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CARING FOR OUR SENIORS: HOW CAN WE SUPPORT THOSE ON THE FRONTLINES?

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WEDNESDAY, APRIL 16, 2008

U.S. SENATE,
SPECIAL COMMITTEE ON AGING
Washington, DC.

The Committee met, pursuant to notice, at 3:02 p.m., in room SD–562, Dirksen Senate Office Building, Hon. Herb Kohl (chairman of the committee) presiding.

Present: Senators Kohl, Carper, Nelson, Salazar, Casey, Whitehouse, Smith and Collins.

OPENING STATEMENT OF SENATOR HERB KOHL, CHAIRMAN

The CHAIRMAN. I want to thank you all for being here today. We will commence—Ranking Member Senator Smith from Oregon will be here shortly. Today, we will be discussing the need to train, support, and expand the range of those individuals caring for older Americans. The Aging Committee has a long and a proud history of moving Congress forward on issues of long-term care.

Last year, this Committee held three hearings on the subject of long-term care in America. However, we primarily focused on the facilities themselves and the Federal standards that applied to them, rather than the people who fulfill the promise and meet the obligations of care. Today, we are shifting our focus to those caregivers.

Millions of older Americans receive care in a medical facility from a licensed professional, such as a doctor or nurse, or from a certified nurse aide at a long-term care facility. You can also receive hands-on care in your own home by hiring a home-health aide or perhaps a live-in personal care attendant. However, the majority of older Americans in need of care rely on a third group, namely, their own family.

There are more than 44 million people providing care for a family member or friend nationwide. These caregivers frequently do the same work as a professional caregiver, but they do so voluntarily and with little or no training. To their loved ones they are the doctor and nurse, the assistant, therapist, and oftentimes, the soul source of emotional and financial support.

You probably know someone who cares for a family member. Perhaps a friend, a neighbor, or a co-worker. If you don't, I am willing to bet that in 10 years you certainly will. In fact, in 10 years it might well be you or myself. By the year 2020, it is estimated that the number of older adults in need of care will increase by fully one-third.

The unfortunate fact of the matter is that, while our country is aging rapidly, the number of health care workers devoted to caring for older Americans is experiencing a shortage—one that will only grow more desperate as the need for these caregivers skyrockets. Given current workforce trends, it is expected that, in the coming decades, we will fall far short of the number of health care workers trained to treat older adults than what we will need.

We indeed face many challenges. We know that few nursing programs require coursework in geriatrics, and that in medical schools, comprehensive geriatric training is a rarity. For the direct care workforce, which includes home health aides and personal care attendants, we know that Federal and State training requirements vary enormously, despite the fact that studies show that more training is correlated with better staff recruitment as well as retention. We also know that family caregivers want enhanced education and training to develop the necessary skills to provide the best possible care for an ailing family member.

Fortunately, knowing what we need to change is just half the battle. After this hearing, we plan to incorporate today's lessons into legislation to expand, train and support the workforce that is dedicated to providing care for the older members of our population.

The Committee is honored to welcome two distinguished panels of witnesses to discuss how we can meet the needs of the long-term care workforce today and work toward its expansion by tomorrow. We will be reviewing the major recommendations released Monday by the Institute of Medicine for improving and expanding the skills and preparedness of the health care workforce. Also we will hear many other perspectives and suggestions from nationally recognized experts with backgrounds in policy, medicine, academics, business and even the art of living.

The United States will not be able to meet the approaching demand for health care and long-term care without a workforce that is prepared for the job.

Again, we would like to thank all our witnesses for their participation today. At this time, we will introduce our first panel.

Our first witness today will be Dr. John Rowe, a professor in the Department of Health, Policy and Management at Columbia University School of Public Health. Dr. Rowe is testifying today as chairman of the Institute of Medicine's Committee on the Future Health Care WorkForce for Older Americans. Throughout his distinguished career, Dr. Rowe has held many leadership positions in top health care organizations and academic institutions, including a stint as CEO of Mt. Sinai NYU Health System and as founding director of the Division on Aging at the Harvard Medical School.

Our next witness will be Dr. Robyn Stone, executive director of the Institute for the Future of Aging Services. Dr. Stone is a noted researcher and leading international authority on aging and long-term care policy. Formerly, she served as executive director and chief operating officer of the International Longevity Center in New York. Dr. Stone also held several prominent roles in the field of aging under the Clinton administration, including assistant secretary for aging in the Department of Health and Human Services.

Before we commence with our first panel, I would like to call upon my colleagues who are sitting up here on the dais for any remarks and comments that they wish to have.

Senator Nelson.

OPENING STATEMENT OF SENATOR BILL NELSON

Senator NELSON. Thank you, Mr. Chairman.

I am concerned, as we look down the road, that we have the proper health care for older adults—geriatrics primary health care, and preventive medicine. That is certainly true in a constituency such as mine—Florida, where we have a high percentage of the population that is age 65 and older.

Mr. Chairman, one that of the little spin-offs that we are having a problem with back on a Medicare bill in the late 1990's, a freeze was put in place on all of the residency programs for medical schools that Medicare funds, the result of which—with no growth since 1998—your high population increase States, such as Florida and Nevada, have not had the residencies to train the doctors. Those States educating the doctors.

But then these doctors go to another residency program. What we find is that a doctor is likely to stay and practice in the area in which they did their residency. As a result, States like mine and Nevada, and about half of the other States are educating the doctors and then losing them. Now, that is a terrible situation for a population like Florida's that is aging. You need those residencies in geriatrics, regular care, internal medicine and preventive care.

So it is one of the issues we are going to have to address. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you for that interesting comment, and a very important comment.

Senator Collins.

OPENING STATEMENT OF HON. SUSAN COLLINS, A U.S. SENATOR FROM THE STATE OF MAINE

Senator COLLINS. Thank you, Mr. Chairman. I want to commend you for calling this hearing to examine our Nation's future health workforce in the face of a rapidly aging population. I think this hearing is particularly significant in light of a recent report from the Institute of Medicine that sounded a warning that we are facing a dramatic and critical shortage of doctors, nurses and other health care professionals who are adequately trained to manage the special health care needs of our Nation's growing population of seniors.

We know that in this country, the most rapidly growing part of the population are those who are age 85 and older, the oldest old. Like Senator Nelson's state, Maine is a State that is disproportionately elderly. I am very concerned about access to health care as my generation and others join this population segment.

We know that older Americans consume far more health care resources than any other age group. We also know that there is a real shortage of health care provides who are trained in geriatrics. In fact, the numbers are truly astonishing. The experts have projected that we need some 36,000 geriatric doctors to care for our

70 million seniors by the year 2030. But only 7,000—about 1 percent of all physicians—are currently certified in geriatrics.

Senator Boxer and I have introduced a bill to take the first steps in this area. It has the support of AARP and other organizations. I look forward to working with the Chairman who has been such a leader in focusing on this issue. I would ask that my full statement be put in the record. Again, thank you for focusing on this very important issue.

The CHAIRMAN. Thank you. By unanimous consent, your full statement will be entered into the record, Senator Collins.

Senator SALAZAR.

OPENING STATEMENT OF SENATOR KEN SALAZAR

Senator SALAZAR. Thank you very much, Chairman Kohl, for holding this hearing on the Aging Committee on this very important issue. I come today here to the Committee with you to address the severe shortage of long-term care professionals available to care for older Americans.

Although the workforce shortage has been documented for many years, new reports that have been issued by the Institute of Medicine show that many workers who are working in long-term care settings are inadequately trained to do the job. Furthermore, vast improvements are needed in geriatric education and curriculums as well as new incentives, to recruit and retain a highly qualified workforce.

Without a doubt, these are some of the greatest challenges facing long-term care today. The situation will only get worse. In three short years, 75 million baby boomers will begin to turn 65. Between 2005 and 2020, the elderly population of the U.S. is expected to double. We must ensure that our health care system include high-quality professionals to meet the growing demand for long-term and chronic care.

Personally I have experienced taking care of many of our loved ones. My mother today is 86 years old. Fortunately, she continues to live on our ranch in southern Colorado. My siblings and I share the responsibility of caring for her. She is doing very well.

Most individuals and families have to make tough decisions on how best to take care of their loved ones. At the very least, we all want the peace of mind that the caregiver we hire to do the job has been adequately trained and meets the highest possible standards. I am hopeful that the witnesses today will address that issue of the kinds of standards that we should have for professional caregivers.

This hearing is critical for us to identify the most effective policy solutions to meet these health care challenges that we are now in the midst of and will only find to be more challenging in the days, weeks, months, years ahead.

Again, I want to thank Chairman Kohl and Ranking Member Smith for holding this hearing.

The CHAIRMAN. Thank you, Senator Salazar.

Senator CASEY.

OPENING STATEMENT OF SENATOR BOB CASEY

Senator CASEY. Mr. Chairman, thank you very much for holding this hearing. I will submit a longer statement for the record. But I did want to commend you for calling this hearing because, in my home State of Pennsylvania, we have a demographic challenge.

Our fastest growing population is 85 and up, as it is in many states, I think. But we are, depending on how you count it, second or third in the ranking of the states for the number of people over the age of 65. It is a critically important challenge for Pennsylvania, and I know, for the nation as a whole.

When I was in State Government, I spent a good deal of time on the issue of long-term care. Some of the most inspiring people I met were people who were delivering that care—certified nurses aides, nursing assistants, whatever categories you use or titles you use. They were people who did back-breaking work and delivered care in ways that—it is hard to describe how much they have benefited our families, doing that kind of work.

After I was in State government for a while, I had the experience, I guess you would call it, that all of us have when a loved one is in the hospital. My father was in a long-term care setting before he died. I was able to see first-hand what that care delivery and care coordination and the quality of the care that we are talking about here today is all about. I realized then, more so than I did as a public official, the kind of skill that is required in delivering quality care to older citizens in the twilight of their lives.

So this issue is important to me personally. But it is a major issue in our State. We need to roll up our sleeves and work on it. I am grateful you called this hearing. Thank you.

The CHAIRMAN. Thank you very much, Senator Casey.

We will now hear from our first panel. First Dr. Rowe and then Dr. Stone.

Dr. Rowe.

STATEMENT OF JOHN ROWE, PROFESSOR, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, MAILMAN SCHOOL OF PUBLIC HEALTH, COLUMBIA UNIVERSITY, NEW YORK

Dr. ROWE. Senator Kohl and members of the Committee. Thank you for the opportunity to testify before you on the critical health care needs of older Americans. As noted by Senator Kohl, I am Chair of the Institute of Medicine's Committee on the future healthcare workforce for older Americans. I am here to discuss the findings and recommendations of the report that we have released early this week.

To start with, I think there is a great myth here in Washington about care of the elderly. The myth is that all we have to do to ensure older Americans' access to care is to fix the issues related to the Medicare Trust Fund's solvency and sustainability. I think that that is half of the problem. We first have to make sure that the health care workforce is adequate with respect to its numbers and its capacity to deliver the care. Even having the money in the system isn't going to get the care to older people if there is no one to provide care.

So it is about time that we turned our attention to this. I compliment you, Senator Kohl and the Committee, for having us here today to discuss this.

Now, the future demand—and I think we can look at this as a kind of demand side and supply side issue, Senator—the future demand for geriatric care is driven by basically two factors. The first is the dramatic increases in the number of elderly that all of you are very familiar with. The second, as noted by Senator Collins, is the fact that the elderly utilize a disproportionate proportion of health care resources. So the 12 percent of our population that is over 65 uses 35 percent of the hospital stays, and 34 percent of the medicines. By 2030, when the population of elders is 20 percent of our population, they will dominate our health care system. That is the demand side. How about the supply side? Well, on the supply side, the answer is quite simple. We are in denial. We are woefully unprepared. But fortunately, we think at the Institute of Medicine that it is not too late. The supply and the organization of the health care workforce for older individuals needs to be dramatically enhanced, or it will simply be inadequate. Let me give you a couple of facts.

As Senator Collins noted, there are only about 7,000 certified geriatricians in the entire United States. More frightening is that this is 22 percent lower in the year 2000. So we are actually going in the wrong direction.

With respect to geriatric psychiatry, there is currently one for every 10,000 older people in the United States. By 2030, at the current rate, there will be one for every 20,000 older people, whether he or she needs a psychiatrist or not.

Less than one percent of the nurses, pharmacists and physician assistants we have currently specialize in geriatrics while only 4 percent of the social workers do. This means that most health care professionals, including doctors, nurses, social workers and others, receive very, very little training in caring for the common problems of older adults.

Standards for the training of nurse aides and home health aides must be strengthened. In the State of California, there are higher training requirements for dog groomers, crossing guards and cosmetologists than there are for nursing aides and home health aides. Informal caregivers, the family and friends of older adults, are also ill-prepared for their significant roles. Innovative new approaches to delivering care to older adults that have been shown to be effective and efficient are not being implemented.

We suggest three approaches. The first approach is to enhance the geriatrics competence of all professional caregivers. We believe there needs to be more training in the schools of medicine, nursing and social work. We believe that these professionals all should demonstrate competence as a function of obtaining their licensure or certification—not just demonstrate that they had the hours of training, but demonstrate that they have the competence.

In addition, we believe that the number of hours that direct workers and nurses aides be given in instruction be increased from the current level of 75 hours, which is the Federal standard, to 120 hours.

The second bucket, if you will, of our three recommendations is to increase the recruitment and the retention of geriatric specialists. We need them. We are not saying that every old person needs a geriatrician any more than anybody with a heart needs a cardiologist. That is not what we are saying.

What we are saying is we need specialists who can train the rest of the workforce on how to take care of the common problems of the elderly, who can do research and develop new models of care and, in fact, can take care of particularly complex and difficult patients.

Unfortunately, there is an economic disincentive to going into geriatrics. In 2005 a geriatrician in this country made, on average, $163,000. An internist—with less training—made $175,000. So if you spend the extra year or two to do a fellowship in geriatric medicine, you are decreasing your future earning potential with our current reimbursement strategies for geriatric care. This suggests to me that our society does not value this additional training.

We have a number of suggestions and recommendations in our report that go to specific ways that we can enhance loan forgiveness, provide scholarships and enhance payments. I would just mention one for you. The National Health Service Corps is well-established, and has been very effective in developing physician manpower for underserved populations. We are calling for a National Geriatric Health Service Corps using the same model. We think that is something that could be put in place pretty quickly.

The third recommendation we have has to do with new models of care. We have a fascination with studying demonstration projects for new approaches to care. Many of these have been found to be effective and cost-efficient, and yet they languish on the shelf, because once the funding for the research project is over, there is no funding to promulgate or sustain them. Therefore, they are just dropped, and the next demonstration project is developed.

We need some follow up and some commitment at CMS to change this so that new models of care which have been shown to be effective and efficient can in fact be sustained and can permeate to our society. Because even if we do the things we are recommending in this report, we are still going to fall short in the workforce. We have to be smarter, more effective and more efficient in how we deliver the care.

We very much appreciate the opportunity to share our recommendations and our findings with you. Thank you very much.

[The prepared statement of Dr. Rowe follows:]

Statement of

John W. Rowe, M.D.
Professor, Department of Health Policy and Management
Columbia University Mailman School of Public Health
and
Chair, Committee on the Future Health Care Workforce for Older Americans
Institute of Medicine
The National Academies

Before the

Special Committee on Aging
U.S. Senate

April 16, 2008

Good afternoon Chairman Kohl, Ranking Member Smith, and distinguished members of the Committee. Thank you for the opportunity to testify before you on the critical health care needs of older Americans and the need for reform. I applaud the Committee for its diligent work on issues affecting older Americans and commend you, Mr. Chairman, for holding this hearing.

My name is John Rowe. Currently, I am a Professor in the Department of Health Policy and Management at the Columbia University Mailman School of Public Health. I am an academic geriatrician and in one of my prior positions was the founding Director of the Division on Aging at the Harvard Medical School.

Today, I come before the Committee in my capacity as the Chair of the Institute of Medicine's Committee on the Future Health Care Workforce for Older Americans. The Institute of Medicine serves as advisers to the nation to improve health. Established in 1970, the Institute of Medicine provides independent, objective, evidence-based advice to policymakers, health professionals, the private sector and the public.

I will be discussing the results and recommendations of a report my committee colleagues and I released on Monday, *Retooling for an Aging America*, which examines our aging population and its effect on the health care workforce.

Our nation faces significant challenges when it comes to ensuring all Americans have access to needed health care services. Specifically, I am here today to call your attention

to a looming crisis that is quickly approaching: the considerable shortfall in the quality and organization of the health care workforce to care for tomorrow's older Americans.

Factors driving the future demand for geriatric care include the following:

- Americans are living longer than ever before, and older adults accumulate disease and disabilities as they age.
- In just 3 years, the first of the 78 million baby boomers will turn 65.
- This combination of aging baby boomers and increased longevity will lead to a near doubling of the number of adults aged 65 and older, from 37 million to over 70 million, accounting for an increase from 12 percent of the U.S. population to almost 20 percent.
- Older adults account for a disproportionate share of health care services. The 12 percent of older Americans today account for 26 percent of all physician office visits, 35 percent of all hospital stays, 34 percent of all prescriptions, 38 percent of all emergency medical responses, and 90 percent of all nursing home use.
- About 80 percent of older adults require care for chronic conditions such as hypertension, arthritis, and heart disease. Almost all Medicare spending and 83 percent of Medicaid spending is for the care of individuals with chronic conditions.

In hearing this daunting list, the question arises: how adequate is our health care workforce supply to meet these impending needs?

The answer is quite simple: we are woefully unprepared. The U.S. health care system is in denial about the impending demands. Little has been done to prepare the health care workforce for the aging of our nation and the current supply and organization of the health care workforce will simply be inadequate to meet the needs of the older adults of the future. For example,

- Today there are only a little more than 7,000 certified geriatricians, a 22 percent decrease from the year 2000. Some expect this number will continue to decline.
- Today, there is only about 1 geriatric psychiatrist for every 11,000 older adults; at current rates of growth, in 2030 there will only be one for every 20,000.
- Less than one percent of nurses, pharmacists, and physician assistants are specialists in geriatrics; less than 4 percent of social workers specialize in aging.
- Health care professionals, including doctors, nurses, social workers, and others receive very little training in caring for the common problems of older adults such as confusion, incontinence, and falls.
- The federal standards for the training of nurse aides and home health aides have not changed since they were mandated over 20 years ago. The state of California, for example, requires more hours than the federal minimum, but has even higher standards for dog groomers, crossing guards, and cosmetologists.
- Informal caregivers, the family and friends of older adults, are also ill-prepared for their significant roles in the care of older patients.
- Innovative new approaches to delivering care to older adults have been shown to be effective and efficient, but most are not implemented widely and instead left to die on the shelf.

In January 2007, the Institute of Medicine charged the Committee on the Future Health Care Workforce for Older Americans with developing a consensus report determining the health care needs of Americans over 65 years of age and to assess those needs through an analysis of the forces that shape the health care workforce, including models of care, education and training, and recruitment and retention.

After examining all relevant factors, hearing testimony from a wide range of experts, and meeting with a variety of stakeholders and interested parties, the committee came to the strong conclusion that steps need to be taken immediately along a three-pronged approach. First, we need to increase the competence of virtually all members of the health care workforce in the basic care of older adults. Second, we need to increase the number of geriatric specialists both to provide care for those older adults with the most complex needs as well as to train the rest of the workforce in basic geriatric principles. Finally, we need to change the way that care is organized and delivered, using each person to his or her highest level of ability, including family, friends, and patients themselves.

There is a great "myth" that effectively addressing the threats of solvency and sustainability of the Medicare Trust Fund will assure older adults access to high-quality care. In fact, funding is only half of the problem: we first need to ensure that our health care workforce has the capacity, both in size and ability, to deliver the health care services that a new generation of older adults will soon need. Having funds available

does not guarantee that there will be someone available to provide the quality care our oldest Americans deserve.

While I encourage all to review the full report of the committee, I will summarize the key recommendations.

Enhancing Geriatric Competence

Virtually all health care workers should be able to provide care for the basic health care needs of older adults. There are a number of challenges to the geriatric education and training of health care workers, including the scarcity of faculty, non-standardized curricula, and a lack of training opportunities.

While the exposure to geriatrics in professional schools has improved, much more formal training is needed. Currently, training is highly variable, ranging from guest lecturers to elective courses to discrete courses in geriatrics. More than half of surveyed medical students and one-quarter of dental students perceive inadequate coverage of geriatric issues in their undergraduate courses.

One notable way in which training is inadequate is the lack of exposure to settings of care outside of the hospital. Since much care of older patients occurs in nursing homes, home settings, and assisted-living facilities, the committee concluded that preparation for the comprehensive care of older patients needs to include training in non-hospital settings. In

addition, the committee recommends that virtually all types of health care professionals should be required to demonstrate competency in care of older adults as a criterion for licensure and certification.

Similar standards are needed for direct-care workers, the nurse aides, home health aides, and personal care aides who are the primary providers of paid hands-on care to older adults. Currently, the federal minimum number of hours of training for most types of direct-care workers is 75 hours, a minimum that has not changed in over 20 years. The committee recommends that states and the federal government should increase minimum training standards for direct-care workers. The federal minimum training for nurse aides and home health aides should be increased to at least 120 hours (the number required by at least the top quartile of states) and their certification should require demonstration of competence in the care of older adults. In addition, states should also establish minimum training requirements for personal care aides.

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

Increasing Recruitment and Retention of Geriatric Specialists and Caregivers

Geriatric specialists are needed in all professions for three significant reasons: they have the clinical expertise needed to care for those older patients with the most complex health care needs, they will be responsible for training the entire workforce in the geriatric principles related to the common health care conditions of older adults, and they will be conducting research on the models of care that are more effective and efficient in delivering these needed services.

Unfortunately, the effort, time, and costs associated with extra years of geriatric training do not translate into additional income. In 2005, a geriatrician earned $163,000 on average compared to $175,000 for a general internist despite the extra training required to become a certified geriatrician. Physicians who select another specialty, such as dermatology, can earn over $300,000 a year. This may be seen as evidence that our society places little value on the expertise needed to care for our vulnerable population of frail older adults.

