, any requirements would be applicable only to facilities and programs seeking eligibility for Federal or State reimbursement for services provided.

ISSUE 4: Should the Federal Government define training requirements for the various types of personnel employed by facilities and programs caring for persons with dementia?

Option 1: *Continue to allow States to define training requirements for staff of programs and facilities caring for persons with dementia.*

Option 2: *Establish specific preemployment, in-service, and continuing education requirements for personnel employed by facilities and programs caring for persons with dementia.*

Under option 1, standards on orientation, in-service training, and continuing education would continue to apply primarily to programs seeking reimbursement through State or Federal programs (Medicare or Medicaid). Option 2 would allow Congress to specify standards on the number of hours, the format, and particular subjects required for each personnel group employed by facilities and programs caring for persons with dementia.

ISSUE 5: Should the Federal Government provide financial support to academic institutions and programs, and to students training for health and social service careers?

Option 1: Eliminate support for educational programs that prepare health and social service professionals in fields related to care of persons with dementia.

Option 2: Sustain general support for programs preparing health and social service professionals through existing legislation.

Option 3: Specify that funds be used for health and social service education to enhance opportunities for training related to care of persons with dementia.

Option 4: Retain support for programs sponsored by Federal agencies that train health and social service personnel in fields related to care of persons with dementia.

Option 2 would continue to rely on legislation such as Title VII and Title VIII of the Public Health Services Act to support programs preparing health and social service professionals. Under option 3, funds could be used to enhance institutional resources (e.g., curriculum, clinical training, faculty) for teaching about topics related to care of individuals with dementia, such as long-term care, geriatrics, neurology, and mental health. Option 4 would involve supporting programs such as Interdisciplinary Team Training in Geriatrics, Geriatrics Education Centers, and Long-Term Care Gerontology Centers.

Options 2 through 4 could be exercised by devoting attention to dementia in existing geriatric training programs. Increased funding for geriatric training was authorized for physicians and dentists in the omnibus Health Act of 1986 (P.L. 99-660). Such training could be encouraged, either directly through legislation or indirectly through hearings and congressional inquiries, to include a focus on dementia. Additional initiatives for nurses and nurse's aides would more directly improve the daily care of the majority of those suffering from dementia.

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