This discrepancy is due in part to the fact that a geriatric specialist derives less income from private payers than from public payers. Medicare and Medicaid payments, which represent almost all sources of payment to geriatricians, fail to fully account for the fact that the care of the most frail older patients with more complex health care needs is especially time-consuming, leading to fewer patient encounters and fewer billings.

The committee recommends that public and private payers should provide financial incentives to increase the number of geriatric specialists in all health professions. All payers should include a specific increased reimbursement for clinical services provided by geriatric specialists.

Programs such as the Geriatric Academic Career Awards administered by HRSA's Bureau of Health Professions have been successful in the development of academic geriatricians but similar opportunities are rare or not available for faculty in other professions. In the nursing profession, the lack of available faculty is a significant barrier to training more nurses. One estimate shows that about 32,000 qualified applicants to nursing programs are denied admission primarily due to the lack of available faculty needed to expand programs. The committee recommends that Congress fund and expand the scope of these awards to support faculty in other health professions.

The committee recommends the establishment of programs that would provide loan forgiveness, scholarships, and direct financial incentives for professionals who become geriatric specialists. The committee found that programs linking financial support to service, such as the National Health Service Corps (also administered by the Bureau of Health Professions), have been very effective in increasing the number of health care professionals who care for underserved populations and should be used as a model for creating a National Geriatric Service Corps to recruit geriatric specialists in all professions.

In addition to professionals, the need for direct-care workers is dire. These workers often have high levels of turnover and job dissatisfaction. They often receive low wages (averaging less than $10 per hour) and have few benefits – many are more likely to lack health insurance and use food stamps than workers in other fields. In addition, they are at significant risk for on-the-job injuries. To help improve the quality of these jobs, more needs to be done to improve job desirability, including greater opportunities for career growth. To overcome huge financial disincentives, the committee recommends that state Medicaid programs should increase pay for direct care-workers and provide access to fringe benefits.

Improving Models of Care

The committee created a vision for the future that follows three principles:

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

The committee conducted extensive research to identify innovative approaches in both the private and public sectors that are getting strong results. A number of new models of care show great promise to improve the quality of care delivered to older adults and reduce costs. Examples include CMS' Program of All-Inclusive Care for the Elderly (PACE) and the Improving Mood: Promoting Access to Collaborative Treatment for Late Life Depression (IMPACT), which resulted from efforts initiated by the John A. Hartford

Foundation. However, the diffusion of these models has been minimal, often due to the fact that current financing systems do not provide payment for features such as patient education, care coordination, and interdisciplinary team care.

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

In order to deliver care more effectively and efficiently, one workforce adaptation that needs extensive development is the expansion of the roles many members of the health care workforce (including technicians, direct-care workers, informal caregivers, and the patients themselves) to include the delivery of more complex services. Job delegation involves the shifting of specific tasks from more specialized workers to less specialized workers or even families, friends, and patients themselves (along with the necessary training to assume these responsibilities). Job delegation has worked in other populations in need. For example, in Africa, the significant shortage of health care workers to care for persons with HIV/AIDS was successfully ameliorated through delegation of tasks to individuals at the community level. Other examples of expanding roles has been seen in our own country through the development of the nurse practitioner and physician assistant professions, as well as the development of specialized skills among many direct-

care workers. More research is needed on how we can best maximize the use of all of individuals in caring for older adults.

As part of this ideal of maximizing the efficient use of workers, the committee recommends that federal agencies provide support for the development of technological advancements that could enhance individuals' capacity to provide care for older patients. This includes the use of assistive technologies which may both reduce the need for formal care and improve the safety of care and care-giving as well as health information technologies, including remote technologies, that improve both the communication among all caregivers and the efficient use of professionals.

Finally, in order to maintain focus on this problem, the committee recommends that the Bureau of Health Professions deliver an annual report on the progress made in addressing the crisis in supply of the health care workforce for older Americans.

Conclusion

Mr. Chairman, my fellow committee members and I hope that this report will serve as a catalyst for systematic change in the structure of our health care system and workforce. It is our profound belief that immediate and substantial action is necessary by both public and private organizations to close the gap between the status quo and the impending needs of future older Americans. Again, I want to thank the Committee for allowing me to testify and I look forward to answering any questions you may have.

The CHAIRMAN. Thank you, Dr. Rowe.

Dr. Stone.

STATEMENT OF ROBYN STONE, DPH, EXECUTIVE DIRECTOR, INSTITUTE FOR THE FUTURE OF AGING SERVICES, AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING, WASHINGTON, DC

Ms. STONE. Chairman Kohl, Ranking Member Smith and members of the Committee, I am really pleased to have the opportunity today to testify on behalf of the Institute for the Future of Aging Services, which is the applied research institute of the American Association of Homes and Services for the Aging, where I am the senior V.P. for Research.

From the beginning of our institute, and actually going back a heck of a lot longer than that—I have been trying to push this issue for the last 25 years—one of our signature areas has been the development of a quality long-term care workforce.

I really commend you, this Committee and also the IOM for finally shining a light on what is the critical piece of our system. Without the people who do the work, all the financing and delivery in the world is not going to solve our problem.

Based on our own work, some of which is included in the written testimony, and the efforts of others such as the IOM, I would like to spend my remaining time laying out for your consideration five broad workforce improvement goals and some possible strategies for achieving them, some of which Dr. Rowe has already alluded.

The first is to expand the supply of new people entering the long-term care field. The need to do this is obvious. The traditional labor pool paid of caregivers is shrinking. Regardless of the vision of long-term care reform, the field will need new sources of personnel. The U.S. Departments of Health and Human Services and Labor should be working together to develop the data infrastructure to track workforce shortages and to report to Congress on the status of the long-term care workforce over time.

Second, workforce development funding needs to be channeled to the recruitment and training needs of long-term care employers. Much of that money goes to other health sectors. Funneling more of those dollars specifically in the long-term care sector will help.

Third, information on long-term care careers should be targeted to post-secondary education and professional schools. Long-term care employers need to be encouraged to zero in on labor that has been poorly tapped in long-term care, such as Hispanics and African-Americans who are underrepresented in nursing careers; young people coming out of high school, individuals with disabilities; and older people who either cannot afford to retire or who want to work part-time.

We also need to think about expanding financial incentives such as tuition subsidies and debt relief and incentive payments for those who choose a long-term care profession.

The second goal is to create more competitive long-term care jobs through wage and benefit increases, including exploring ways to achieve more wage parity between long-term care and acute care, and to explore how to leverage current Federal and State long-term care financing to raise wages and improve benefits, including im-

plementing incentives such as pay for performance and other approaches that target payments effectively to address workforce issues.

The third goal is to improve working conditions and the quality of the jobs themselves. Higher wages and better benefits are not likely to be sufficient, because high turnover is a sign of unhappy employees. The Federal Government could grant financial incentives and/or regulatory relief to employers and states that achieve measurable improvements in working conditions and are able to demonstrate reduced turnover and improved job satisfaction while maintaining quality of care.

We could also think about creating one or more centers on long-term care leadership and management innovation to develop, identify and disseminate education and training programs, apprenticeships and best practices.

The fourth goal is to make larger and smarter investments in workforce education and development. In my judgment, one of the most important workforce improvement priorities—and Dr. Rowe talked about this as well—should be to highlight the need to rethink and totally redesign the preparation, credentialing and ongoing training of long-term care administrators, medical directors, nurses, allied health professionals and direct care workers.

Finally, the fifth goal is to moderate the demand for long-term care personnel. It is unlikely that the need for new workers can ever be completely reconciled with our growing demand because of our aging of our population. We need to promote significant investment in developing and testing and disseminating promising technologies designed to improve service delivery efficiency and to reduce the demand for hands-on care.

In addition, we have to provide better incentives to family caregivers who are already carrying the bulk of this work. This should include considering things like giving social security credits to those who leave the workforce to perform full-time care giving and to really further develop programs, so families know where to turn to for help and have more than the crumbs that they are getting currently through some of our programs.

Allowing states to consolidate current grants related to long-term care service organization and delivery and education and training—as Dr. Rowe was saying, we need to go beyond demos and actually get some of our promising models to scale, so that they become the norm rather than the exception.

In closing, what is most important is that any approach be broad-based and address the multiple issues that have and will drive today's workforce problems and future trends. Long-term care must be viewed as a related but independent sector from health care. Workforce improvement initiatives must be targeted specifically to the development of long-term care professionals across the full spectrum of settings, and not just included as an afterthought in efforts to bolster the hospital and ambulatory care workforce.

AAHSA and IFAS continue to explore solutions at the policy and practice levels and have recently created a national "Workforce cabinet" comprised of a range of stakeholders who are interested in addressing this crisis. We look forward to working with the Senate

Special Committee on Aging to ensure continued progress in this area. Thank you very much.

[The prepared statement of Ms. Stone follows:]

Dr. Robyn I. Stone

Executive Director

Institute for the Future of Aging Services

American Association of Homes and Services for the Aging

Before the

Senate Special Committee on Aging

Hearing on

Impending Shortages of Health Professionals Trained to Care for Older Adults

April 16, 2008

Institute for the Future of Aging Services
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Statement by Dr. Robyn I. Stone
Executive Director of the Institute for the Future of Aging Services (IFAS) and Senior Vice President of Research at the American Association of Homes and Services for the Aging (AASHA)

Chairman Kohl, Ranking Member Smith and members of the Committee, I am pleased to have the opportunity to testify on behalf of the Institute for the Future of Aging Services (IFAS), the applied research institute of the American Association of Homes and Services for the Aging (AAHSA) where I serve as the Senior Vice President for Research.

The members of AAHSA (www.aahsa.org) serve as many as two million people every day through mission-driven, not-for-profit organizations dedicated to providing the services people need, when they need them, in the place they call home. Our 5,700 members offer the continuum of aging services: adult day services, home health, community services, senior housing, assisted living, continuing care retirement communities and nursing homes. AAHSA's commitment is to create the future of aging services. IFAS was developed nine years ago to act as a bridge between the practice, policy and research communities to advance the development of high quality health, housing and supportive services for America's aging population.

From the very beginning of the Institute, one of our signature areas has been the development of a quality long-term care workforce. I would, therefore, like to thank the Committee for allowing me to speak about what many thoughtful stakeholders regard as a crisis. To get right to the bottom line, I think the crisis looks like this: There is a well-documented shortage of competent professionals and paraprofessionals to manage, supervise and provide long-term care services in facility-based and home care settings—the result of high turnover, large numbers of vacancies and difficulty attracting well-trained, committed staff. This workforce instability contributes to:

- Service access problems for consumers, which in many cases, has seriously compromised their safety, quality of care and quality of life;
- Excessive provider costs due to the need to continuously recruit and train new personnel and use temporary higher cost contract staff; and
- Extreme workloads for administrators, nurses and paraprofessional staff, inadequate supervision, less time for new staff to learn their jobs and high accident and injury rates.

The growing demand for long-term care, resulting from aging baby boomers and a much smaller pool of traditional caregivers, means the future will be immeasurably worse without decisive action by both public and private sectors.

IFAS has conducted a number of studies over the years that have examined both the problems and potential solutions to the long-term care workforce crisis. Based on our

work and the efforts of others such as the Institute of Medicine, I would like to spend my remaining time laying out for your consideration six broad workforce improvement goals and some possible strategies for achieving them. I do so with some fear and trepidation. Resolving workforce issues is inextricably related to all other aspects of transforming the long-term care system. How the United States chooses to meet growing demand for long-term care in the future will have a significant impact on the number and type of personnel that will be needed, how they should be compensated and trained, the nature of their work and the settings in which they work. I know from my own hard experience in working on long-term care reform as part of the Clinton administration, it isn't easy!

So, the long and the short of it is that ultimately the goals for workforce improvement must fit within a larger vision of what the long-term care system is expected to do, how it should be organized and financed and how services should be delivered. With that very large caveat, I will highlight five goals around which to organize workforce improvement efforts. Much of what I say today is drawn from several attached reports and IFAS' websites (www.futureofaging.org; www.bjbc.org) that include a broad array of strategies and recommendations.

Goal One: Expand the supply of new people entering the long-term care field.
The need to do so is obvious. The long-term care workforce is dominated by women who now have many other career choices. The administrative and nursing workforce is aging and many are nearing retirement. The traditional labor pool of caregivers is shrinking. Regardless of the vision of long-term care reform, the field will need new sources of personnel. The following initiatives seem promising and doable:

- There are wide variations in long-term care workforce shortages across regions, states and localities. Requesting the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Labor (DOL) to work together to develop the data infrastructure to track workforce shortages and to report to Congress on the status of the long-term care workforce would be a helpful planning and policy development tool for states, municipalities and employers.

- Workforce development funding under the Workforce Investment Act, TANF and other workforce development programs totaled 5.3 billion dollars in 2005. More of this funding needs to be channeled to the recruitment and training needs of long-term care employers.

- Information on long-term care careers should be targeted to post-secondary education and professional schools. Recruiters for large employers could engage deans and faculty in colleges and universities, medical schools and other graduate schools and programs in joint initiatives that expose students to long-term care career options and opportunities.

- Long-term care employers could be encouraged to zero in on sources of labor that have been poorly tapped in long-term care, such as Hispanics and African Americans who are underrepresented in nursing careers, unemployed immigrants

who were trained in health care in their native countries, young people coming out of high school who might never have considered a long-term care career, individuals with disabilities, unemployed males, mothers with young children and retirees who may only want to work part-time.

- Financial incentives such as tuition subsidies/debt relief and incentive payments for those who choose a long-term care profession could be used to expand the labor pool of physicians, nurses, and allied health professionals entering this sector.

Goal Two: Create more competitive long-term care jobs through wage and benefit increases.

Almost all stakeholders agree that low wages and a lack of employer-based health insurance, particularly for direct care workers, makes recruiting and retaining employees more difficult. Some employers argue that they cannot afford to raise wages or offer more benefits because of their dependence on public reimbursement. In the long run, higher wages and benefits are tied to fundamental reforms in how long-term care is financed and reimbursed. In the shorter term, a number of different strategies might be tried.

- Proposals could be developed to achieve more wage parity between long-term care and acute care, perhaps by convening a federal-state working group to recommend financing options.

- A working group of various stakeholders could be charged with developing proposals to leverage current federal and state long-term care financing to raise wages and improve benefits. Among the issues the work group could address are implementing incentives, such as "pay for performance" and other approaches that target payments effectively to address workforce issues."

Goal Three: Improve working conditions and the quality of long-term care jobs. Higher wages and better benefits are not likely to be sufficient to attract a high quality workforce. High turnover is a sign of unhappy employees. While many providers have gotten that message, many others have not. Too few long-term care professionals have the leadership, management and supervisory skills needed to motivate and lead frontline workers. A number of ideas could be further explored.

- The federal government could grant financial incentives and or regulatory relief to employers and states that achieve measurable improvements in working conditions and are able to demonstrate reduced turnover and improved job satisfaction while maintaining quality of care.

- DOL could be asked to study working conditions in all long-term care settings and recommend new fair labor standards or other worker protections to reduce injuries and work-related stress and improve worker safety.

- One or more "Centers on Long-Term Care Leadership and Management Innovation" could be funded by the Health Resources and Services Administration in HHS to develop, identify and disseminate education and training programs, intern and apprenticeships and best practices aimed at developing leadership and management skills in long-term care administrators, medical directors, directors of nursing, charge nurses and team leaders.

Goal Four: Make larger and smarter investments in workforce education and development.

In my judgment, one of the most important workforce improvement priorities should be to highlight the need to rethink and redesign the preparation, credentialing and on-going training of long-term care administrators, medical directors, nurses, allied health professionals and direct care workers.

- Government at the federal and state level should be encouraged to match long-term care employer investments in workforce development.

- The Institute of Medicine, as a second phase of its study of the health care workforce, could create a special sub-study devoted to the preparation and credentialing of the professional and paraprofessional long-term care workforce. Part of the study should examine the extent to which federal and state requirements for credentialing professionals and direct care workers are evidence-based and how they impact recruitment, retention and job performance including quality of care and whether and how they should be modified.

- States could be given incentives to work with nursing and medical schools, community colleges, professional associations, unions and other worker groups to conduct a "top to bottom" review of the relevance and effectiveness of their credentialing, education and training requirements.

Goal Five: Moderate the demand for long-term care personnel.
It is unlikely that the need for new long-term care workers can ever be completely reconciled with growing demand from population aging. While investments in the prevention and cure of chronic diseases could have a major impact on long-term care demand, they are beyond our scope today. There are other strategies that may have a less dramatic but still important impact on reducing the need for hands-on care. Potential initiatives could include:

- Promoting significant federal investment in developing, testing and disseminating promising technologies designed to improve service delivery efficiency and reduce demand for hands-on care in both home care and facility-based settings.

- Encouraging funding of new programs to enable frail and disabled older adults to manage more of their own care.

- Providing incentives to family caregivers so they can continue to shoulder the bulk of caregiving responsibilities. These incentives could include giving social security credits to those who leave the workforce to perform full-time caregiving and further developing formal and referral programs so families know where to turn for help.

- Allowing states to consolidate current grants related to long-term care service organization and delivery and education and training, now received from HHS and DOL, and redirect them to testing and bringing to scale comprehensive models of more efficient service organization and delivery. Grant approval could be tied to integrating workforce improvement goals into the state consolidated plan.

In closing, I want to emphasize that there are certainly many other ways to think about workforce improvement goals, and certainly many other strategies and initiatives that could be tied to the goals I have identified. To me what is most important is that any approach be broad-based and that it addresses the multiple issues that have and will drive today's workforce problems and future trends. I also think it is important—whatever goals and initiatives you select—to accompany them with concrete benchmarks that allow you to measure whether any real progress is actually made in achieving the goals you lay out.

Finally, our experience with seeding comprehensive workforce change and improvement efforts in IFAS shows us that long-term care must be viewed as a related but independent sector from health care. That is, workforce improvement initiatives must be targeted specifically to the development of long-term care professionals across the full spectrum of settings and not just included as an afterthought in efforts to bolster the hospital and ambulatory care workforce. Effective implementation, furthermore, is dependent on the collaboration of multiple stakeholders-- including employers, consumer advocates, professional associations, unions and other worker groups, educational institutions and government entities.

AAHSA and IFAS have committed to the development of a quality, sustainable long-term care workforce. We continue to explore solutions at the policy and practice levels and have recently created a National Workforce Cabinet comprised of a range of stakeholders who are interested in addressing this crisis. We look forward to working with the Senate Special Committee in Aging to ensure continued progress in this area.

The CHAIRMAN. Thank you, Dr. Stone.

This time we will turn to members of the Committee for questions and comments. We will start with the Ranking Member, Senator Smith.

Senator SMITH. Thank you, Mr. Chairman. For the record, I would like to put my statement in the hearing record.

The CHAIRMAN. We will do it.

[The prepared statement of Senator Smith follows:]

PREPARED STATEMENT OF SENATOR GORDON H. SMITH

I want to thank Senator Kohl for holding this important hearing today. The work of our health care providers and caregivers is crucial to helping of our elderly family members age with dignity. Unfortunately, workforce shortages in this vital health care and aging support system continue to plague the industry. Identifying the best methods to recruit and retain caregivers in the aging network is an issue of particular interest for me, and I thank the panelists for sharing their expertise on this topic with us today.

I particularly want to thank Sally Bowman from Oregon State University for flying across the country to share her knowledge about this field with us.

I also look forward to testimony from Dr. Rowe. As a member of the Finance Committee, I am charged with ensuring the efficiency of our Medicare and Medicaid systems. While I am a strong supporter of both programs, each faces challenges as our nation ages and health care costs continue to explode. I look forward to hearing Dr. Rowe's recommendations for system reform.

Last year, I had the pleasure of serving as a member of the National Commission for Quality Long-Term Care, which was co-chaired by former Senator Bob Kerrey and former Speaker Newt Gingrich. The Commission studied in depth the needs and constraints placed upon the long-term care workforce. On any given day, the long-term care workforce serves about 10 million Americans, the vast majority of whom are elderly. But the workforce suffers from low retention rates and a shortage of trained professionals.

The Commission learned that long-term care professionals feel that they need more training, that they have high rates of injury and that many are paid what they feel are inadequate wages. These are just some of the many problems that we must look at in order to ensure that when help is needed, it can be provided.

We also know that caregivers, who may be the child or spouse of an elderly or disabled person, suffer from the stress of trying to lead their own life while helping their loved ones stay in their home. Some caregivers may have disabilities themselves and struggle under the pressure of trying to avoid living in a facility. I am a strong proponent of supports, including respite care, for these caregivers including the Family Caregiver Support Program in the Older Americans Act.

I urge support for the work that I have done with Senator Lincoln to encourage the Appropriations Committee to increase funding to programs in the Older Americans Act. Again, this year, we led a letter asking appropriators to provide a nine percent increase in funding. Although more is needed, we believe this is a good start in making our seniors a priority and helping them to remain healthy and in their homes, where they want to be, as they age.

As some of you may know, I am from the small community of Pendleton, OR. I want to emphasize the particular difficulties that are faced in maintaining a health care and support system in rural areas. Remote locations, small numbers of patients, and difficulties in training and maintaining staff, are just some of the problems that lead to reduced access to help our loved ones in rural communities.

Like most health care professions, nurses are facing devastating shortages, especially in rural communities. Senator Clinton and I have introduced the Nursing Education and Quality of Health Care Act to increase the nurse workforce in rural areas, expand nursing school faculty and develop initiatives to integrate patient safety practices into nursing education.

Whether its nurses, physicians or allied health care workers, as the number of older Americans grows, the shortage of all health care professionals will be exacerbated.

In recent years, federal funding for programs to strengthen the health care workforce has taken a direct hit. I have written a letter to my fellow colleagues indicating my strong support to increase this funding, which will improve the geographical distribution, quality and diversity of the health care professions workforce.

As we discuss the challenges facing elder care at today's hearing, it is important to keep in mind that by 2030, the number of older adults in the United States will nearly double as the 78 million members of the baby boom generation begin turning age 65 in 2011. Our health and support systems are drastically lagging behind where we should be at this point in time to plan for the future.

I hope that today's hearing will inspire some new and effective ways that we can ensure providers of care are there when our seniors are in need.

With that, I turn to Chairman Kohl.

Senator SMITH. I want to give a particular thank you to Sally Bowman from Oregon State University for flying across the country. She will be on the next panel. I appreciate these two excellent presentations.

I wonder, Mr. Rowe, is there a State that is doing much of what you described? Is there a model out there that we should look to, or other states can look to, for achieving some progress in this area of preparing for a geriatric generation that is coming?

Dr. ROWE. I am wishing it was Oregon. But I am not sure.

Senator SMITH. I was hoping you were going to say so.

Dr. ROWE. I don't think so. But I do think that, if you look across the states and, you know the states are laboratories of democracy, right—there is a lot of different stuff going on. Much of it offers good models. You will find some models of Medicaid in some states, and some other models in other states focusing on different elements of the health care spectrum that are best practice. I think that one can assemble a profile of all the best practice. Some medical schools do a much better job of committing to geriatrics. Some nursing schools do a much better job than others.

There are good best practices, and models out there that do work and can be replicated, no question.

Senator SMITH. Isn't it a fact that people respond to incentives? Don't we need to look at things at the Federal level to incent physicians and nurses to go into geriatrics?

Dr. ROWE. Absolutely, and nurses and social workers. Some people have asked me since Monday, when we released the report, how can geriatricians make less than internists? How can that be? It is because all of their patients are on Medicare; whereas the internist is practicing with a population that has some Medicare beneficiaries, and other people paid by private insurers that have paid generally higher than Medicare. Internists have a different payer mix and a greater possible income.

So obviously, the fix to that is not too difficult, Senator; because there are—if you increase the payment from CMS for individuals with geriatric expertise—who have a board certification or a qualification—it is not going to cost that much. There are only 7,100 of them in the United States. It would at least provide an incentive, or rather, at least it would remove a disincentive for those individuals, with geriatric expertise.

Senator SMITH. Thank you, Mr. Chairman.

Dr. ROWE. Thank you.

The CHAIRMAN. Thank you very much, Senator Smith.

Senator CARPER.

Senator CARPER. Thank you. My colleagues that were here before me, Mr. Chairman. I just have one question. I am going to ask this question tongue-in-cheek. Then I would like to yield to them.

Dr. Stone, you said in your statement, you mentioned the term aging baby boomers? I was wondering how old do you have to be to be considered an aging baby boomer?

Dr. STONE. You have to be 60 this year.

Senator CARPER. I will just tell you that. Thank you. [Laughter.]

Dr. STONE. Sorry.

Dr. ROWE. I think there is some flexibility around that, Senator.

Senator CARPER. All right. Let me hasten to add, I asked the same question of Senator Nelson before he left. He said it is a question of mind, not of body.

Ms. STONE. Of course.

Dr. ROWE. Of course.

Dr. STONE. I have been aging for 30 years with the work I have been doing. I love every minute of it.

The CHAIRMAN. Thank you very much.

Senator SALAZAR.

Senator SALAZAR. Dr. Rowe and Dr. Stone, thank you for the testimony. The question I would have is on the issue of standards.

Dr. Rowe, I think you characterized it as this is a place in life where there really are no standards for those who work in the profession providing direct care; that we have higher standards for probably people who work in shops and lots of other places than we do in this area.

What would you propose that we do in terms of standards? Is that a function that we ought to leave to the states to devise standards? Is it something that has to be done at the national level? What kind of standards would you propose?

Dr. ROWE. Well, first of all, I think it is important to recognize that the standards the number of federal training hours of that are required, which we think should be increased significantly, have not changed in 20 years.

The training now for these individuals—nurse's aides, home health aides—is pretty much procedural training, how to shift a patient from a bedside to a commode, or into a wheelchair, or to help change dressings or the clothing of a patient, rather than background information about the aging process and about the characteristics of geriatric medicine and identifying risk factors for falls or medication adverse effects. So there is a real curriculum we think could be added.

There are Federal and State standards for some of these providers and just State standards for others. We feel that the Federal standards should be increased from 75 to 120 hours; and that the State should meet at least those standards, although if they wanted to have more, that would be fine.

But it is a dual requirement. So there is a Federal role here, which is obviously germane to your Committee.

Senator SALAZAR. Dr. Stone, do you have a comment?

Dr. STONE. Yes. I would add a couple of things. First of all, I think Dr. Rowe was talking about the kinds of training that is provided now and that could be. I will give you an example of a program in Wisconsin that we evaluated a number of years ago called Wellspring, which is a quality improvement model in nursing.

These CNAs were the leaders of clinical research teams. They had training together with the nurses and nurse practitioners—off-

site training for several days and around each clinical area; then they came back and were really taught, not just through observation, but actually more like an assessment without doing it. I think CNAs were not allowed to actually do the assessment. But they are the nurses' eyes and ears.

Within a year of doing this program, working around incontinence care—and I have a doctorate in public health—and I will tell you that these CNAs were amateur epidemiologists. They understood everything that was involved in the care that they were providing. They were no longer just moving somebody to a toilet. They were helping them with hydration and preventing decubitus ulcers.

The empowerment and the knowledge that was imparted to these folks was totally different than the kind of training that they get today. That is really what we are talking about here. It is not just a numbers game. It is really a qualitative difference in the kind of training, which then translates in the work that they are going to be doing.

Dr. ROWE. It enhances their self-esteem and their enjoyment and retention in the workforce.

Dr. STONE. I would say that, Senator Smith, on your end, Oregon has the best Nurse Delegation Act in country.

Senator SMITH. That is what I was expecting.

Dr. ROWE. Yes. Well, she had more time to come up with something.

Dr. STONE. Because of the Nurse Delegation Act in Oregon, the development of this frontline workforce has been phenomenal. Many other states have actually looked to Oregon to replicate that, to allow more good delegation; which is not just letting people do anything, but delegating where they have had significant training in dementia care and medication management, which leaves the other levels of staff—and Jack actually talked about this at the IOM report release a couple of days ago—to do the work that they need to do, so that everybody really becomes a team.

Senator SALAZAR. Thank you, Chairman Kohl.

The CHAIRMAN. Senator Casey.

Senator CASEY. Keep it up. Thank you, Mr. Chairman.

Dr. Stone, Dr. Rowe, thank you for your testimony. But also thank you for the scholarship that goes into the testimony itself and the experience.

I am trying to think of it—must have been 10 years ago now that the Philadelphia Enquirer did a whole series on, as a lot of newspapers have over the years, on long-term care. One line from one of those series, one of those stories, I should say, in the series has stayed with me forever. The writer said something along the lines of advocates for the frail elderly say that life can have quality and meaning, even to the very last breath. Such a simple yet profound statement about the end of life and the value of it.

There is one thing I wanted to ask you about, because you both addressed it in different ways and with a lot of scholarship. It is the challenge of recruiting and retaining, but especially recruiting people to do this work—the back-breaking work, in many cases with low wages and inadequate benefits—all of the things that we know that are not attractive about this work.

My sense of it is, spending some time with direct-care workers, especially CNAs and people at that level of the workforce, is that they really do have a sense of mission about it and a sense of purpose. I just wanted to get your reaction to this—both of you have talked about the urgency of recruitment and retention. Both of you have talked about the wage and benefits aspects of this.

But let me ask you this. Somewhere along the way in the last 8 or 10 years, I read a study done of what these workers bring to the table in terms of their own attitudes about their work. At least in one survey, I remember that wages and benefits weren't at the top of the list. It was the stake they had in the management of the place in a long-term care setting, or their involvement with the care.

Dr. STONE. Right.

Senator CASEY. They wanted to feel like they were part of the decisionmaking and how care was delivered. I just wanted to have you speak to the broader question of recruitment, but in addition what motivates people to do this work, and how we can incentivize motivating it?

Dr. STONE. I could talk from the direct care worker area. We have done a lot of work in this. Clearly, that is true. The organization of the work and the involvement in the actual activities that go on every day is what really makes the difference for these folks. No. 1 is caring for the people. I mean, there is a tremendous connection. Second is having the empowerment and the support from organizations, whether it is a home-care agency or a nursing home or assisted living or a hospital, to really do that work as part of the team.

The beauty of the geriatric focus is that everybody across the entire spectrum—whether it is the physician, the nurse, the social workers, the allied health professionals, the frontline caregivers—all are getting this kind of interdisciplinary training around how to really work together. In the best of all worlds, where you have seen real models work, everything rises.

One of the things that I really like about the IOM report and this Committee today, that we are not just talking about direct care workers, we are not just talking about physicians, nurses, social workers. We are talking about it across the spectrum. This has got to be a systemic change, because we can help the direct care workers. I mean, they already are committed to what they do. But unless we get the entire system to work together around this, it is not going to work.

So we need everybody in this together at every single level.

Dr. ROWE. I think that the difficulties that we are having in generating and sustaining the workforce differ at each level. There are tremendous drivers with respect to morale and conviction and dedication for the direct care workers. But then the characteristics of other parts of the workforce—the shortages of other workers to help them get their work done—and their low salary, drives them out.

At the nursing end, the problem is not enough instruction, not enough faculty. There aren't enough geriatric nurse faculty in American nursing schools to train individuals to be specialists in nursing.

On the physician side, there are a lot of funded genetic fellowship programs that go vacant every year, because physicians aren't applying for them. About half of the slots in the country go vacant. Part of that has to be that the average medical student graduate has $100,000 in debt. They are looking at the specialty, which is the lowest paid. So that has to be, at least for some of them, an important consideration.

But I think the secret here is a commitment to help the entire workforce, not just one piece of it; because our problem is compounded by the deficiencies in each level. If we had deficiencies at one level, but we were OK in the others, we could work it out. We need a commitment to help the entire workforce by having the sophistication to recognize that the different elements of the workforce have different problems and need different fixes. There is not a one-size-fits-all fix here.

Dr. STONE. I would like to just add one little thing. This is about economic development, because these are the sectors that are growing in the 21st century. So it is also an investment in our economy to think about how we shift a little bit from where we have been putting a lot of our resources and redistribute into where the jobs are going to be over the next 20 and 30 years. So it is a challenge. But it is also an incredible opportunity.

Senator CASEY. Thank you.

Dr. ROWE. Thank you.

The CHAIRMAN. Well, thank you both very much. You have been informative and helpful. We appreciate it.

Yes, sir, Senator Carper.

Senator CARPER. I actually did have a serious question too. Could I?

The CHAIRMAN. Sure.

Senator CARPER. Thanks. I am going to be stuck on that first question for a while.

Somewhere in what I have read coming into the hearing today, I noted that we are going to need an additional roughly 3 million, 3.5 million people to provide health care for us aging baby boomers and others in our population just to maintain the current ratio of providers to the total population. We do a whole lot in our state, our congressional delegation. We try to help Delaware Technical Community College, University of Delaware, Lesley College, some of our hospitals where they train nurses, to try to make sure that they have the resources they need to train the workforce that will be needed to take care of the rest of us.

On the other hand, though, we also look to a couple of our hospitals. We have a VA hospital in northern Delaware that we are very proud of. They use information technology. In fact, we do this nationwide through the VA in ways that enable us to save costs, save lives, make your folks providing the health care more productive. I am sure you are familiar with the work that they have done.

Another of our larger hospitals is called Christiana Care. They have a visiting nurses association—I think they use a telehealth system—that they find is a cost-effective, user-friendly way to manage nursing resources and need for services.

Have you identified any technologies that are being developed or used to reduce the demand for hands-on—care using well-trained

hands to provide the care that we are going to need? Or some technologies that are still being developed? Can you give us some examples that we might find encouraging?

Dr. ROWE. We have a section of our report that deals with technologies, Senator, specifically. There are various technologies and remote monitoring technologies, so that problems are detected sooner, and somebody isn't lying on the floor of their kitchen for three days without anyone knowing it; and therefore is much more ill when they are discovered than they would have been with earlier intervention.

Senator CARPER. Give us a couple of others.

Dr. ROWE. Well, one can have technologies where you can understand what individuals' vital signs, blood pressure and pulse and temperature and monitoring those, so you know the effects of various medications. There are technologies that help move patients, that make it much easier for individuals to move patients around and position them.

There are a whole variety of recommendations here that we think NIH and other organizations have a real opportunity to conduct additional research on that might be very helpful—and that could help to make up for the shortage, Senator, in the workforce; because we are just not going to get there. Even if you and your colleagues did everything that we recommended and other groups would recommend, it is really going to be hard to get there.

So we are going to have to rely on these new technologies. We have to invest in more bioengineering research.

Senator CARPER. Dr. Stone.

Dr. STONE. I would just add a couple of things. One is in the area of medication management, which is a big one, particularly for people living in the community. There are increasing technologies for actually helping patients with more self-management. To the extent that can happen, we can have less need for people to be in people's homes, and monitoring them. I would also like to put in a plug for AAHSA's Center for Aging Services Technology.

Senator CARPER. What is it called?

Dr. STONE. The Center for Aging Services Technology, which is one of the centers within the American Association of Homes and Services for the Aging, which has brought together researchers, providers and companies who are actually interested in exploring technologies that are going to mitigate the need for some of this labor, but also provide efficiency, to complement the labor that is needed as well. So it is not an either/or. It really is complemetarity.

Dr. ROWE. If we have the technologies, then we have to have the standards to train the health care workers in the use of the technology.

Dr. STONE. Right.

Dr. ROWE. This is a very, very important consideration. So that is going to even further enhance the training requirements. You can't just, you know, wheel the technology into the room. We have to have somebody who understands how to apply it and how to understand what it is telling them.

Senator CARPER. We used to visit my mom when she was living down in Florida. She had early dementia. I remember—some of my colleagues may recall with relatives of their own, or people in the

audience—we kept her medicines in what looked like a fishing tackle box. There are certain medicines you are supposed to take in the morning and at noon, in the afternoon, you know, with meals and so forth. We were always concerned that she took the right medicine at the right time.

My sister and I used to say, "I wonder if anybody has ever actually looked at the medicines she is taking." They were prescribed by a range of different physicians who probably never met each other, never talked to each other. We were wondering, "Does anybody ever think about what all these medicines taken together do to our mom?" So are you suggesting that we have some technology that actually does that kind of thing these days? That is good. That is a good thing.

Last question, if I could, Mr. Chairman.

My youngest son is a senior in high school, graduating. His girlfriend has an older brother who is going through med school. He is going through his rotations right now. We were talking to him not long ago and saying, "Well, what kind of doctor do you want to be?" He told us—he obviously hadn't really made up his mind. But I don't think he is thinking about specializing in geriatrics.

He told us about some of the things that medical students are most interested in becoming—dermatologists, are like, right at the top of the list. We said, "Why?" He said it was because it is the nature of the work. It is not bad. It is not heavy lifting. They are paid pretty good. They are paid pretty good.

Dr. ROWE. On average, $300,000.

Senator CARPER. Yes.

Dr. ROWE. Versus $163,000 for geriatrics.

Senator CARPER. Versus what?

Dr. ROWE. Versus $163,000 for geriatrics.

Senator CARPER. That would give somebody pause, wouldn't it? It is about what we make around here, isn't it?

Dr. ROWE. It is not that dermatology isn't important. It is obviously important. But it is an interesting comparison.

Senator CARPER. You are suggesting that one of the reasons why the pay for those specializing in geriatrics isn't high is because a lot of the compensation comes from Medicare. If you look at what we pay for Medicare compared to what people can——

Dr. ROWE. I recognize that we have a Medicare trust fund problem. But the fact is that if we paid geriatricians who have qualifications and a way to recognize that, given the scale of the financial problems you folks deal with, there are only 7,100 of them in the United States. It is just not going to cost that much. It might remove a disincentive, so that half those fellowships will not go empty every year.

Senator CARPER. Very well. Thank you both very much.

Thanks, Mr. Chairman.

The CHAIRMAN. Senator Whitehouse, do you have any comment or question?

Senator WHITEHOUSE. I'm trying to get my microphone to work. There we go. Thank you, Mr. Chairman, yes.

This has been a matter of considerable interest in Rhode Island. As you probably know, Richard Besdine at the Brown University Medical School is probably——

Dr. ROWE. I wrote a text book with Richard Besdine.

Senator WHITEHOUSE. Well, he was probably the first person to get specialized geriatric education. He had to go over to Scotland to get it at the time. There was no such thing in the United States. Since then, as you have pointed out, it continues to be a very underrepresented field. The financial incentives aren't great.

But it is a highly specialized field. People really need to know how the body of a very elderly person is truly different than the body of younger people and be able to appreciate that in the way they treat them.

But the cost issue is considerable. I wonder if you could comment on whether you find opportunities, or where you find opportunities, in improved coordination of care that may ideally lead to cost savings as a result of chronic care being better managed, that could then be plowed back into.

Dr. ROWE. Yes.

Senator WHITEHOUSE. Increased reimbursement for the geriatric community.

Dr. ROWE. I think it is a very sophisticated question. Dr. Besdine at Brown University and I founded the program in geriatrics at Harvard Medical School together many years ago, along with Dr. Wetle. I know him well.

We do speak in our report, the IOM report, about models of care that have proven to be cost-effective and have improved quality of care. There are a number of characteristics of these programs. There is a long list of them here.

Senator WHITEHOUSE. One of them is improved information technology support.

Dr. ROWE. Some of them relate to that. Some of them are just interdisciplinary teams, job delegation. IMPACT is a program the Hartford Foundation funded to recognize and treat depression in the elderly early, which was very effective and cost-efficient. But once the study was over, there was no funding to keep it going, because the kinds of things the people were doing in the team were not supported by Medicare.

So the point we have made in the discussion is that there needs to be a consideration of how to sustain new models. We have a whole bunch of proven things that we are not implementing into our health care system.

Senator WHITEHOUSE. I would love to follow up with you offline on that.

Dr. ROWE. It would be our pleasure, Senator.

Senator WHITEHOUSE. I think there has been a lot of work done on this. It seems to me that the next step is to find some pilot projects where it can be given a little bit more real-world shakeout. Then perhaps put in systemwide——

Dr. ROWE. You have some integrated health systems in Rhode Island that could implement these in several hospitals at once.

Senator WHITEHOUSE. Yes, great.

Dr. Stone.

Dr. STONE. I would just like to add one thing, however, because we have about 25 years of history in this. The problem is that we also need to have people trained to do it. The whole new issue around the medical home, for example, that is supposed to be the new panacea for coordination—unless you have people who are trained to understand how to coordinate, the model will not work. You have to get back to what people can do in order to actually implement that.

Senator WHITEHOUSE. Yes. You have an airplane, you have got to have pilots who can fly it.

Dr. ROWE. Yes. It is not a naturally occurring event.

Dr. STONE. It is not just going to happen.

Dr. ROWE. We need to get these people together and they will start behaving differently.

Ms. STONE. Yes.

Dr. ROWE. They need to be trained.

Senator WHITEHOUSE. Understood.

I thank the Chairman.

The CHAIRMAN. Thank you very much, Senator Whitehouse.

We thank the first panel. We appreciate you being here.

Moving on to the second panel, our first witness will be Martha Stewart, who needs little introduction. In addition to being the founder of Martha Stewart Living Omnimedia, which includes her expansive multi-media portfolio of award-winning brands, Ms. Stewart has experienced life as a family caregiver for her mother, Martha Kostyra.

In 2007, Martha was inspired to open the new Martha Stewart Center for Living at the Mt. Sinai Medical Center in New York. The center is an outpatient facility for geriatric medicine, which provides clinical care and education for patients, offers training for physicians and coordinates healthy aging research and practices.

We will hear from Dr. Todd Semla, who is the president of the American Geriatrics Society, where he has been a member of the editorial board of Annals of the Long-term Care since 2002. Dr. Semla is a clinical pharmacy specialist with the U.S. Department of Veterans' Affairs Pharmacy Benefits Management Service, as well as an associate professor at Northwestern University's Feinberg School of Medicine.

Next, we will hear from Mary McDermott, a member of the board of directors for the Wisconsin Quality Home Care Commission. A former corporate systems efficiency expert, Ms. McDermott left her job in 2000 to become a full-time care provider for her parents. She understands long-term care training and quality of care issues, as both a service provider and a family caregiver.

Senator Smith, would you like to introduce your witness?

Senator SMITH. Thank you, Mr. Chairman.

Ms. Sally Bowman is a respected professor of human development and family sciences at Oregon State University, where she has been a faculty member since 1994. She will share with us her experience working with families who have long-term care needs and the importance of gerontology specialists. Thank you, Sally.

The CHAIRMAN. We thank you all for being here. Just one comment. Martha Stewart does need to leave rather soon. So we are

going to ask her to give her testimony and answer questions. Then we will move on to the other three.

Ms. STEWART.

STATEMENT OF MARTHA STEWART, FOUNDER, MARTHA STEWART LIVING OMNIMEDIA, NEW YORK, NY

Ms. STEWART. I appreciate the invitation to testify before you today and am honored to be here. You have chosen a subject that is increasingly critical to our quality of life—not only for older Americans but for family members who care for them. I look forward to learning from the work of the Committee as it continues to examine this issue.

The experience of the distinguished professionals on your panel today will be important as well. I especially appreciated the remarks of Dr. John Rowe and Dr. Stone.

I respond to your invitation today as a member of a family whose eyes were opened by personal experience and to share what we have been learning at the Martha Stewart Center for Living at Mount Sinai Medical Center in New York City.

My professional life has been centered on the home, the well-being of the family, and everything that these subjects encompass. When I began working in this area more than 25 years ago, the subject of homemaking as it relates to families was largely overlooked, though the interest was clearly broad and the desire for information strong. My colleagues and I soon discovered we were satisfying a deeply felt unmet need.

Today I see a similarly unmet need. Our aging relatives and the families who care for them yearn for basic information and resources. We all know that this is a significant sector of our society. More than 75 percent of Americans receiving long-term care rely solely on family and friends to provide assistance. The majority of these caregivers are women, many of whom are also raising children. Often, these women are working outside the home as well.

I understand the challenges family caregivers face. My mother, Martha Kostyra, passed away last year at the age of 93. My siblings and I were fortunate that she was in good health almost until she died. But we still came to know first hand the number of issues that needed to be managed.

First, it is difficult, especially in smaller cities and rural locations, to find doctors experienced in the specific needs that arise with age. Think of all that this includes: the effect of medications on elderly patients; how various medicines interact with one another; warning signs for depression and onsets of other conditions increasingly common in the elderly.

How do we ensure that they take their medications? How do we help structure our parents' lives so that they can live independently for as long as possible? How do we support the generation of caregivers who devote so much of themselves to their parents' aging process?

This only touches on the myriad of issues, of course. Worry is the backdrop for everything these families do. What if the parent falls? What if she leaves the burners on? What if he takes his medications twice or forgets to take them at all?

Now I am learning even more about the physical, emotional and financial toll that the experience can exact. Caring for an aging parent or loved one can be another full-time job. In fact, 43 percent of baby boomers have taken time off from work, and 17 percent have reduced hours to help care for an aging parent. They do this at a time when their expenses are rising.

One recent study found that half of those caring for a family member or friend 50 years or older are spending, on average, more than 10 percent of their annual income on caregiving expenses. Many dip into savings and cut back on their own health care spending to cover the bill. Is it any wonder that family caregivers are at increased risk of developing depression, anxiety, insomnia and chronic illnesses themselves?

In our Kostyra family, we were grateful to be there for my mother, who had given so much to us and was a well-loved presence in our lives and in the lives of her 13 grandchildren. Our experience in her final years, and my resulting awareness of the issues many Americans face, is one of the reasons for the creation of the Center for Living. The goal of the Center, which is dedicated to my mom, is to help people to live longer, healthier, productive lives even as they age.

We have set a goal at the Center to use research and the practice of geriatric medicine to try to elevate the level of eldercare and its importance in our society. Did you know that there is currently one geriatrician to every 8,500 baby boomers? That is clearly not adequate.

We are also working to develop new tools and resources for caregivers. We are collaborating with a large number of organizations and motivated, experienced individuals, many of whom have been studying these issues for years. There are numerous devoted and knowledgeable people in arena, and we hope we can all learn from each other.

This is a field that eventually impacts most families in emotional and encompassing ways. Yet sometimes it is the simple solution that holds an answer. Not long ago at the Center, a woman brought in her father who had suffered a stroke two years earlier. After the stroke, he had been told that he could never eat again and was placed on a feeding tube. He was devastated and depressed. He had spent his life as someone with a passion for good food, and his future looked very bleak to him.

At the Center, a doctor experienced in geriatric care asked the man to drink a glass of water. He did, without a problem. "If he can do this," the doctor said, "he can eat." This simple exchange improved the man's quality of life immeasurably. I am sure it improved the quality of his daughter's life, too, knowing that her father was happier and could eat.

I want to share with you three things I have learned from our work at the Center and that others may find useful. One, we must make an effort to coordinate care. Most older Americans have several doctors. It is important for these doctors to cooperate with one another and work closely with caregivers.

Two, it is important that we as a society recognize the stresses and challenges that caregivers face and support them as best we

can. We want to ensure that their health isn't undermined by the demands of eldercare.

Three, we must encourage families to open up a dialog now. Even if your older relatives are in good health, as my mom was, it is important to plan for a day when they might not be.

I have always been a firm believer in the role of preparation and organization in progressing toward a goal. My concern today is whether our country and our overstretched medical system can possibly meet the demands of those 76 million baby boomers who will start turning 65 in the next two years. We are on the cusp of a health and caregiving crisis that has to be addressed now. I know you recognize this, and that is why we are here today.

I thank you for your dedication to this important matter and for the opportunity to express my thoughts.

In fact, I am here with Dr. Brent Ridge, who was a geriatrician at Mt. Sinai hospital. Brent is now working with me on the Center for Living and on other initiatives involving caregiving. We are writing a handbook for caregivers. We have gotten as far as a very complete outline. Now we are starting on the actual text.

It is a very difficult job. There are lots of handbooks, lots of guidebooks. But very few of them address all the very serious subjects that a caregiver and the aging population really have to face.

So thank you very much again for inviting me here.

[The prepared statement of Ms. Stewart follows:]

Martha Stewart
U.S. Senate Special Committee on Aging
April 16, 2008

Chairman Kohl, Ranking Member Smith and members of the Committee: I appreciate the invitation to testify before you today and am honored to be here.

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First, it's difficult, especially in smaller cities and rural locations, to find doctors experienced in the specific needs that arise with age. Think of all that this includes: the effect of medications on elderly patients; how various medicines interact with each other; warning signs for depression and onsets of other conditions increasingly common in the elderly. How do we ensure that they take their medications? How do we help structure our parents' lives so they can live independently for as long as possible? And how do we support the generation of caregivers who devote so much of themselves to their parents' aging process?

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- We must make an effort to coordinate care. Most older Americans have several doctors. It's important for these doctors to cooperate with one another and work closely with caregivers.

- It is important that we, as a society, recognize the stresses and challenges that caregivers face and support them as best we can. We want to ensure that their health isn't undermined by the demands of eldercare.

- We must encourage families to open up a dialogue now. Even if your older relatives are in good health, it's important to plan for a day when they might not be.

I have always been a firm believer in the role of preparation and organization in progressing toward a goal. My concern today is whether our country and our over-stretched medical system can possibly meet the demands of 76 million baby boomers who will start turning 65 in the next two years. We are on the cusp of a health and caregiving crisis that must be addressed now. I know you recognize this and that is why we are here today. I thank you for your dedication to this important matter and for the opportunity to express my thoughts.

The CHAIRMAN. Thank you, Ms. Stewart. In what ways do you think the Martha Stewart Center for Living at Mt. Sinai Medical Center meets the needs of older adults, their families as well as to professionals who serve them?

Ms. STEWART. Well, in many, many ways. We rebuilt the geriatric center at Mt. Sinai to make it a very comfortable and welcoming place. There are more than 3,000 patients that visit the Center on a regular basis. Every patient at the Center is assigned to a clinical social worker to help patients and families with the many social and financial issues that accompany aging.

In addition to over 20 geriatricians at the Center, there are also cardiologists, nephrologists, endocrinologists, nutritionists, psychiatrists, gynecologists and pain specialists, all in one place, which really does facilitate the coordination of the care of these patients.

Electronic medical records rather than paper charts are used here, so that all doctors can easily access patient information and can check up on the care of these patients. That way, there isn't a medicine that is going to react badly with another medicine, which oftentimes does happen with these patients.

My mom visited, oh, I don't know how many different doctors. She was always—and when I called her up, she was always going to another doctor. I said, "Mom, are you taking all your records?" She said, "Oh, I know exactly what I am doing." But not really. I mean, because it was very complicated. I couldn't even understand what she was taking. I mean, I saw the drawers of things. So this is terribly important, this medical records sharing that is going on now.

We have wellness lectures and yoga and T'ai Chi and meditation classes—it's also very important just to encourage the aging to do those very vital exercises. Every medical student who graduates from Mt. Sinai rotates through the Martha Stewart Center for Living, so that they graduate having some exposure to managing the care of this special patient population. So that is another way to encourage the universities, the medical schools, to get students into thinking about geriatric medicine.

We just opened the Center, as I said, late last year. So it is really too early to pronounce our model successful. But we are confident that it will be and that our complete approach to patient care can be integrated into other medical facilities in this county and hopefully elsewhere.

The CHAIRMAN. Thank you.

Senator SMITH.

Senator SMITH. Ms. Stewart, I think we are all grateful that you are here. Certainly I admire your Center for Living. What you just described is ideal. Your mother was in a rural area. I am from a rural part of Oregon. I think about all the things that we need to do yet in Government. In fact, we are holding this hearing to try to elicit good ideas.

It seems to me, with the demographic aging of our country, if people are counting on Government to fix it all, make it perfect, I think our faith in that is probably going to be disappointed.

But you spoke about your mother. It reminded me of how we lost our mother. My mother had 10 children. It was, at the end of a

wonderful, beautiful life, when she had a very sudden bout of pancreatic cancer. We all took turns at her bedside taking care of her.

It just does seem to me that one of the missing ingredients here that is part of living is that we will all die. Her death was, in fact, if it can be described as beautiful, it was that. It was because she had her family around.

I wonder if you have a message for American families as to our responsibility to our parents, not just to be there, but perhaps to become more educated. Is there a part of your Center that trains family members to take care of their moms as they are dying?

Ms. STEWART. Well, that is what the book will help, the book that we are working on, the Care Living Guide, which I hope will encourage the children of the aging to take it very seriously that mom or dad plans for the future. You know, my mom just didn't—she really didn't plan.

She had six kids. We were all well-off. We could all take care of her. She was self-sufficient. She never asked us for anything. She had been a teacher. She had her pensions. She did all her bookkeeping herself. She did her tax returns herself. She was quite an astute and intelligent woman.

But she never really said, you know, maybe I shouldn't really be in western Connecticut. It wasn't so rural, but she still needed a car to get anywhere. She became her friends' chauffeur. She was chauffeuring friends that were younger than she was, because she was still able to drive at 93.

But she didn't plan to, you know, go to a warmer climate. She didn't plan to make herself more comfortable as she aged. She really felt that the activity around her was the most important thing. We continued to give her that activity. I mean, she did 40 segments on my television program. Even her own children didn't realize that. They didn't realize what a fantastic contributor she had been to my life and to the lives of so many other older people in America. She gave them lots of hope that they could age gracefully as my mother had.

But even that aside, the whole aging and the whole dying process just made me realize that you have to plan. You have to have help. You have to have intelligent resources, not just financial, but from everyone to get old gracefully and live well until you die.

Senator SMITH. Perhaps to Americans living in rural places, a word of counsel to become educated and, literate on caring for our parents.

Ms. STEWART. Absolutely. Very important.

Senator SMITH. Probably good counsel to all of us to be nice to our kids and keep family relationships strong, because if you live in Pendleton, OR, like I do, you may not have all of the care that you might in Connecticut, for example.

Ms. STEWART. Well, even in Connecticut, some of her friends don't have any care—ones without children and without—I see it all the time. They come to me asking for help. I am there to help them, because it is a community.

Senator SMITH. Well, I thank you for what you are doing. It is commendable example for all of us. You have added measurably to this hearing and to bringing our focus on this emerging problem.

The CHAIRMAN. Thank you, Senator Smith.

Senator SALAZAR.

Senator SALAZAR. Thank you very much, Chairman Kohl.

Thank you, Ms. Stewart, for testifying here today and to all the panelists as well for being here today. Thank you also for leading the way in helping us figure out what we ought to be doing with our elderly population and dealing with long-term care issues.

I have a question of you, because frankly you are a master of marketing and communication throughout the country and throughout the world. I think when I hear Senator Smith's question to you about how we get our families involved and educated about long-term health care issues, it goes way beyond that.

I come from a family of eight children. My family has lived on the same farm for 150 years, almost 300 miles south of Denver, CO. We took care of my father until he passed away from Alzheimer's at age 85. My mother, who is 86, still lives on the ranch. We take turns taking care for her. So I understand the importance of the nexus between the children and the parents.

But I also think that, as a society, we aren't very good in terms of planning for those later stages of life, whether it is financial planning, whether it is medical planning, if long-term health care is a part of that. So based on your expertise and communications, how is it that we can move our society to having a more honest and educated view of what we do as we get through the aging process?

Ms. STEWART. Well, things have changed, I think, tremendously in the United States. We have become more youth-centric than aging-centric. I think that that has to—we have to have a shift because of this huge number of baby boomers that are reaching 65 years old. That is still not old. I mean, you are still a vital person at 65 years old.

But as you get older, you realize that you have to rely on others many times for transportation, for meals, for just living expenses. We have not really done a good job in teaching our children to care for the elderly. Our advertising is still focused on the young. We should be focusing more on the aging population.

I think that is all going to happen. I am working on a magazine for women over 50 now. I need this magazine. I know all my friends need this magazine. One doesn't exist in this country without trying to encourage and inform, and I am going to spend the rest of my time doing this kind of educating. I think that there are other people in my position that can also be very, very helpful. But that doesn't mean that we can't also focus in Government on these issues and medicine on these issues to get people focused on the care and the well-being of the aging population.

Senator SALAZAR. I appreciate it very much. Senator Whitehouse and I once worked together as attorneys general for a number of years and had a number of initiatives with AARP and other organizations trying to deal with it.

Ms. STEWART. They have done a phenomenal job. But they don't reach everybody. That is a problem.

Senator SALAZAR. Sometimes I wonder there are a lot of efforts out there from lots of organizations and lots of wonderful-meaning people. But I wonder how effective we are being in terms of actually reaching the population at a point where they are making decisions for the long-term. Sometimes, my senses is that we have

made some progress. But if there is 100 miles to go, we have gone maybe only the first mile——

Ms. STEWART. I think there are 100 miles. I think that we really do have to focus. I intend to, as an individual. I hope many other people do too.

Senator SALAZAR. Thank you for being here today.

Ms. STEWART. Thank you.

The CHAIRMAN. Thank you very much.

Senator CASEY.

Senator CASEY. Thank you, Mr. Chairman.

Ms. Stewart, thank you for your testimony and for the insight you bring to us from a personal perspective as well, which I think informs all of us.

I was looking at your testimony in the last section, when you have I guess—there are three bullet points. The second one, when you talk about, "It is important that we as a society recognize the stresses and challenges that caregivers face and support them as best we can."

I was thinking about one initiative in Pennsylvania about 20 years ago it started. I am pretty sure it is still being funded. It was called Aid to the Caregiver. It was an innovative way to have Government help a little bit to provide aid or respite care of one kind or another. I think there have been similar models in the Federal Government.

But I just wanted to have you expand upon that point in terms of what you have seen, either in the public sector or the private sector and non-profit sector, of models or programs that speak to the goal of trying to give some aid or relieve some of that stress.

Ms. STEWART. Well, there is Gail Hunt who heads up the National Alliance for Caregiving. She has been a wonderful resource to us at the Center for Living at Mt. Sinai also. Dr. Robert Butler, who founded the department at Mt. Sinai. It is the oldest geriatric department in America. I don't know if you know that. Now, he has also founded the International Longevity Center. He is actively involved in confronting this caregiving crisis.

So there are people really working in this area, really trying to help solve the problem. It is just a question of focus. It really is—and a large focus.

Senator CASEY. What is it about the way that that kind of respite care is given? In other words, if you have a particularly difficult situation you are caring for, and it is usually women that are doing this—caring for an older relative, a parent or something like that. What do you think is the—and this is a broad generalization—but what do you think is the most common relief they can be provided with?

Is it taking a day off? Or is it more giving them a break a couple hours a day. Or is it a longer break?

Ms. STEWART. It is very hard to say. I personally work 7 days a week. I have many jobs that I do for my company. But I always tried to see my mother ever single Sunday. Someone would go to pick her up, bring her to my house. The last 6 months or so, she wasn't really driving a distance. She could drive around town, but couldn't really drive a distance any longer. I live about 35 minutes from where my mother lived.

But I would have her over, try to entertain her. On her 93rd birthday, I had a dinner party for her. She controlled the conversation. We asked her to just reminisce. I had all my friends there—not her friends, but my friends. So they could really get to know her. Who knew she was going to die a few months later?

But it was fascinating, because she really wanted to be independent. But she really wanted to have the interaction. Making time to have the time to be interactive with an elderly person in your family, or taking the time to just contribute to an organization, so that you could give time to somebody else, it is very important. It is just a way of living.

That is what we are trying to do in the Center. We are trying to be a place where you can go, learn and be cared for, and feel wanted. I think that is really one of the major things.

In New York, there are many older people. I was looking up the statistics today about the numbers of elderly. In New York, 13 percent are over 85 years old; in Pennsylvania, 15.15 percent; Maine, 14.4 percent; Florida is the highest, 16.79 percent. That is a lot of people. It is getting to be bigger and bigger and bigger over 65 now.

So we just have this big challenge.

Senator CASEY. Thank you very much.

Ms. STEWART. Wish I could answer all the questions.

The CHAIRMAN. Thank you very much.

Senator WHITEHOUSE.

Senator WHITEHOUSE. Thank you, Mr. Chairman.

Thank you for being here, Ms. Stewart. I was struck by the question of the distinguished senator from Oregon, because I did not know until this minute that we shared the common experience of having our mothers die from pancreatic cancer.

Ms. STEWART. Painful and horrible.

Senator WHITEHOUSE.—Senator Salazar mentioned, when we were attorneys general, we did a certain amount of work on, in my case, particularly end-of-life care, which is sort of a particularly sensitive and tender aspect of all of this; but also one that is potentially very ennobling.

The experience that I have seen and heard of from too many people is that, at that time, there are far too many Rhode Islanders and far too many Americans who are experiencing far too much pain, who are experiencing far too much either confusion about or failure of, their advance directives, and far too many who are experiencing continuing medical intervention that is well-intentioned, but is kind of on the "don't just stand there, do something" theory.

Frankly, everybody would be better off if the family had the chance to stop, settle down and deal with the occasion and experience of that loved one's passing away. I just think we are terrible at that in this country, by and large.

I was delighted to hear that Senator Smith's family had the experience of having a beautiful death. We have had a beautiful death in my family. We have also had some pretty unpleasant ones. The difference seems to follow along these lines. It is something you can prepare for, if it is done right. But there is very little support for those decisions.

In fact, institutions seem to be leaning very strongly in favor of less pain medication, with continuing confusion over what the ad-

vance directive means, and general disinterest in complying with them. Then for God's sake, let's not stop doing things until it is all over, even if that is highly painful and costly emotionally to the family.

I am just wondering what thoughts you bring to that particular issue.

Ms. STEWART. Well, I am a fighter. I am going to be here forever. I am never willingly going to die. I wish I could find the fountain of youth that we are all looking for. But you can't really, I think in this Committee, approach it that way.

You just have to really encourage support of caregiving and support of geriatric medicine to deal with the problems of the elderly. I think that that is really what we have to focus on, having places like the Mt. Sinai Center, the Martha Stewart Center for Living that will really help those patients with many, many, many different problems there and not burden the family with everything. The family can't really take the brunt of it all.

I don't think it is just the family. The family will help, but a lot of people don't have large families and lots of kids. What is going to happen to those people?

So it is a huge challenge. It has to be dealt with, as I said, in a very systematic and careful way to develop programs and encourage the universities to encourage people to study geriatric medicine and provide subsidies for caregivers. I don't really know anything about any of that. All I know is that they need information, education and help.

Senator WHITEHOUSE. Well, you are a great communicator. You are a great person at helping Americans experience the transitions and passages of their lives, birthdays and things like that in a more favorable way than they might otherwise. I would urge you to think about the end-of-life care. Thank you.

Ms. STEWART. Thank you.

The CHAIRMAN. Ms. Stewart, thank you so much for being here. You have helped us immeasurably and we appreciate your giving us your time today.

Ms. STEWART. Excuse me for having to leave. I have some other obligations I have to go to. But I greatly appreciate the invitation.

The CHAIRMAN. Thank you so much.

We now turn to the second member of the panel, Dr. Todd Semla.

STATEMENT OF TODD SEMLA, PHARMD, PRESIDENT, AMERICAN GERIATRICS SOCIETY, EVANSTON, IL

Dr. SEMLA. Good afternoon Chairman Kohl, Ranking Member Smith and members of the Committee. Thank you for inviting the American Geriatrics Society to address the Committee on preparing our nation's health care workforce for the growing number of older Americans.

The American Geriatrics Society is a non-profit organization of 7,000 health professionals dedicated to improving the health, independence and quality of life of older Americans. Geriatricians are primary care physicians who complete residencies in family practice or internal medicine, and at least one additional year of fellowship training in geriatric medicine.

Geriatricians specialize in the often complex health condition and requirements of older adults. As Dr. Rowe stated, today there are fewer than 7,200 certified geriatricians practicing in the United States—roughly half the number needed.

There are similar shortages in other disciplines. In all disciplines, there are insufficient number of geriatrics faculty to train upcoming geriatricians and conduct aging research. Today I will offer some solutions for your consideration. Many parallel the recommendations of the recently released IOM report on the geriatrics workforce.

We need to establish Federal loan forgiveness programs for geriatric health professionals. Encouraging future physicians burdened with school loans to consider a career in geriatrics is a challenge because of financial disincentives, as you have heard. In most fields of medicine, additional training results in higher income, but not so in geriatrics. A national loan forgiveness program would offset at least a portion of the financial burden of pursuing a career in geriatrics.

As you heard Senators Boxer and Collins have introduced a geriatrics loan forgiveness bill. We support the principles underlying this bill.

We need Congress to reauthorize expand and fund Title VII health professions programs. We have specific recommendations for the three programs that are critical to training health care professionals in geriatrics.

First, AGS recommend expanding the Geriatric Academic Career Awards (GACA) to support not only career development for geriatric physicians in academic medicine, but also junior geriatrics faculty in other health professions such as nursing, pharmacy and social work. We recommend creating a mid-career GACA award that would support and retain clinician educators as they advance in their careers.

Second, we recommend expanding the Geriatric Education Center Program to support 14 additional GECs. Currently there are 48 in 36 states. Ideally, the mandate of the GECs would also be expanded to include training of direct-care paraprofessionals.

Third, we recommend that Congress consider expanding the geriatric faculty fellowship programs by creating mid-career fellowships that would allow faculty from all disciplines to receive training in caring for older adults.

We need to support Title VIII nursing workforce development programs, the largest source of Federal funding for advanced nursing education supporting almost 50,000 nurses and trainees in 2008. The Title nursing comprehensive geriatric education program supports training for nurses who care for the elderly, curricula relating to geriatrics care and training of faculty in geriatrics.

We need to expand and enhance support for geriatric research, education and clinical centers also known as GRECCs. These are centers of geriatric excellence within the VA At the outset, we believe five new GRECCs should be established and funded, which would be in keeping with the congressional authorization in 1985.

We need to address problems with Medicare GME policy. The number of Medicare-funded graduate medical education slots has not increased since the enactment of the Balance Budget Act of

1997. We need to expand the number of GME slots, particularly in the field of geriatrics, and resist proposed funding cuts to this program.

We need to provide adequate coverage for necessary and cost-effective services. We must reform Medicare and the nation's health care system to realign reimbursement and incentives. Senators Lincoln and Collins have introduced legislation that would fill a major gap in Medicare by covering geriatric assessment and care coordination services for beneficiaries of multiple chronic conditions, including dementia. Changes like this to Medicare coverage are important incentives for geriatricians and other primary care providers.

We need to collaborate to train and prepare the direct care workforce and family caregivers. AGS commends the IOM report for recommending increased standards for all direct care workers. We are also developing materials for certified nursing assistants with a focus on care of older adults.

In addition to our AGS Foundation for Health and Aging, we provide support and information to informal caregivers through programs like Eldercare at Home. We would be pleased to collaborate with the Committee on any efforts to develop programs for both direct care and informal caregivers.

To conclude, there are already serious shortages of geriatrics health care providers. Given the coming silver tsunami, these shortages will reach crisis proportions unless we work together now to address them.

Thank you again for the opportunity to participate in today's important and timely hearing.

[The prepared statement of Dr. Semla follows:]

STATEMENT OF

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ON BEHALF OF THE

AMERICAN GERIATRICS SOCIETY

BEFORE THE SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

April 16, 2008

INTRODUCTION
Good afternoon Chairman Kohl, Ranking Member Smith and Members of the Committee:

Thank you for inviting a representative of the American Geriatrics Society to speak with you today about steps our nation must take to prepare our health care workforce to care for the rapidly growing number of older Americans.

I am Dr. Todd Semla, President of the American Geriatrics Society, a non-profit organization of almost 7,000 health professionals dedicated to improving the health, independence and quality of life of all older Americans. I am also a registered pharmacist, Clinical Pharmacy Specialist for Pharmacy Benefits Management Services for the Department of Veterans Affairs, and Associate Professor in the Departments of Medicine, and Psychiatry & Behavioral Science at Northwestern University's Feinberg School of Medicine. The views that I express today are solely those of the American Geriatrics Society and do not necessarily represent the views of the Department of Veterans Affairs or Northwestern University.

I appreciate this opportunity to participate in today's hearing as President of the American Geriatrics Society. The Society provides leadership in geriatrics patient care, research, professional and public education, and in public policy advocacy efforts aimed at ensuring access to quality health care for older adults.

The American Geriatrics Society strongly supports efforts to ensure access to high quality, cost-effective health care. As our nation ages, we must take steps, now, to address the growing shortage of health care professionals trained to meet the unique health care needs of older adults, and we must restructure our health care system in ways that promote more appropriate, cost-effective care for older Americans.

Today, I will briefly outline the need for legislative policies and government initiatives that will ensure that we have a well-trained workforce that provides such care to the rapidly growing population of older Americans.

OUR AGING POPULATION
The US Census Bureau projects a dramatic increase in the number of older Americans, beginning in 2011 when the first of the baby boomers turn 65. Between 2005 and 2020, the population of Americans younger than 65 is expected to grow by about 9%, while the population of those 65 and older is projected to grow by about 50%.

In 2005, there were over 35 million Americans 65 or older – roughly 12% of the US population. By 2030, when the last of the baby boomers will have reached 65, that number will exceed 70 million. At that time, approximately 20% of the US population will be 65 or older. The number of adults in the US who are older than 85 -- the "old-old" -- is also expected to double, from 4.7 million in 2003 to 9.6 million in 2030, and to double again, to 20.9 million, in 2050. These are unprecedented demographic shifts.

These shifts will place additional pressure on health care providers, especially providers who specialize in geriatrics, as these professionals are already in short supply. Older people do have unique health care needs. They tend to have multiple and overlapping chronic and often progressive health conditions, including some that manifest with symptoms differing from those in younger adults and respond differently to treatment. Many older patients take multiple medications which may interact in adverse ways. With age, an increasing number have cognitive and other disabilities that further complicate their care; it is estimated that as many as 10 million baby boomers will get Alzheimer's disease.

Because of their unique and complex health care needs, old and old-old adults tend to require more clinician time than younger adults. Adults 65 and older, for example, average six to seven visits to physicians per year -- compared with two to four visits annually for those under 65. They also require more time per visit.

For all these reasons, the coming demographic shift will lead to a significant increase in demand for health care providers trained to meet the unique health care needs of older people.

HEALTH PROVIDERS WITH TRAINING IN GERIATRICS
The field of geriatrics promotes preventive care, with an emphasis on care management and care coordination that aims to help older patients maintain functional independence in performing daily activities and improve their overall quality of life.

Geriatricians are primary care physicians who are experts in caring for older adults. After completing residencies in family practice or internal medicine, geriatricians must satisfactorily complete at least one additional year of fellowship training in geriatric medicine. Following this training, a geriatrician must pass an exam to become certified and then pass a recertifying exam every 10 years. Geriatricians and other geriatrics health care providers, such as nurses, pharmacists and social workers with special training in the field, typically focus on frail older adults and those with the most complex health problems. Older adults with less complex health problems do not necessarily need to be in the care of geriatrics professionals.

Geriatric training emphasizes an interdisciplinary approach to medicine and care coordination. Geriatricians typically work with a coordinated team of other providers such as nurses, pharmacists, social workers, and physician assistants. In addition to providing care for older patients, members of the geriatrics team educate patients, family members and other informal caregivers with the goal of involving them as active, effective participants in care. Team members also offer informal caregivers support, assistance, and advice to better prepare them to provide supportive care in the home. Geriatrics health care providers are in particularly short supply and unless steps are taken now, this shortage is likely to reach crisis proportions as the baby boomers age.

Although older adults with less complex health problems may not necessarily need specialized geriatrics care, all older people should be cared for by health care professionals with sufficient training in the care of older adults to make them competent to meet this group's unique needs. Just as children have health care needs that differ from those of adults, older adults have health care needs that differ from those of younger adults. As the nation ages, it's increasingly imperative that we: (1) have an adequate supply of geriatrics health care professionals; and (2) ensure that all health care providers receive training in the fundamentals of geriatric care.

PROVIDER SHORTAGE
There are only 7,128 certified geriatricians practicing in the US -- roughly half the number currently needed. Wisconsin counts only 154 geriatricians; Oregon, 71, and Arkansas, 54.

By 2030, it is projected that we will need 36,000 geriatricians to care for the 70 million older Americans -- a ratio of approximately 1 to 1,945 persons 65 and older. According to the Demographic Services Center, Wisconsin Department of Administration, the Wisconsin population of persons 65 years of age and older will be 1,336,384 in 2030. In order to meet the national ratio, we estimate that Wisconsin will need 687 geriatricians by 2030.

Geriatric psychiatrists, who have much needed expertise in recognizing mental health problems among older adults, are also increasingly hard to come by. By 2030, there will be an estimated 2,600 geriatric psychiatrists practicing in the US, not nearly enough to care for the projected 70 million older Americans.

Few health care professionals are pursuing advanced training in geriatrics. In 2007, a mere 91 residents who graduated from US medical schools entered geriatric medicine fellowship programs (roughly 0.5% of all medical students in that graduating class), about half the number who entered these programs in 2003. Fewer than 1% of nurses go on to become certified gerontological nurses and only 3% of advanced practice nurses specialize in the care of the aging. Fewer than 1% of pharmacists are certified in geriatrics and fewer than 1% of physician assistants specialize in geriatrics.

The decline in the number of US medical school graduates choosing careers in internal medicine and family medicine – the two primary care fields that are the source of applicants for geriatric fellowship programs – is a significant contributor to the shortage of geriatricians. Financial disincentives play a key role in this decline since physicians in internal medicine and family medicine earn significantly less and have less predictable work schedules than those in other medical and surgical specialties, such as dermatology, radiology, and plastic surgery. Consequently, fewer young physicians are choosing general internal medicine or family practice and, as a result, significantly decreasing the potential applicant pool for geriatric fellowships and significantly decreasing the supply of primary care physicians that will be needed to ensure coordinated care for older adults.

Inadequate Medicare reimbursement is also a leading deterrent to entering geriatrics, which is one of the lowest paying medical specialties. Medicare payments continue to fail to keep up with inflation or cover many of the services – such as care coordination -- that are integral to providing high quality care to older adults.

Caring for older adults, particularly those with complex medical problems, is complex and time-intensive. While Medicare provides adequate compensation for procedures and interventions, it offers inadequate, or in many cases no, reimbursement for the more in-depth consultations, follow-ups, and meetings and phone calls among members of the interdisciplinary geriatrics team that are central to quality care, maintenance or restoration of function, and quality of life for complex elderly patients.

Dramatic discrepancies in reimbursement across medical and surgical specialties – between dermatology and geriatrics, for example -- further exacerbate difficulties recruiting physicians and other professionals into geriatrics. In these and other ways, current reimbursement policy threatens older Americans' access to appropriate care.

SOLUTIONS TO THE PROVIDER SHORTAGE AND TRAINING GAP
There are a number of potential solutions to the provider shortage and training gap.

- **Reauthorize, Expand and Fund Title VII Health Professions Programs: GACAs, GECs, and Geriatric Faculty Fellowships**

We recommend that Congress reauthorize health professions education programs established under Title VII of the Public Health Service Act, which includes the Geriatrics Health Professions Programs. We encourage Congress to build upon this program's success by providing additional initiatives to recruit, train and retain health professionals in the field of geriatrics. In addition, we recommend that Congress increase overall Title VII funding levels commensurate with projected needs, including increases for the expansion and enhancement of Geriatrics Health Professions Programs.

While increased recruitment into geriatrics is imperative, we also need to offer primary care physicians, nurses and other health care providers, who are not specialists, more comprehensive training in the care of older adults. Again, every older person need not see a geriatric specialist, but all older adults should see health care providers with adequate training to

meet older people's unique health care needs. The Title VII Geriatrics Health Professions Programs are integral to providing such training. Title VII geriatrics health professions funding supports three initiatives: the Geriatric Academic Career Awards (GACAs), the Geriatric Education Center (GEC) program, and geriatric faculty fellowships. I will describe each of these in brief.

The Geriatric Academic Career Awards (GACA) support the career development of newly trained geriatric physicians in academic medicine. The AGS supports efforts to develop and enhance the GACA program to support junior geriatrics faculty and expand its availability to other health care professionals. We also support modifying the program so that the award can be paid to the institution. This is critical to helping the next generation of physicians become much-needed clinician educators. We also support establishing a mid-career GACA award that would support and retain clinician educators as they advance in their careers. In addition, we recommend creating a GACA-like award for advance practice nurses, pharmacists, and social workers.

The Geriatric Education Center (GEC) program provides grants to support collaborative arrangements involving health professions schools and health care facilities that provide multidisciplinary training in geriatrics. Currently, there are 48 GECs in 36 states and US territories. We at AGS recommend that additional GECs be funded in the 14 states that do not currently have these centers: Colorado, Connecticut, Delaware, Idaho, Illinois, Indiana, Louisiana, Massachusetts, Mississippi, North Dakota, South Dakota, Utah, Vermont, and Virginia. Six states -- (California, Florida, New York, North Carolina, Pennsylvania, and Texas) have more than one GEC which is appropriate given their larger size and larger populations of older residents.

In addition to shortages of clinicians, shortages of faculty needed to conduct research and to train health care professionals to provide appropriate care to older adults are also cause for concern. Faculty generally come out of geriatrics fellowships, but there are fewer than 200 fellows currently enrolled in fellowships nationwide, and many of these will not elect to pursue academic careers as clinician educators or research investigators due to the relative paucity of funding sources and financial support. Shortfalls are equally acute, if not worse, in geriatric psychiatry, geriatric nursing and geriatric pharmacy. The problem is particularly acute if one considers the need for geriatrics faculty to train all medical, nursing, pharmacy and allied health professions students to complete the minimum competency requirements for the care of older patients.

GECs are an important mechanism for training health care professionals who care for older adults. It would be ideal if both the number of GECs increased and their mandates were expanded to include the training of paraprofessionals, since this cadre of providers is responsible for providing the lion's share of direct care to older adults.

Geriatric faculty fellowships, the third initiative financed with Title VII Geriatrics Health care Programs funds are also critical to training. The fellowships help prepare physicians, dentists, and behavioral and mental health professionals to teach geriatric medicine, dentistry and psychiatry.

Funding for these three initiatives is a small but highly effective investment in ensuring that older adults receive high quality health care now and in the future. A health care workforce that is well-versed in the unique health care needs of older adults has a tremendous impact on the quality of care provided. In 2005 alone, the National Association of Geriatric Education Centers reports that Title VII-funded Geriatric Education Centers delivered low-cost geriatrics training interventions to more than 50,000 health care providers who collectively reported over 8.6 million appointments with older patients.

Recognizing the central role of Title VII programs in preparing the health care workforce, Congress has provided funding and support for these programs in past fiscal years.
AGS is working with Congress again this year to secure critical funds needed to support all Title VII programs, including Geriatrics Health Professions Programs, for fiscal year 2009.

- **Support Title VIII Nursing Workforce Development Programs**

Title VIII Nursing Workforce Development programs are the largest source of federal funding for advanced education nursing; workforce diversity; nursing faculty loan programs; nurse education, practice and retention; comprehensive geriatric education; loan repayment; and scholarship. In 2006, over 48,698 nurses and nursing students were supported through these programs.

By investing in these programs, Congress can strengthen the American health care delivery system, as nurses provide cost-effective, quality care. Increasing funding for the nursing comprehensive geriatric education program, for example, would be highly cost-effective. The program supports additional training for nurses who care for the elderly; development and dissemination of curricula relating to geriatric care; and training of faculty in geriatrics. It also provides continuing education for nurses practicing in geriatrics.

AGS also supports increased funding for the Advanced Nursing Education program, which provides grants to nursing schools, academic health centers, and other entities to enhance education and practice for nurses in master's and post master's programs. These programs train, among others, nurse practitioners, clinical nurse specialists, nurse educators, nurse administrators, and public health nurses.

The Nurse Education Loan Repayment Program and the Nurse Faculty Loan Program are equally important. The former repays 60 to 85% of nursing student loans in return for at least two years of practice in a facility with a critical shortage of nurses. The latter provides loans to support students pursuing masters and doctoral degrees; upon graduation, recipients are required to teach at a school of nursing in return for repayment of up to 85% of their educational loans, plus interest, over four years.

The proposed FY 2009 budget would cut funding for the Nurse Education Loan Repayment Program and the Nurse Faculty Loan Program 30%. These programs are critical at a time when nurses, particularly those with expertise in the care of older patients, are already in short supply. In addition, the budget would completely eliminate all funding for Advanced Education Nursing Grants. We urge Congress to increase funding for these programs.

- **Support Loan Forgiveness Programs**

A career focused on caring for older adults can be particularly financially unattractive for physicians who carry increasingly large medical school loan debts. The Association of American Medical Colleges (AAMC) reports that in 2006, over 86% of medical school graduates carried educational debt -- owing an average of $130,000. This figure is expected to increase as both private and public institutions raise tuition to keep pace with rising costs. Over the past 20 years, median medical school tuition and fees have increased by 165% in private schools and by 312% in public schools. The weight of medical school and undergraduate debt already make a career in primary care and in geriatrics less attractive. Physicians aren't the only professionals affected. In 2006, a student entering an accelerated nurse practitioner program at a private school had to borrow roughly $65,000 and could expect his or her loans to top $165,000 by graduation.

Incentives, such as federal loan forgiveness legislation, are among the remedies needed to make careers caring for older adults more appealing and to address recruitment and retention

problems. In 2005, South Carolina passed legislation creating an innovative and successful loan forgiveness program designed to attract more doctors with specialized training in geriatric medicine. This program forgives $35,000 of student loan debt incurred during medical school for each year of specialized fellowship training in geriatrics. Applicants must agree to practice in the state for at least five years. California and Oklahoma are weighing similar legislation.

Such legislation is also needed at the federal level. Currently, there are two geriatrics loan forgiveness bills before Congress:

The Caring for an Aging America Act (S. 2708), introduced by Senator Barbara Boxer (D-CA), would establish a Geriatric and Gerontology Loan Repayment Program that would be administered by the Health Resources and Services Administration (HRSA) in the US Department of Health and Human Services. This program would provide loan repayment for physicians, physician assistants, advance practice nurses, psychologists and social workers who complete specialty training in geriatrics or gerontology and who agree to provide full-time clinical practice and service to older adults for a minimum of two years. The program would award payments of up to $35,000 a year during the first two years of practice. Participants would be eligible to work a third or fourth year and receive loan payments of up to an additional $40,000 per year.

The second piece of legislation, the **Geriatricians Loan Forgiveness Act (H.R. 2502)**, introduced by Congresswoman Rosa DeLauro (D-CT), would provide incentives to doctors and psychiatrists pursuing additional training in geriatrics. Specifically, the measure would extend the National Health Service Corps Loan Repayment Program to geriatric training, forgiving $35,000 of educational debt incurred by medical students for each year of advanced training in geriatric medicine or psychiatry.

- **Medicare GME Incentive**

The number of Medicare-funded Graduate Medical Education (GME) slots has not increased since the enactment of the Balanced Budget Act of 1997, which included a provision freezing the number of slots at 1996 levels.

The proposed 2009 budget includes provisions for dramatic decreases in the Medicare IME payments to hospitals and the Medicaid program that will result in loss of Medicaid GME payments in those states that provide this funding. If these provisions are enacted, teaching hospitals will incur significant revenue shortfalls that will require changes in their GME programs. With diminished GME revenue it is likely that hospitals will make choices regarding their GME programs that advantage those specialties that have a favorable operating margin (e.g., cardiology, orthopedics) and disadvantage specialties like geriatrics that do not have as clear a link to their bottom line. This could only amplify the shortages in geriatrics providers that we currently experience.

Medicare currently reimburses hospitals for GME payments pro-rated on the percentage of a hospital's patient days that are Medicare days. Geriatrics fellowship programs (including Geriatric Medicine and Geriatric Psychiatry) are the only GME programs that care for only Medicare patients. Thus, it could be argued that for individuals in these programs, hospitals should get full GME payments, with no reduction for non-Medicare patient days. While this benefit would not directly impact the trainees going into such programs, it would make it more advantageous for hospitals to invest in the growth of these programs. Furthermore, if these enhanced GME payments to hospitals are tied to a requirement for financial incentives to physicians choosing to train in Geriatrics (e.g., loan repayment), there could be a direct impact on the career choices of physicians in training. Such a model could also be used to address other national physician workforce needs such as the increasing shortage of primary care physicians, by creating the incentives for those training in internal medicine and family medicine.

Under the current physician reimbursement system, marketplace forces will not balance the composition of the physician workforce to meet the needs of an aging population. There needs to be a mechanism, such as adjustments in GME payments, to mold the composition of the needed workforce.

- **Expand and Enhance Support for America's Geriatric Research, Education and Clinical Centers (GRECCs)**

The nation's Geriatric Research, Education and Clinical Centers (GRECCs) are "centers of geriatric excellence" designed to advance research, education, and clinical care in geriatrics and gerontology and incorporate advances into the VA health care system. About half of the Department of Veterans Affairs active patient population, numbering close to 6 million, is over age 65.

There are currently 20 GRECCs nationwide. To better serve the health care needs of our nation's aging veterans, AGS recommends that there be at least one GRECC in each Veterans Integrated Service Network (VISN). At the outset, we believe five new GRECCs should be established and funded – which would be in keeping with Congressional authorization in 1985. Ideally, we would like to see an additional four to five new GRECCS authorized and funded by Congress.

There is an important issue concerning GRECCS that I wish to bring to your attention. Existing GRECCs have experienced an increasing number of long-standing vacant positions. In addition, the VA only provides funding for one full-time position (1 FTE) for education per GRECC. Unfortunately, positions often are put on hold due to budget constraints and competing priorities. In addition, salaries are often not competitive. Further funding, or existing funding protected from competing local programs, to ensure adequate staffing and support of these important research, education and clinical centers would lead to enhanced training and care for older veterans, their caregivers, and others who will benefit from research and other advances at GRECCs.

- **Ensure Appropriate Reimbursement and Incentives**

AGS urges Congress to address problems with Medicare reimbursement to providers, including the flawed Sustainable Growth Rate formula now used to determine payments to physicians. Realigning reimbursement and incentives to make the care of older adults financially viable is of the utmost necessity.

- **Provide Adequate Coverage for Necessary and Cost-Effective Services**

In addition to ensuring that we have enough well trained providers to care for our aging population, it's essential that we support a comprehensive approach to care for elderly patients, many of whom suffer from multiple chronic conditions. Frail older adults, and those with multiple health problems, can benefit significantly from care provided by geriatricians and other geriatrics professionals, as they are at high risk for hospitalization, medication interactions, and poor health outcomes related to their chronic conditions as well as drug interactions and adverse drug events.

More than 20% of older adults have at least five chronic conditions, such as heart disease, diabetes, arthritis, osteoporosis, and dementia. Studies have found that providing such patients with care in keeping with the principles of geriatrics – which call for comprehensive geriatric assessments and coordinated care, among other things -- is both effective and cost-effective. Potential savings are significant – the roughly 20% of older Americans with five or more chronic health problems now account for nearly 70% of Medicare spending.

Research suggests that geriatric assessment can reduce the incidence of adverse drug events, the need for specialty services, diagnostic studies, emergency room visits, and hospitalizations

– and may cut the costs of acute care. A randomized controlled trial involving nearly 1,000 seniors recently reported in the *Journal of the American Medical Association (JAMA)* found that geriatric care management in primary care improved the quality of medical care for geriatric conditions, demonstrated improvements in health-related quality of life measures, and reduced emergency department visits over two years. In the most complex older patients, hospitalization rates were reduced in the intervention group compared to usual care by over 40% in the second year of treatment. Linking geriatric assessment with coordinated care may result in further savings.

In June 2006, the Medicare Payment Advisory Commission (MedPAC) stated that "[c]are coordination has the potential to improve value in the Medicare program. Even if individual providers deliver high quality, efficient care, overall care for a beneficiary may be sub-optimal if providers do not coordinate across settings or assist beneficiaries in managing their conditions between visits."

The **Geriatric Assessment and Chronic Care Coordination Act (S. 1340 and H.R. 2244),** legislation introduced by Senators Blanche Lincoln (D-AR) and Susan Collins (R-ME) and Representatives Gene Green (D-TX) and Fred Upton (R-MI), would fill a major gap in Medicare by covering geriatric assessment and care coordination services for beneficiaries with multiple chronic conditions, including dementia. We urge Congress to approve this important legislation. In addition to ensuring that beneficiaries receive the health care they need, Medicare coverage for the range of care coordination and management services provided by geriatricians and other providers will provide an important incentive for more physicians to enter and stay in the field of geriatrics.

MORE SOLUTIONS: BUILDING ON AND COMPLEMENTING PRIVATE AND NONPROFIT FOUNDATION EFFORTS TO IMPROVE HEALTH CARE FOR OLDER ADULTS

Several foundations are funding efforts to train health care providers to better meet the unique health care needs of older adults and these efforts can serve as models for additional or complementary public programs.

In 1997, the Donald W. Reynolds Foundation made grants totaling $28.9 million in support of the Donald W. Reynolds Center on Aging and Department of Geriatrics at the University of Arkansas. Reynolds went on to provide similar support to the University of Oklahoma in 2001. Since 2001, the Foundation, which is nationally recognized for its commitment to geriatrics, has supported an initiative that has provided 30 medical schools with funding totaling $59.6 million with the goal of improving training in geriatrics. The program requires a one-to-one institutional match from each school. Reynolds is currently selecting a fourth cohort which will bring the total number of schools receiving funding to 40. A related Reynolds initiative is its Consortium for Faculty Development to Advance Geriatrics Education (FD~AGE). The Donald W. Reynolds Foundation established the consortium in 2004 when it awarded grants totaling $12 million to four leading geriatrics institutions with the mandate to strengthen faculty expertise in geriatrics at academic health centers throughout the United States.

Together, Duke University, Johns Hopkins University, Mount Sinai School of Medicine and UCLA form the Consortium. The primary goals of this program are to increase the number of geriatricians who have expertise as clinician educators, develop geriatrics teaching skills among non-geriatrics faculty, and improve the effectiveness of geriatrics faculty members at their home institutions. Each institution has received a grant of $3 million over six years which is being used to provide fellowships to train clinician educators in geriatrics and train junior faculty members. As a part of their efforts, the four institutions are working to place as many faculty as possible in other institutions once their training is completed. All Consortium members also offer one-week mini-fellowships and courses to strengthen the geriatrics knowledge of faculty members who teach medical students and residents at other institutions throughout the

United States and provide on-site consultation to other academic health centers aimed at strengthening their geriatrics training.

The John A. Hartford Foundation, located in New York City, is American's leading philanthropy with a sustained interest in aging and health. With over 100 active grants nationwide to improve health of older Americans, the Foundation is a committed champion of health care training, research, and service system innovations that will ensure the well-being and vitality of older adults. Since 1983, Hartford has granted over $410 million in funds for programs that target nursing, social work, and medicine. Some 80% of its spending is directed at increasing academic geriatric capacity in medicine, nursing and social Work. These efforts include faculty scholars programs in each discipline and centers of excellence in geriatric medicine, geriatric psychiatry and geriatric nursing. Among its many grants, Hartford has partnered with the AGS since 1994 on an effort to increase the geriatrics expertise of surgical and related medical specialists by, among other things, creating a research agenda for research in these areas, funding residency education programs, and funding research career development awards. Hartford and AGS are joined in this effort by The Atlantic Philanthropies.

- **Extend Public Investment to Bridge the Training Gap**

Public investment in, or the establishment of federal programs modeled after, training initiatives similar to those pioneered by the Reynolds Foundation, the John A. Hartford Foundation, and the Atlantic Philanthropies could help bridge the nation's serious geriatrics training gap.

Among other things, AGS recommends the creation of **mid-career fellowships** that would allow faculty from all disciplines to receive training in caring for older adults so they could then train the next generation of providers.

- **Collaborate to Train and Prepare Direct Care Workforce and Family Caregivers**

The American Geriatrics Society supports efforts to improve training for the nation's direct care workforce and education for family and other informal caregivers.

Direct care workers, such as certified nursing assistants, home health aides and personal and home-care aides, provide much of the direct care older Americans receive. Certified nursing assistants, for example, provide as much as 80% of the direct care that older adults in long-term care receive This group of providers will be integral to ensuring that we are able to provide quality care to older adults in the future.

AGS' Board recently approved the Society's moving forward with development of curricular materials for certified nursing assistants with a focus on care of older adults. As we did when developing a curriculum for emergency medical technicians, we plan to bring together a number of stakeholders to develop these materials.

In 1999, the Society established the AGS Foundation for Health in Aging with a primary goal of better supporting older adults and their informal caregivers. The Foundation's award-winning caregiving guide, *Eldercare at Home*, offers practical advice for those who are caring for their older loved ones at home. The foundation's free "Aging in the Know" Web site, at www.healthinaging.org, is a one-stop resource for caregivers, older adults, and others who wish to learn more about the diseases and disorders that most commonly affect older adults.

We would be pleased to collaborate with the Senate Committee on Aging and other organizations on any efforts to develop programs for both direct care and informal (family) caregivers.

CONCLUSION

To sum up, we are facing an unprecedented increase in the number of older adults in this country -- a doubling of the older population, from roughly 35 to 70 million, by 2030.

Older adults have both more and more complex health problems than younger adults and utilize significantly more health care resources. Their health care needs are unique – they differ from those of younger adults just as the health care needs of children differ from those of young adults. Older people tend to have multiple and overlapping chronic and often progressive health conditions, including some that manifest with symptoms differing from those in younger adults and respond differently to treatment. Many older patients take multiple medications which may interact in adverse ways. With age, an increasing number have cognitive and other disabilities that further complicate their care.

There are already serious shortages of geriatricians and other geriatrics health care professionals with specialized training that prepares them to meet the unique needs of complex and frail older patients. There are also shortages of generalist health care providers who have some supplemental training in meeting the needs of older adults. These shortages will reach crisis proportions unless steps are taken – now – to address them.

To this end we urge Congress:

- To support and expand geriatrics training programs – such as the Title VII Geriatrics Health Professions programs and Title VIII Nursing Workforce Development Programs – and increase the number of Medicare-funded Graduate Medical Education slots. These programs and training opportunities not only prepare health care professionals to provide higher quality, more cost-effective care to older adults, they also advance the careers of researchers and academics who can conduct aging research and train future generations of health care professionals.

- To institute and support loan forgiveness programs for health care professionals pursuing careers caring for older adults.

- To expand and provide more resources to the VA GRECC program in order to better address the health care needs of our nation's aging veterans.

- To reform Medicare and the nation's health care system to realign reimbursement and incentives in ways that both encourage promising candidates to specialize in and continue practicing geriatrics and encourage non-specialist health care providers to care for older patients.

- To implement legislation and initiatives that support higher quality, cost-effective care, such as the Geriatric Assessment and Chronic Care Coordination Act.

We thank you again for inviting us to participate in today's important hearing.

April 16, 2008

The CHAIRMAN. Thank you, Dr. Semla.
Ms. MCDERMOTT.

STATEMENT OF MARY MCDERMOTT, PERSONAL CARE WORKER AND BOARD OF DIRECTORS MEMBER, WISCONSIN QUALITY HOME CARE COMMISSION, VERONA, WI

Ms. MCDERMOTT. I would like to thank Chairman Kohl and Ranking Member Smith and other distinguished members of the Committee for this opportunity to speak to you today about home care. I am here today with SEIU, the largest health care union in the country with almost a million members of health care workers.

In the last 11 years I have had the opportunity to view home care from several perspectives. Currently I provide hands-on assistance for my mother and coordinate work of several other caregivers. I am also an officer on the board of directors for the Wisconsin Home Care Commission, a nonprofit organization established in 2006 to assist consumers looking for providers of home care and personal care services.

Before taking on the care of my parents, I worked as an efficiency expert analyzing, designing cost-effective quality standards, core competency curriculums, training programs and operational processes. My background has enabled me to bring important professional expertise into this very personal arena.

In 1997, my mother suffered a stroke and, along with my disabled father, moved from Michigan to my home in Wisconsin, so that I could assist them in providing the care that they needed. We, like many families, wanted to avoid putting my parents in a nursing home.

Families want choices in their long-term care for their loved ones. My experience is that caregivers who choose this field often lack medical and geriatric skills and knowledge. This is particularly true of people who care for family members and are often isolated and unaware that support is even available.

Direct care workers, like other workers, need career support that includes continuing education, training, career guidance. Such training can help individual caregivers in the field create long-term caregiving relationships with their clients and reduce the turnover that we are now seeing nationally.

I was fortunate to work with my parents, very high-quality RNs and LPNs to obtain the training that I needed to care for my parents and then to train others to care for my parents. I cannot begin to express my appreciation to Dr. Barczi and the geriatrics team at the VA Hospital in Madison for the training that they gave on an as-needed basis.

They were also very valuable in giving me support, when I needed it, on making health care decisions for my father; and gave me valuable suggestions as how to approach care planning as changes occurred with my father's health status. Their partnering with us significantly reduced hospitalization, cost and improved the quality of the care that was provided in my home.

I know from personal experience that direct care can be physically demanding and emotionally challenging. We in the field struggle to retain the current workforce, given the low wages, the lack of health and other benefits available and the lack of opportu-

nities for any advancement. Homecare workers' wages are among the lowest in the service sector. One in five health care workers lives below the poverty level.

Under a recent Supreme Court ruling, most home care workers are not entitled to even minimum wage or the overtime protection of the Fair Labor Standards Act. Congress can rectify this by passing S. 2061, the Fair Home Health Care Act. I urge the members of this Committee to sign on to that important legislation.

Until we treat home care workers with the respect they deserve, pay them a living wage, give them health care, we fail as a country to provide the professional workforce that is so desperately needed with our growing population of seniors and the people with disabilities. A knowledgeable, experienced and responsive worker can significantly improve the quality of life for many clients.

Some states are offering home care training for aides and personal care workers. But in some places, it has been local unions who have been addressing this training gap. After developing a registry to enable consumers to choose from among available workers, the Wisconsin Home Care Commission will offer supportive services for both home care workers and consumers, including training.

SEIU supports the development of a core competency curriculum, which emphasizes consumer choice and preferences and requires training in communication, problem solving and relationship skills. Such training enables workers to understand and respond to consumer preferences and to provide them with the high quality of care that they deserve.

While training is crucial to the development of a professional workforce, it is only one factor. We need to do a better job with Federal and State funding for long-term care and improving wages and benefits. If we don't, the training alone will not be enough.

Again, I thank the Committee for giving me this opportunity to speak today. I welcome any questions.

[The prepared statement of Ms. McDermott follows:]

Testimony of Mary McDermott, SEIU
Before the Senate Committee on Aging

I would like to thank Chairman Kohl, Ranking Member Smith and other distinguished members of the Committee for this opportunity to speak with you today about home care. I am here today with SEIU, the largest health care union in the country with almost one million health care workers.

In the last 11 years I have had the opportunity to view home care from several perspectives. Currently I provide hands on assistance for my mother and coordinate the work of several other caregivers. I am also an officer on the board of directors for the Wisconsin Home Care Commission (WHCC), a nonprofit organization established in 2006 to assist consumers looking for providers of home care and personal care services.

Before taking on the care of my parents, I worked as an efficiency expert analyzing and designing cost-effective quality standards, core competency curriculums, training programs, and operational processes. That experience provides the framework through which I view the challenges facing home care today. My background has enabled me to bring important professional expertise to this very personal arena.

In 1997, my mother suffered a stroke and, along with my disabled father moved from Michigan to my home in Wisconsin so that I could assist in providing the care they needed. We, like many other families, wanted to keep my parents at home instead of putting them in a nursing home. Families want choices for the long-term care of their loved ones.

Relying on the analytical skills I developed as a business executive, I worked with RNs & LPNs to develop care and communications plans so that we could respond to my parents' needs. My father died in October 2005, but my mother survives, receiving 24-hour a day assistance at home from myself and others.

Since 2000, caregiving has become a full-time occupation for me. Although my parents and I knew we needed a team of caregivers, it was difficult to hire private home care workers. Most candidates lacked the necessary training in skilled care or the experience providing supportive services.

My experience is that caregivers who choose this field often lack medical or geriatric skills and knowledge. They're loving people who in their hearts want to assist others, but sometimes lack fundamental training that is often necessary to meet their clients' needs. This is particularly true of people like me, who care for family members, who are often isolated and unaware that support is available. Direct care workers are like other workers: they need career support that includes continuing education, training, and career guidance if they are interested in advanced health care occupations.

I've worked with men and women who exhibit a true talent and a commitment to providing the elderly with the services and supports they need to stay at home. Many of

these caregivers would like to improve their skill set or gain more information about the field so they can move up. I have helped some get their CNA certification through trainings I have offered in my own home. People want the opportunity for growth and training that will foster pride in their work. Such training is likely to keep individual caregivers in the field, create long term caregiving relationships with clients and reduce the turnover we see nationally.

I was fortunate enough to work with my parents to provide the training I and others needed to be competent and confident care providers. I cannot begin to express my appreciation to the VA Hospital in Madison for the training they gave on an as needed basis such as IV, catheter, and wound care. They also made valuable suggestions on how we should approach care planning as changes in the status of my father's health occurred. Their partnering with us significantly reduced hospitalization, cost, and improved the quality of care provided in my home. If we could replicate this type of training for caregivers, we'd be on the right track.

I know from personal experience that direct care can be physically demanding and emotionally challenging. We in the field struggle to retain the current workforce, given the very low wages, the lack of health benefits, and the lack of opportunities for advancement. Homecare workers' wages are among the lowest in the service sector, and one in five home health care aides lives below the poverty level. Unlike most other entry level jobs in our country, home care workers often start off with no training and no foreseeable wage increases or advancement opportunities, regardless of skills or success in carrying out the preferences of clients.

Under a recent ruling of the Supreme Court most home care workers are not entitled to minimum wage or overtime protections of the Fair Labor Standards Act. Placing these employees outside the mainstream of workers covered by our nation's most fundamental employment standards is both unsound labor policy and long-term care policy as we face a growing shortage of workers willing and able to perform these essential services. Congress can rectify this by passing S2061 the Fair Home Health Care Act. I urge the Members of this Committee to sign on to this important piece of legislation. Until we treat home care workers with the respect they deserve, pay them a living wage, and give them health care, we will fail as a country to have the professional workforce that is desperately needed to care for our growing population of aging seniors and people with disabilities.

A knowledgeable, experienced and responsive worker can significantly improve the quality of life for many clients. That is something I have seen with my parents and struggled with as they have sought additional assistance. My experience has been that even the most responsive and attentive new workers need one-on-one training with the consumer and with other more experienced caregivers. This is not solely intuitive work and we now have much higher acuity individuals in need of home care than in the past. It has been an honor and a privilege to train caregivers and be a caregiver for my parents. In that respect we have been fortunate.

As the largest union for home care workers, SEIU has a long been concerned about workforce issues, including training. Although there are specific federal training requirements for Medicare home health aides, there are no federal training requirements for home care aides and personal care assistants and few opportunities. Currently many states offer training for home care aides and personal care workers, but in some places it is been local unions who are addressing this training gap with their own training programs often through jointly administered Taft-Hartley Training Funds. In some states, home care commissions not only assist consumers connect with available workers, but they also offer training programs for both workers and consumers. After developing a registry to enable consumers to choose from among available workers, the Wisconsin commission will be offering other supportive services for both home care workers and consumers, including training.

SEIU supports the development of a core competencies curriculum which correctly emphasizes consumer choice and preferences and requires training in the communication, problem solving and relationship skills that enable workers to understand and respond to consumer preferences and provide them with the high quality care they deserve.

But let's not fool ourselves. While training is a crucial step to developing the professional workforce we need, it is only one factor and without better federal and state funding for long term care and improving wages and benefits, it will surely not be enough.

I again thank the Committee for this opportunity to speak with you today, and welcome any questions.

The CHAIRMAN. Thank you, Ms. McDermott.
Dr. Bowman.

STATEMENT OF SALLY BOWMAN, PHD, ASSOCIATE PROFESSOR, DEPARTMENT OF HUMAN DEVELOPMENT AND FAMILY SCIENCES, OREGON STATE UNIVERSITY, CORVALLIS, OR

Ms. BOWMAN. Good afternoon, Ranking Member Smith, Mr. Chairman and Committee members. I appreciate this opportunity to share my remarks today, focusing first on the links among living arrangements, health and caregiving; and second on the need for educational strategies to train a sustained and capable workforce of professionals, paraprofessionals and informal family caregivers.

In late life, the individual preference to age in place means that housing, health care services and personal caregiving are intertwined. Consumers and health care providers have positively responded to the philosophy that older individuals should be able to receive services in the least restrictive physical environment possible.

The challenge and the opportunity is to link services to individual needs, rather than to the type of residential setting in which the individual happens to live. The advantage of this approach is that declining health status does not require multiple relocations for an individual. Moving from place to place is difficult for aging persons and their family members and is problematic for health care coordination.

How will the desire to age in place affect baby boomers? They will reside in a wide variety of home, community and institutional settings, receiving services from a combined workforce of professionals, paraprofessionals and informal caregivers. Projections indicate that the greatest growth in long-term care settings will be in assisted living, residential care and home and community-based services.

This will make Senator Smith happy. Oregon was the first State to apply for and receive a Medicaid waiver to provide home and community-based services in 1981. For over 25 years, Oregon's financing, reimbursement and licensing policies have favored the growth of adult foster care, assisted living, and residential care facilities while reducing nursing home use. These policies resulted in savings in public resources. At the same time, they provided living arrangements that valued independence and privacy.

Indeed, many frail older adults, with both physical and cognitive disabilities, are living in all these diverse long-term care settings and in the community rather than in nursing homes. Because Medicaid daily reimbursement rates for adult foster homes, assisted living and residential care facilities in Oregon are less than half the daily rates for nursing facilities, the decrease in Medicaid cases in nursing facilities—from 69 percent to 37 percent over 14 years has resulted in considerable savings of tax dollars.

So for example, in 2004, reimbursement of Medicaid long-term care recipients who resided in adult foster care, assisted living and residential care facilities rather than nursing homes saved Oregon taxpayers about $700,000 per day.

The goal of combining individualized care with a normal life is a challenge regardless of the physical setting. It highlights the need for a well-trained network of formal and informal caregivers. The projected shortfall in formal and informal workers needed to care for these aging baby boomers, including myself, requires increased efforts in education and training at every level.

Geriatric Education Centers, GECs, are and will continue to be a key player in this effort. These centers focus on the training of professional workers in long-term care—including physicians, nurses, social workers, allied health workers. GECs have helped to provide aging-related education to these health care workers and have also been essential to incorporating geriatric curricula into the training of new professionals.

The Oregon GEC focuses on outreach to rural areas where, in comparison to urban areas, a larger percentage of the population is older, disabled and suffers from chronic diseases. Yet most rural health care providers have not received geriatric training.

As part of our participation in the Oregon GEC and also part of the land-grant mission, the Oregon State University Extension Service in the College of Health and Human Sciences has offered a regional 2-day gerontology conference for 300 to 400 direct care practitioners annually for the past 32 years. This conference reaches frontline workers and community service providers who serve an aging population.

Collaborative partnerships involving higher education institutions, community colleges, private foundations, state and local government units on aging, nonprofits and employers can all expand opportunities to meet the educational needs of informal family caregivers. Educational and training strategies may include publications for late-life decisionmaking; Web-based checklists; interactive board games; community education workshops, both series or as single events; and one-on-one consultations.

The nationally disseminated caregiver training program, Powerful Tools for Caregiving, was produced by a partnership in Oregon between a community-based hospital and Oregon State University faculty members. Evaluations have shown that family caregivers become empowered to practice self-care strategies and develop tools that enhance their caregiving efforts.

Because the vast proportion of long-term care to older adults is provided by family members and by paraprofessionals, attention should focus on supporting these frontline caregivers. Because long-term care requires one-on-one assistance, labor is the major cost and determinant of quality of care.

Recruitment and retention of direct care workers in all types of long-term care organizations continues to be a significant challenge. The Better Jobs Better Care national demonstration projects have shown that key dimensions of job satisfaction—such as adequate training, rewards and incentives, career ladders, reducing workloads—all affect intentions to stay in or leave the workforce. Changes in public policies at the state and local levels and related funding will be required to institutionalize management practices that can lower the turnover rates of frontline workers.

Thank you for this opportunity.

[The prepared statement of Ms. Bowman follows:]

Prepared Statement for the Record

Dr. Sally Bowman, Associate Professor,
College of Health and Human Sciences,
Extension Family and Community Development
Program,
Oregon State University

United States Senate
Special Committee on Aging

Hearing Regarding
Caring for our seniors: How can we support those
on the frontlines?

Washington, D.C.

April 16, 2008

Good afternoon, Ranking Member Smith and members of the committee, my name is Sally Bowman and I appreciate this opportunity to serve as a witness. My remarks today will focus first on the links among housing, health, and caregiving; and second on educational strategies for the workforce of professionals, paraprofessionals, and informal (typically family) caregivers.

In late life, the individual preference to *age in place* means that housing, health-related services, and personal caregiving services are intertwined. Consumers and health care providers have positively responded to the philosophy that older individuals should be able to receive services in the least restrictive physical environment possible. The challenge and the opportunity is to link services to individual needs, rather than to the type of residential setting in which the individual happens to live. The advantage of this approach is that declining health status does not require multiple relocations for an individual. Moving from place to place is difficult for aging persons and their family members, and also problematic for health care coordination.

How will the desire to age in place affect baby boomers? Baby boomers will reside in a wide variety of home, community, and institutional settings, receiving services from a combined workforce of professionals, paraprofessionals, and informal (typically family) caregivers. Projections indicate that the greatest growth in long-term care settings will be in assisted living, residential care, and home and community-based services.

Oregon was the first state to apply for and receive a Medicaid waiver to provide home and community-based services in 1981. Over the course of 25 years, Oregon financing, reimbursement, and licensing policies favored the growth of adult foster care, assisted living, and residential care facilities, while reducing nursing home use. These policies resulted in estimated savings in public resources and at the same time provided living arrangements that valued independence and privacy.

And indeed, many frail older adults, with both physical and/or cognitive disabilities, are living in all these diverse long-term care settings and in the community, rather than nursing homes.
Because Medicaid daily reimbursement rates for adult foster homes, assisted living, and residential care facilities in Oregon are less than

half the daily rates for nursing facilities, the decrease in Medicaid cases in nursing facilities from 69% to 37% (1990-2004) resulted in considerable savings of tax dollars. For example, in 2004, reimbursement of Medicaid long-term care cases who resided in adult foster care, assisted living, and residential care facilities rather than nursing homes saved Oregon taxpayers appropriately $700,000 per day.

Although maintaining a wide variety of residential care choices will depend on both market trends and policy conditions, maximizing choice in long-term care options will be important for baby boomers and their family members. The goal of combining individualized care with a normal life is a challenge regardless of the physical setting, and highlights the need for a well trained network of formal and informal caregivers.

The projected shortfall in formal and informal workers needed to care for aging baby boomers requires increased efforts in education and training at all levels. Geriatric Education Centers are and will continue to be a key player in this effort. These Centers focus on the training of professional workers in long-term care, including physicians, licensed nurses, social workers, and allied health workers such as physical and

occupational therapists. Geriatric Education Centers have helped to provide aging-related education to these health care workers and have been essential to incorporating geriatric curricula into the training of new professionals.

The Oregon Geriatric Education Center focuses on outreach to rural areas, where, in comparison to urban areas, a larger percentage of the population is older, disabled, and suffers from chronic diseases. Yet most rural health care providers have not received geriatric education. As part of our participation in the Oregon Geriatric Education Center and part of the land-grant mission, Oregon State University has offered a regional 2-day gerontology conference for 300-400 direct care practitioners annually for the past 32 years. This conference reaches front-line workers, such as nurses and care managers, in addition to individuals in a wide range of occupations, such as administrators of residential care facilities, pharmacists, clinical psychologists, ombudsmen, and community service providers who serve an aging population.

Collaborative partnerships involving higher education institutions, community colleges, private foundations, state and local government units on aging, nonprofits, and employers can expand opportunities so

as to meet the educational needs of informal family caregivers to older adults. Educational and training strategies may include web-based checklists and publications for late life decision making; board games; community education workshops, both series and single events; and one-on-one consultations.

As an example, the Oregon State University Extension Service and College of Health and Human Sciences developed many consumer publications on aging-related decisions, such as selecting a nursing home and hiring in-home care workers. A national example of a partnership of four land-grant institutions, the United States Department of Agriculture Cooperative State Research, Education, and Extension Service and the AARP Foundation, is Prepare to Care, scheduled for completion for National Caregiver Month in November, 2008. This project will include a toolkit of educational resources for community educators targeted to local employers and employees. The goal is to reach two audiences: employers, whose bottom line can be enhanced by recognizing and supporting employees who provide elder care; and the vast numbers of aging baby boomers who must balance their jobs with caregiving to older family members.

The nationally disseminated caregiver training program, "Powerful Tools for Caregiving," was produced by an Oregon partnership between Oregon State University faculty and a community-based hospital. Evaluations of Powerful Tools have shown that family caregivers become empowered to practice self-care strategies and develop tools that enhance their caregiving efforts. This training, and other evidence-based community education programs, such as "Chronic Disease Self Management," are based on the application of self-efficacy theory: In order to take care of ourselves as caregivers or as older adults with chronic conditions, we must learn skills that increase our sense of personal control over our situations.

Another type of training strategy for both health care workers and family caregivers is the use of games in the classroom and beyond as a learner-centered strategy. Oregon State University faculty developed "The Families and Aging Board Game." The game has been used successfully in university gerontology and geriatrics courses, with long-term care staff, and also by family members as a tool to discuss those difficult family decisions that are inevitable in later life.

Because the vast proportion of long-term care to older adults is provided by family members and by paraprofessional workers,

attention should focus on supporting these frontline caregivers. Because long-term care requires one-on-one assistance, labor is the major cost and determinant of quality of care. Recruitment and retention of direct care workers in all types of long-term care organizations continues to be a significant challenge. The *Better Jobs Better Care* national demonstration projects, funded by the Robert Wood Johnson Foundation and the Atlantic Philanthropies, have shown that key dimensions of job satisfaction, such as adequate training, rewards and incentives, career ladders, and reducing workloads affect intentions to leave the workplace. Changes in public policies at the state and local levels and related funding will be required to institutionalize the management practices that lower the turnover rates of frontline workers.

I thank you again for the opportunity to show the connections among housing, health, and caregiving as well as the need for educational strategies to train a sustained and capable workforce of professionals, paraprofessionals, and informal or family caregivers. These educational efforts will depend in large part on your policy actions.

Note: In Oregon, there are four types of licensed long-term care settings. These include:

Assisted living facility – serves six or more residents, provides a range of personal care and health-related services, offers private apartments with full bathrooms and kitchenettes, and emphasizes aging in place.

Residential care facility – serves six or more residents, provides a range of personal care and health-related services, but lacks the physical design requirements of assisted living facilities. Residential care facilities have tended to be smaller than assisted living facilities, but have also added Alzheimer's care units in recent years.

Adult foster home – a private home or dwelling built for the purpose of providing care to up to five residents.

Nursing facility – provides nursing care on a 24-hour basis, and meets Medicare and Medicaid nursing home requirements.

The CHAIRMAN. Thank you, Dr. Bowman.

Questions from the panel?

Senator SMITH.

Senator SMITH. You speak of the importance of Oregon's Geriatric Education Center to rural areas. The conference, you hold it every year? Where do you hold it? Different places? What kind of attendance do you have?

Ms. BOWMAN. We hold that event in Corvallis, because that is our tradition. We get a vast proportion of participants from the rural areas actually not from the metro areas. There are other conferences for family caregivers and for practitioners held around the State. You, in fact, hold one yourself.

Senator SMITH. I do, yes.

Ms. BOWMAN. You get a fantastic attendance, because you have great speakers. I think you also give free lunch.

Senator SMITH. Yes, we do. You all heard there is no such thing. But there is at my aging conference, a free lunch.

Well, you know, listening to your testimony, a comment about Ms. Stewart that, you know, in some urban areas, maybe there are more caregivers, there are more professional people. But I wonder if, in your judgment, end-of-life care is as good or better in rural areas in Oregon.

Ms. BOWMAN. Well, I think you have to look at the whole continuum of care and compare it, rural to urban areas. I think if we are going to talk about end-of-life care, one of the things that I didn't hear mentioned was the role of hospice. So often people bring in hospice 3 hours before the patient dies.

There are resources. But, you know, one of the wonderful things about rural areas is the social support system.

Senator SMITH. That is right.

Ms. BOWMAN. The friends and neighbors who check on people who are living alone. So I think we need to emphasize that importance of the rural support. Through the GEC, we try to do road shows and do as much as we can to provide geriatric training to the rural health care practitioners in those areas.

Senator SMITH. Well, I think I appreciate you mentioning hospice. I think they are working alongside the angels as far as I am concerned. I have seen the work they do as both wonderful and merciful. I would simply add a word of encouragement to families to bring hospice in earlier, because they—at least in our family's case—they were helpful in training and making sure we did the right things. They are present in rural areas. They certainly are in rural Oregon.

But I appreciate your focus on rural Oregon. Obviously I care about all of Oregon. So I wonder if you have any comment about how we are doing in our urban centers of Portland and Eugene and Corvallis perhaps as well. How are doing? Are we up to speed? Got a lot more work to do?

Ms. BOWMAN. You know, I think the wonderful thing about not having enough resources is that you partner to get things done. What I have been so proud of and so pleased about are the variety of partnerships to meet the needs of families in this State. The Family Caregiver Support Program, the Alzheimer's Association,

AARP, the universities, community colleges—everyone partners to try to meet that need.

Senator SMITH. Are they communicating in that partnership?

Ms. Bowman. They do. I think we can't underestimate the importance of community education workshops, whether it is the extension service or whoever. You know, I, for example, did a workshop in Enterprise, Oregon. I think they closed down the nursing home. There were 100 people there. What they said to me was nobody ever comes to Enterprise, Oregon.

So I think the importance of getting training for family members as well as all the health care workers we have talked about today who need geriatric training—I think we can do it. But we have to really work on public-private sector partnerships.

Senator SMITH. Well, for our CSPAN audience, if you ever go to Enterprise, Oregon, you won't want to leave. It is one of the most beautiful parts on Planet Earth.

Again, Sally, thank you for coming this long way across the Oregon Trail to the nation's capital, and your testimony; and Mary, yours as well. Todd, thank you for your participation today.

The CHAIRMAN. We thank the panel profusely for being here and giving us your wisdom and your experience. This whole area of caring for seniors in our society is daunting in terms of the needs, the kind of things that we need to do to attract people to the area, to see that they get trained and paid, so that our seniors can get the care that they need and deserve and must have in the years ahead.

We appreciate your being here. We appreciate your testimony. You can be sure we will continue to be in touch with you. Thank you so much.

Thank you all for being here.

[Whereupon, at 4:49 p.m., the Committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF SENATOR SUSAN M. COLLINS

MR. CHAIRMAN, thank you for calling this hearing to examine our nation's future health workforce needs in the face of our rapidly aging population.

This afternoon's hearing is particularly significant in light of the report issued by the Institute of Medicine (IOM) earlier this week. The IOM report, titled "Retooling for an Aging America," sounds a warning that we are facing a critical shortage of doctors, nurses, and other health care professionals who are adequately trained to manage the special health care needs of our nation's growing population of seniors.

America is growing older. Today, more than 37 million Americans are age 65 and over, and these numbers will rise dramatically when the "baby boom" turns into a "senior boom." Over the next twenty years, the number of Americans over the age of 65 is expected to more than double. In Maine, more than a quarter of our population will be over 65 in 2030.

Nowhere does the aging of America present more risk and opportunity than in the area of health care. It is not just that there will soon be more older Americans. It is also that older Americans are living longer. Americans 85 and older—our "oldest old"—are the fastest growing segment of our population. This is the very population that is most at risk of the multiple and interacting health problems that can lead to disability and the need for long-term care.

Older Americans consume far more health care resources than any other age group. Moreover, their health care needs are very different from those of younger persons. While younger people typically come in contact with the health care system for treatment of a single, acute health care condition, older people often have multiple, chronic conditions like heart disease, diabetes, arthritis, and Alzheimer's disease—or any combination of the above.

Geriatrics is a medical specialty or style of practice that is specifically designed to address the complex health care needs of older patients. The essence of geriatrics lies in coping rather than curing. Its emphasis is on helping older adults maintain their quality of life and ability to function independently, even in the presence of chronic age-related diseases and disabilities.

With its emphasis on maintaining "functional independence," geriatrics offers great promise not only for improved health and quality of life for older persons, but it also has the potential to reduce overall medical and long-term care costs. According to a report by the Alliance for Aging Research, the U.S. realizes at least $5 billion in health and long-term care savings for every month that the physical independence of older people is extended. According to the Alliance, this is a conservative estimate.

Unfortunately, as the IOM report reveals, we are facing a dramatic shortage of health care professionals who are adequately prepared to deal with the complex health care needs of seniors.

Despite the obvious need, relatively few physicians, nurses and other health care professionals are pursuing careers in geriatrics or gerontology. While experts have projected that 36,000 geriatricians will be needed to care for our 70 million seniors in 2030, only 7,000—about one per cent of all physicians—are currently certified geriatricians. Only about one percent of nurses are certified gerontological nurses and only 3 percent of advanced practice nurses specialize in care of the aging.

Moreover, while most physicians do care for older patients, very few receive formal geriatric training. While almost all medical schools require some "geriatric exposure," the IOM report notes that this training is often inadequate. Less than 35 percent of our nursing baccalaureate programs require coursework in geriatric settings.

In the face of the approaching tidal wave of aging Americans, we simply cannot afford to ignore the IOM's warning. That is why I was pleased to join Senator Boxer in sponsoring the Caring for an Aging America Act, which takes some important

first steps to ensure that our health and long-term care workforces are prepared to meet the needs of our aging population.

Our legislation would provide $130 million in federal funding over five years to attract and retain health care professionals and direct-care workers with training in geriatrics by providing them with loan forgiveness and career advancement opportunities. It would also create a Health and Long-Term Care Workforce Advisory Panel for an Aging America to examine and advise the Secretary of Health and Human Services, the Secretary of Labor and Congress on workforce issues related to our aging population.

Again, MR. CHAIRMAN, thank you for calling this hearing, and I look forward to working with you on this important issue.

PREPARED STATEMENT OF SENATOR ROBERT P. CASEY, JR.

Mr. Chairman, I want to thank you for scheduling this important hearing. It is critical that we fully investigate all issues surrounding the direct care workforce and the increasingly older population in America.

This is a critical time for the health care workforce in this country. With the first of the baby boom generation on the cusp of retirement, the demand for direct care workers will increase exponentially in the coming years and decades. It is estimated the number of adults aged 65 and older will almost double from 37 million to over 70 million between 2005 and 2030. This is an 8 percent increase from 12 percent to 20 percent of the United States population.

In Pennsylvania, the projected increase is slightly larger. People over 65 will comprise 22.6 percent of the population by 2030 going from 1.9 million to over 4 million older citizens.

As the baby boom generation ages, we will need more caregivers and we will also need to change our approach to care, emphasizing greater prevention and more coordinated care. Shortages in caregivers for older citizens exist across the spectrum of care. The direct care workforce is woefully inadequate to meet the needs of the increasing number of older citizens who will require care. By 2030 it is estimated we will need an additional 3.5 million health care workers to care for our older citizens, a 35 percent increase from today.

With respect to physicians, only one percent of all physicians in the United States are currently certified as geriatricians. Experts project we will need 36,000 geriatricians by 2030.

The nation is already experiencing a severe shortage of registered nurses and less than 1 percent are certified gerontological nurses. Without increases, the total supply of nurses is projected to fall 29 percent below requirements by the year 2020.

In Pennsylvania, projections indicate the state will need an additional 24,610 direct care workers. This is an increase of 19 percent and a rate of growth nearly three times the state average for all occupations.

We must begin to address these shortages right now or we will suffer the consequences of our inaction tomorrow.

Almost every person in this room has a family member or a friend who has required long term care. From my experience with my father, who was hospitalized for a significant period of time toward the end of his life, I know what a positive impact that knowledgeable and skilled health care professionals can have.

On Monday, the Institute of Medicine released a study entitled "Retooling for and Aging America: Building the Health Care Workforce". This document provides us with a detailed roadmap to expanding the direct care workforce, meeting the increasing needs of older citizens, and changing our approach to the models of care we provide our citizens in order to emphasize greater prevention, and more effective coordination of care.

This report highlighted three main goals we must achieve: 1) increase the training and educational opportunities for all providers of geriatric health care; 2) improve upon the recruitment and retention of all providers and specialists in geriatric health care by improving wages, benefits and working conditions; and 3) redesign models of care so that prevention and coordination of care are prioritized and older citizens themselves can participate as much as possible in their own care.

These are important steps forward that we must take. Our older citizens need and deserve quality and coordinated health care as they age. These are our parents and our grandparents and they've worked hard for us and for our country. Now we owe them respect and dignity as they age. It will take time to build up the workforce we need, this is not something we can accomplish overnight. This is a daunting task, but a task we simply must undertake.

I look forward to hearing the testimony of all the witnesses today as they share their knowledge and experiences with the committee. I look forward to working with them, the members of this committee and others to ensure that our older citizens will have the care they need—and deserve—in their later years.

PREPARED STATEMENT OF SENATOR BARBARA BOXER

I would like to thank Senator Kohl, Ranking Member Smith, and members of the Senate Special Committee on Aging for having this hearing, and bringing attention to this important issue. I also want to commend the Aging Committee for its long and influential history of exploring and investigating issues that concern our senior citizens and their families.

California is home to 3.9 million people age 65 and older, more than any other state. That population is projected to increase to 8.3 million by 2030, growing from 11 percent to 18 percent of the state' population.

Preparing our workforce for the job of caring for older Americans is an essential part of ensuring the future health of our nation. Right now, there is a critical shortage of health care providers with the necessary training and skills to provide our seniors with the best possible care. This is a tremendously important issue for American families who are concerned about quality of care and quality of life for their older relatives and friends.

Quite simply, the demographic imperative is clear: with the number of adults aged 65 and older projected to almost double from 37 million today to nearly 72 million by 2030, we must start now if we are going to adequately train the health care workforce to meet the needs of an aging America. We cannot afford to wait any longer.

According to the Institute of Medicine, only about 7,100 U.S. physicians are certified geriatricians today; 36,000 are needed by 2030. Just 4 percent of social workers and only 3 percent of advance practice nurses specialize in geriatrics. Recruitment and retention of direct care workers is also a looming crisis due to low wages and few benefits, lack of career advancement, and inadequate training.

It is clear that there is a need for federal action to address these issues, and that is why Senator Collins and I have introduced the Caring for an Aging America Act (S. 2708). Senator Collins has been a strong leader on aging issues and I look forward to working with her and this Committee to move this legislation forward.

The Caring for an Aging America Act would help attract and retain trained health care professionals and direct care workers dedicated to providing quality care to the growing population of older Americans by providing them with meaningful loan forgiveness and career advancement opportunities.

Research suggests that geriatricians have the highest job satisfaction ratings among all physician specialties, and they find working with older adults to be richly rewarding. Yet despite high job satisfaction rates, it remains difficult to recruit adequate numbers of health and social service practitioners to the fields of geriatrics and gerontology, which remain among the least well-compensated specialties. This is why Senator Collins and I introduced our bill. The Caring for an Aging America Act would help to address these financial disincentives.

Specifically, for health professionals who complete specialty training in geriatrics or gerontology—including physicians, physician assistants, advance practice nurses, social workers and psychologists—the legislation would link educational loan repayment to a service commitment to the aging population, modeled after the successful National Health Services Corps. The bill would also expand loan repayment for registered nurses who complete specialty training in geriatric care and who choose to work in long-term care settings, and expand career advancement opportunities for direct care workers by offering specialty training in long-term care services. Lastly, the legislation would establish a health and long-term care workforce advisory panel for an aging America.

Ensuring we have a well-trained health care workforce with the skills to care for our aging population is a critical investment in America's future. This legislation offers a modest but important step toward creating the future health care workforce that our nation so urgently needs.

Our bill has strong support from the health care and senior communities. The report released this week by the Institute of Medicine, *Retooling for an Aging America: Building the Health Care Workforce,* endorses the financial incentives in our bill—including loan forgiveness linked to service—as a key way to recruit geriatric providers in the health professions.

The Caring for an Aging America Act has been endorsed by nearly 30 national organizations, including AARP, American Academy of Physician Assistants, Amer-

ican College of Nurse Practitioners, American Geriatrics Society, American Psychological Association, Coalition of Geriatric Nursing Organizations, and the National Association of Social Workers.

I look forward to working with my colleagues to ensure that we meet our obligations to the seniors of our nation to improve their care. We owe it to our parents, grandparents, and ourselves.

DR. ROBYN STONE'S RESPONSES TO SENATOR SMITH'S QUESTIONS

Question 1—Support and Training for Caregivers

In the testimony that each of you provided, you state that you believe training opportunities should be made available for informal caregivers. I agree and I feel that we should work to better support our nation's caregivers, as they are the backbone of the system to ensure the safety and welfare of our seniors. They also help seniors age in their homes, where all of us would prefer to be as we get older. I am working with Senator Lincoln to increase funding to the National Family Caregiver Support Program run by the Administration on Aging. I think the help provided by this program, primarily coordinated by the Area Agencies on Aging located throughout each state, is so important. But more supports must be made available as the number and needs of caregivers increases.

Question 1. How do you think we can engage the aging network, including Area Agencies on Aging, State Agencies on Aging, and other entities to facilitate additional training and help for informal caregivers?

Answer. The SUAs, the AAAs and other aging network organizations have multiple opportunities to improve upon and expand training for informal caregivers. First, they need to recognize that family and other informal caregivers face the same challenges as paid direct care workers including how to provide care to their loved one (both the clinical and technical aspects of the care delivery), how to communicate with the formal sector (including communication related to cultural competence), how to make decisions in crisis situations and how to take care of themselves. Since community colleges, vocational tech schools, and other educational institutions are developing more comprehensive training programs for direct care workers (certified nursing assistants, home health aides, and personal care workers), aging network providers should consider partnering with these entities to offer the same curriculum and teaching methods to informal caregivers. Many nursing homes also provide both orientation and in-service training to direct care workers and could provide a venue for offering training programs to informal caregivers in the community. These organizations should also partner with local workforce investment boards in their communities (funded through Department of Labor) who are charged with career development for entry level workers in the long-term care sector. Finally, I believe the Family Support Program, administered through the Older Americans Act, has been a great symbolic gesture to the millions of informal caregivers across the country. But the resources are limited and the ability of the AAAs and other organizations to provide assistance to families varies tremendously. The Congress should look at options for expanding the resources to this program through the OAA and also ensuring that the organizations are meeting some standard in terms of the services offered to caregivers.

Question 2—Support for Community Health Centers

Community Health Centers (CHCs) are the foundation of the nation's health care safety net. I believe these centers have an important role in keeping the doors open to patients who otherwise might be unable to afford health coverage. In Oregon, health centers provide over 130 points of access, where upwards of 180,000 Oregonians receive care each year.

However, the success of these centers, and indeed, our entire health care system, is directly dependent on a well-trained health professions workforce. A March 2006 study in the Journal of the American Medical Association found that CHCs—especially those in rural areas—are understaffed, including shortages of family physicians, dentists, pharmacists and registered nurses.

Question 2. Although there are existing health professions programs to encourage health care providers to serve in these settings—they still are not receiving the support they need. Do you believe they are effective? What more could be done to encourage medical professionals to practice medicine in rural/underserved areas?

Answer. The Community Health Centers have targeted primarily families and children; relatively few of these organizations have identified the geriatric population as a key user group. This is ironic given the fact that most rural communities are aging much more rapidly than their urban counterparts. The first step in ameliorating this situation is to build the capacity of the CHCs to care for the elderly

population, including hiring staff that are trained in geriatrics and gerontology and that know how to meet the needs of rural elders. Special financial incentives need to be created to attract physicians, nurse practitioners and physician assistants, nurses, social workers, therapists and others who are interested in caring for the geriatric population, including debt relief surrounding educational expenses and stipends that allow people to live in these communities. The CHCs also need to expand their use of technology to help reach the elderly in remote, frontier areas. Finally, they need to understand the aging network resources that are in most rural communities (including the AAAs, senior centers, special transportation programs, rural nursing homes and senior housing providers) and partner with these organizations.

Question 3—Medicare and Medicaid Legislative Relief

Each of the panelists' testimony mentioned the important role that Medicare and Medicaid play in the topic of ensuring a robust health care workforce. As a member of the Finance Committee, I am deeply committed to ensuring that the system works for our beneficiaries and responds to our nation's demographic change. I feel that apart from big funding increases to ensure appropriate training and recruitment of professionals, we also need to make sure administration of the Medicare and Medicaid programs is running smoothly and we're reducing burdens on training opportunities. A bill that I have introduced with Senator Lincoln, the Long-Term Care Quality and Modernization Act, would among other things, allow nursing facilities to resume their nurse aide training program when deficiencies that resulted in the prohibition of the training have been corrected and compliance has been demonstrated, instead of the current two-year wait period.

Question 3. Knowing the great need to educate our nurses with more experiences in geriatrics, what support can be given to schools of nursing and long-term care facilities to develop strong clinical partnerships?

Answer. Many nursing homes have developed excellent "home grown" training programs for their direct care workers that not only help them to do the their current work but provide career ladders or lattices for these individuals. Given the lack of quality training programs in many communities, I commend you for your efforts to allow nursing homes to resume training programs as soon as possible. In addition, there are relatively few opportunities for nursing students to have rewarding clinical placements in nursing homes and other long-term care settings. When they do, however, many become committed to this sector and seek out job opportunities there. The Congress needs to consider mechanisms for supporting nursing school placements in nursing homes, assisted living and home care that provide meaningful and challenging experiences for students who then will help to expand the labor pool in these settings. This might entail developing Centers of Excellence where Nursing School/Nursing Home partnerships that meet certain criteria would be eligible for multiple years of funding to support the training program and placements costs. I would suggest that similar programs be developed for medical and social work schools to prepare medical directors and clinical social workers for this growing field.

Question 4—National Service Corps vs. Title VII (Health Professions) Programs

We understand older Americans tend to utilize health services more than younger individuals, and by 2030, 20 percent of the U.S. population (71 million Americans) will be age 65 or older. Conversely, many health professionals are retiring as this population will require greater demand of our public health workforce. As you know, the President proposed to zero out many health professions programs in the Fiscal Year 2009 budget. Through the years, the Administration has conveyed that funding direct primary care through the National Health Service Corps is a better investment than funding HRSA's Title VII programs, which they believe lack focused objectives.

Question 4. What are your thoughts on this issue—is the National Health Services Corps a better program to improve the placement of providers in underserved areas and support training in primary care?

Follow Up: a. What are your suggestions for improving the efficacy of or expanding Title VII programs as we face the aging of our population and of the healthcare workforce?

Answer. I do not believe that these options are mutually exclusive. I strongly recommend developing a specific track in the National Health Services Corp for people who are interested in working in geriatric settings—including nursing homes, assisted living and home care. For this to work, however, funds would need to be dedicated specifically to these settings to attract the "best and the brightest". At the same time, it is important to strengthen the Title VII programs that invest in educational opportunities for the professions as well as helping to develop a larger cadre of health professionals in the field. In particular, some resources need to be redeployed to target the development of the geriatric workforce, including physi-

cians, nurses and ancillary health professionals who would be interested in geriatric/long-term care settings if financial incentives were available. I would, furthermore, recommend strengthening the Geriatric Education Centers across the country that have helped to train many health professionals in the field.

Question 5—Recruiting a More Diverse Workforce

In your testimony, you mention the need for long-term care employers to focus on new sources of labor that previously have been poorly utilized in the health care workforce, such as minorities and retirees.

Question 5. How do you think long-term care employers can best be encouraged to do this and are there models for ways that employers can effectively reach out to better recruit from these under-utilized groups?

Answer. With respect to older adults and retirees as prospective caregivers in the long-term care sector, one of our BJBC studies found that elderly individuals and employers are interested in expanding these opportunities. This may be a viable option for many older adults who cannot afford to retire as well as those who are interested in pursuing a caring career. Title V of the Older Americans Act currently focuses on job development for older adults. I recommend that a special program be developed to create partnerships between the Title V providers and long-term care employers (nursing homes, assisted living and home care) to explore the potential of using this program to expand the labor pool. The National Health Services Corps could also experiment with a Retiree Corps that could be recruited to work in these settings. Both of these options, of course, would require sufficient training resources to prepare and support this workforce. In addition, a study would be required to explore challenges to the recruitment of older workers including issues related to access to Medicare and Social Security benefits and physical barriers (e.g., the need to lift residents/clients) that would deter the hiring of elderly workers.

With respect to a more diverse workforce, the direct care workforce in long-term care settings is already incredibly ethnically, racially and culturally diverse. The real issue here is to develop culturally competent workplaces that respect all caregivers and that provide training in the overt and more subtle cultural differences that can cause communication problems and poorer quality care delivery. Employers also need to explore mechanisms for hiring a more diverse supervisory and clinical staff including nurses, social workers, therapists, medical directors, primary care physicians and administrators. This could start with the development of partnerships between these employers and historically black colleges and universities and their counterparts in the Hispanic community. Resources could also be provided to employers with a diverse direct care workforce to help them develop career ladders for CNAs, home care aides and personal care workers who are interested in becoming nurses, social workers and administrators in this sector. Finally, some providers have developed strategies for recruiting foreign professionals (particularly nurses) into this sector (although most of this recruitment has been for hospitals). A targeted strategy needs to be developed that recognizes a code of ethics as it relates to both the countries or origin and the needs of the workers who come to work in the U.S. through these routes.

MARTHA STEWART'S RESPONSE TO SENATOR SMITH'S QUESTION

Question 1—Geriatric Education & Training at Mount Sinai

I understand the Martha Stewart Center for Living supports the education of both practicing and future physicians, as well as patients, caregivers and the community. Further, physicians at the Center also support education through community talks, screenings and health fairs.

Question 1. Would you describe how this model of care was created and how it has benefited the patients who receive care at the Center for Living?

Answer. The Martha Stewart Center for Living, now with 4,000 patients, is one of the largest outpatient practices in the country catering specifically to the health care needs of older adults. The models of care have been developed over time at the Department of Geriatrics and Adult Development at Mount Sinai School of Medicine, which was founded by Dr. Robert Butler and is the oldest such department in the country. Doctors, nurses, and social workers at the Center continue to innovate their approach. Patients see the Center as their medical home, and its interactive programming allows them to become active participants in managing their well-being.

TODD SEMLA'S RESPONSES TO SENATOR'S SMITH QUESTIONS

Question 1—Lack of Nurse Educators

Currently, less than one percent of the nation's 2.4 million practicing nurses are certified as gerontological nurses or geriatric advanced practice nurses. This statistic underscores the importance of educating students in gerontology. In 2007, the American Association of Colleges of Nursing reported that 40,285 qualified applicants were turned away from baccalaureate and graduate nursing programs. The top reason cited by schools of nursing was a lack of expert faculty. The bill I introduced with Senator Clinton, The Nursing Education and Quality of Health Care Act of 2007, would help to address the faculty shortage by creating a Nurse Faculty Development program focused on offering scholarships and fellowships for nurses who wish to become faculty.

Question 1. Knowing the demand for educators is high, what other support can be given to nurses who wish to become geriatric nurse faculty?

Answer. AGS recognizes that the shortage of faculty in schools of nursing with baccalaureate and graduate programs is a continuing and expanding problem. AGS requests that Congress supports providing $200 million in fiscal year 2009 appropriations funding for Title VIII Nursing Workforce Development Programs, the largest source of funding for advanced nursing education. As stated in our testimony, before the Senate Special Committee on Aging, Title VIII nursing comprehensive geriatrics education program supports training for nurses who care for elderly, curricula on geriatric care, and training of faculty in geriatrics. In addition, the programs are the largest source of federal funding for advanced education nursing; workforce diversity; nursing faculty loan programs; nurse education, practice and retention; comprehensive geriatric education; loan repayment; and scholarship.

AGS also requests that Congress support all Title VII Health Professions Programs at FY 2005 levels of $300 million. Specifically, we ask that Congress fund Geriatrics Health Professions Programs under Title VII at least at the FY 2007 levels of $31.5 million. Title VII Geriatrics Health Professions Programs supports three initiatives: Geriatric Education Centers (GECs) Program, geriatric faculty fellowships, and Geriatric Academic Career Awards (GACAs) all which are critical to improving recruitment and retention of Geriatrics Health Professionals. The AGS supports efforts to develop and enhance the GACA program to support junior geriatrics faculty and expand its availability to other health care professionals, including nurses. We also support establishing a mid-career GACA award that would support and retain clinician educators as they advance in their careers. In addition, we recommend creating a GACA-like award for advance practice nurses.

In addition to the suggestions outlined in our testimony, we ask Congress to consider the recommendations contained in the June 2005 American Association of Colleges of Nursing (AACN) white paper entitled, *Faculty Shortages in Baccalaureate and Graduate Nursing Programs.* The paper addresses the scope of the problem and strategies for expanding the supply of nursing faculty (See http://www.aacn.nche.edu/publications/whitepapers/facultyshortages.htm for more information).

Among the strategies to alleviate the shortage and expand the supply of nursing faculty are:

- Identify any existing regulatory requirements that limit nurses with non-nursing graduate degrees from teaching in nursing programs, so that efforts to remove these barriers can be planned.
- Utilize the expertise of junior faculty by partnering them with senior, fully qualified faculty who can provide course oversight and faculty support without requiring the more labor-intensive team teaching.
- Remove impediments to graduate study for working nurses, such as offering more convenient times for courses, encouraging partnering institutions to offer students more flexible work schedules to accommodate class schedules, and offering courses specifically for partnering health care facilities, possibly at their site(s).
- Examine college/university retirement policies and work to eliminate unnecessary restrictions to continued faculty service, particularly mandatory retirement ages and financial penalties for retired faculty who return to work part-time.

In collaboration with the *Hartford Institute for Geriatric Nursing*, the AACN also administers a Geriatric Nursing Education Project (GNEP), which is funded by the John A. Hartford Foundation. The GNEP incorporates several complementary programs to ultimately improve nursing care for older adults through curriculum enhancement, faculty development and scholarship opportunities. (See http://www.aacn.nche.edu/education/Hartford/index.htm for more information).

The programs include:

• Awards for Excellence in Gerontological Nursing Education
• A Faculty Development Institute Offered through the Geriatric Nursing Education Consortium
• New Series of Web-Based Interactive Case Studies Available

The AACN also administers The John A. Hartford Foundation funded Enhancing Geriatric Nursing Education for Baccalaureate and Advances Practice Nursing Programs, an initiative that supports gerontology curriculum development and new clinical experiences in 30 selected baccalaureate and graduate nursing programs. (See http://www.aacn.nche.edu/education/Hartford/ShowcasingInnovations.htm for more information).

According to projections from the Bureau of Labor Statistics (BLS), there will be more than one million vacant positions for registered nurses (RN) by 2010 due to growth in demand for nursing care and net replacements due to retirement. It is critical that we ask Congress to implement the recommendations from AACN and continue to encourage our nursing workforce to participate in the program opportunities outlined above to ensure we have an adequate and well-trained nursing workforce to care for the aging population.

Question 2—Public Health Emergencies

In the event of a public health emergency, public health providers at the local level will be among the first responders.

Question 2. Does HRSA train individuals so they are able to respond to the needs of vulnerable populations, such as seniors?

Answer. AGS Recommendations: Currently, HRSA does not train individuals so they are able to respond to the needs of vulnerable populations such as seniors, in the event of a public health emergency.However, it would seem like a natural extension of their training as it is estimated that some 3.4 million, or 34 percent, of all calls for emergency medical services involve older patients. Our rapidly aging population will only increase the pressure on our emergency medical system. This population has specific and often complex medical needs. To ensure that older adults receive quality care prior to arriving at the hospital, first responders must acquire the additional knowledge, skills, and attitudes that encompass the basic concepts of geriatric medicine.

In 2003, AGS and the National Council of State Emergency Medical Services Training Coordinators (NCSEMSTC), along with Jones and Bartlett Publishers (J&B) partnered to develop a program that will train prehospital professionals (first responders, EMTs, and paramedics) to deliver state-of-the-art care to older adults. The continuing education curriculum called GEMS (Geriatric Education for Emergency Medical Services) emphasizes the unique conditions and needs of older patients. (See http://www.gemssite.com/ for more information).

As America's 77 million baby-boomers age, the number of emergency calls involving older patients will likely rise significantly. People are living longer and therefore are often sicker and present more complicated conditions. Emergency responders are going to have to be well-trained at recognizing serious medical problems in the elderly.

The AGS believes that first responders must be aware of the complexities of treating older people or they may not take correct action. Communications are particularly important and EMS providers will need to recognize symptoms of drug interaction, dementia, elder abuse, and heart disease, all common problems among older people.

Unfortunately, there is no identified source of funding that would support states offering such training to EMS providers. Congress could look at creating an Emergency Medical Services Geriatrics program that is modeled on the Federal Emergency Medical Services for Children (EMSC) Program. This program was developed in 1984 and since that time, Federal grant money has helped all 50 States, plus the District of Columbia, the Commonwealth of the Northern Mariana Islands, American Samoa, US Virgin Islands, Guam, and Puerto Rico. (See http://bolivia.hrsa.gov/emsc/ for more information).

The EMSC program has improved the availability of child-appropriate equipment in ambulances and emergency departments. Federal grants to States and territories have supported hundreds of programs to prevent injuries, and has provided thousands of hours of training to EMTs, paramedics and other emergency medical care providers. The success of the program has led to legislation mandating EMSC programs in several states, and to educational materials covering every aspect of pediatric emergency care.

The EMSC Program is saving children's lives. A similar program focused on geriatric patients is needed as well as these populations both present unique health care needs that require additional training. Such a program would support the state

training coordinators in ensuring that EMS providers receive training in the unique health care needs of older adults.

Question 3—Importance of Social Workers

In your written testimony you mentioned the importance of loan forgiveness and specifically mention social workers. As you may know, yesterday was World Social Work Day, and I was honored to introduce a bill with Senator Mikulski to work to increase the number of social workers and ensure federal assistance exists to help them remain in their field, including loan forgiveness. As you also mention in your testimony, care coordination is important for so many of our vulnerable elderly with chronic health conditions, and while we may not think of them in this capacity, social workers do a great deal to ensure care is coordinated for so many of our vulnerable citizens.

Question 3. What do you think are the best ways to support social workers who focus on our elderly vulnerable populations and how can we perhaps better train them in care coordination models that you've discussed today?

Answer. AGS Recommendations: The AGS believes that social workers trained in the field of geriatrics are imperative and therefore, strongly supports incentives for social work students who train to care for our aging population. Incentives, such as federal loan forgiveness legislation, are among the remedies needed to make careers caring for older adults more appealing and to address recruitment and retention problems.

The National Institute of Aging estimates the nation will require 70,000 trained, "aging savvy"professional social workers by 2020. Currently, only 5% of social workers are trained in aging issues.

As stated in our testimony, the AGS strongly supports the 'Caring for an Aging America Act' introduced by Senator Barbara Boxer (D-CA), which would, among other things, establish the Geriatric and Gerontology Loan Repayment Program for social workers, along with physicians, physician assistants, advance practice nurses and psychologists who complete specialty training in geriatrics or gerontology and who agree to provide full-time clinical practice and service to older adults for a minimum of two years. While loan forgiveness is a very good start, it is also important to find a method to support specific training programs—as all schools do not equally prepare students for practicing with older adults and for care coordination.

The Hartford Partnership Program for Aging Education (HPPAE) was created to meet the workforce demand for geriatric social workers by training and educating more than 1,000 social workers in older adult care and to establish a specialized aging curriculum in Masters of Social Work programs across the country. The HPPAE is an eight-year initiative coordinated by the Social Work Leadership Institute (SWLI) at the New York Academy of Medicine and is funded by the John A. Hartford Foundation. In 1999, 80 percent of the HPPAE graduates who participated in the program's pilot study went on to pursue careers in the field of aging. Currently, 72 schools in 32 states have adopted the Hartford Partnership Program for Aging Program. Graduates of these programs are highly sought after by employers in the field. (See http://www.socialworkleadership.org/nsw/ppp/about.php for more information)

In addition, current practitioners and those who enter the aging field do not always stay in the field because of challenging working conditions. Continuing education focused on care coordination and payment for care management are important methods to increase retention.

The AGS also supports creating a GACA-like award for social workers. The Geriatric Academic Career Awards (GACA) funded under Title VII Health Professions Programs of the Public Health Service Act supports the career development of newly trained geriatric physicians in academic medicine.

The field of geriatrics promotes preventive care, with an emphasis on care management and care coordination that aims to help older patients maintain functional independence in performing daily activities and improve their overall quality of life. Social workers are an important part of the geriatric team. Now is the time to address social work recruitment into the field of aging and build on programs that train social workers to provide care coordination and case management.

MARY MCDERMOTT'S RESPONSES TO SENATOR SMITH'S QUESTIONS

Question 1—Nursing Shortage in Rural Areas

In Oregon, our nursing shortage is most acute in rural areas, as I can imagine is the case in Wisconsin. Our schools are turning away potential nursing students that could be serving in these areas. Since the 2002 academic year, the number of qualified applicants turned away by Oregon nursing schools has increased by more than 300 percent, with more than 1,500 qualified applicants being turned away in 2007.

Question 1. I am curious if Wisconsin is experiencing similar challenges, and as a personal care worker, could you share with us what effects older Americans are experiencing from the health care workforce shortage, including nurses and other health care professionals, in rural areas?

Answer. The problems with nursing schools which you site for Oregon are identical in Wisconsin. This happened to my daughter who was a four point student and wanted to be a nurse. When she reached the point in her education to enter the nursing program she was told there was a two year wait before she could continue her education. Long story short, she changed directions. My sister-in-law, a surgical RN in California complains that the nurses coming out of nursing school now are inadequately trained as they attempt to rush as many through as possible. This is a complaint I have heard from RNs in WI, MI, NJ, NC, and FL. The problem appears to be on two levels, limited training availability and inadequate training. The impact to the elderly is they have less availability to nursing professionals and people who are available lack some basic training and most generic training.

The farther you get from communities with populations of ten thousand the worse the problem becomes and the elderly are forced to rely on friends, family, and neighbors. While I personally feel the old fashioned community support model is beneficial to all parties involved, it should not be the sole avenue of home care support. It does not provide the consistent preventive professional service that older people need. It can also diminish their feelings of independence, dignity, and can cause feelings of being a burden which leads to depression with its corresponding health care issues. They are also open to criminal predators who target the elderly.

I have worked in a consulting capacity with a few home health care agencies over the last ten years to improve their hiring and training practices as well as the quality of their care. Actually I think they got tired of my stealing their employees. An agency will receive $25.00-40.00 dollars per hour and pay their workers between $5.00-9.00 per hour. The agencies are in a population base of 400,000 and my community has a population of 9,000, but I advertised in the larger population. When the agencies placed ads in good economic times, they average between three to five responses from uneducated people or students. They are lucky if they get one qualified person and will need to run ads repeatedly to get that one person. During bad economic times they may get eight to twelve responses with the same results of a possible one qualified person.

There is a perception, which for the most part is true, that privately advertised home care pays more. Consequently the ads get more attention as well as a greater number of highly trained overly qualified people. Generally these are people who are looking to supplement their income, flexible hours that will work with their family's needs. Also included are those who work better outside of an institutional environment and professional home care workers. I set up a system of three team members with myself as back-up between 1997 and 1999. The team included one RN ($27.00 per hour), one LPN ($17.00 per hour), and one CNA ($9.00 per hour). In 1998 I was told both my parents were in critical condition and would most likely not live six months. I utilized each team members's talent/training level to the tasks best suited with the mandate to spoil my parents rotten. It must have worked well since my father lived until October 2005 and my mother is still alive.

Once we passed this critical and financially burdensome stage, we switched the team profile to two CNAs daily and one RN for weekly visits. By this time I had become able to train aides in my parent's care, including the generic skills that most were lacking. In 1998 the ads we ran generated eight responses of which three were qualified. In 2000 we had ten responses of which two were qualified. In 2003 we had 150 responses. Twelve people over qualified foreign licensed RNs and LPNs (one of which was a doctor) highly trained medical personnel which had to be retrained and re-licensed in this country, from Ireland, Russia, and Palestine, and Romania. Their employment needs were too temporary to suit our situation and their monetary expectations were no longer feasible for us. Three respondents were students in medical fields and two were professional home care workers. The majority of respondents were not fit for a phone conversation. Several did not speak English. Even when English was their native language they took the term unintelligible to

whole new level. Imagine the dire health consequences of miscommunications with people who maybe hard of hearing or suffering from dementia when being cared for by such workers. We hired one student willing to make a one year commitment who is now a medical assist specializing with the disabled and elderly and one professional home care who still works here 4 hours a week.

While the numbers may look like an upturn is occurring with people in the home health field it is not. Economic conditions and population growth through immigration have an increasingly greater impact on the number of those who are responding to ads for home care work. Workers who are in the field because of economic reasons are not always the best because they leave as soon as their financial issue is resolved or are not consistent on the job. It is impossible not to notice that for private care ads, as well as agency ads, qualified applicants have flat lined or even declined, though the number of responses has increased.

Many people who have found themselves in the position of suddenly making care decision for their parents have sought direction from me over the years. It is always the case that solving their problems is much more difficult when their parents live in small towns. I can't tell you how many times I hear "Thank God for that lady next door". Programs targeting rural areas are most certainly warranted and will only increase in necessity with the experiential growth that our population of seniors is experiencing.

Question 2—Caregiver supports

In your testimony, you mention that you are a caregiver for your mother and that you also were for your father. You also mention that you did extensive work to ensure an appropriate and trained team was hired to help you care for them. I know that the purpose of funding through the Older Americans Act is to help provide supportive services and referrals for the elderly and their family members to help seniors stay in their home, and out of facilities, as they age.

Question 2. Did you receive any information, referrals or caregiver help through your local Area Agency on Aging and how do you think we can better ensure that caregivers, like you, receive the support you need?

Answer. From 1997 to 1999, I was exposed to many doctors, hospital social workers, nursing care facilities. With all the health care professionals I dealt with not one provided the information or resources that would have saved me over $300,000.00. I did aggressively go after information in the first year. The only option anyone wanted to speak to me about was putting my parents in a nursing home. It was a learning experience without direction. Thankfully that fit my career specialty, so developing processes and analyzing needs allowed me to put together the perfect team profile and care plan for my parents. In 2000, I left my career to pick up some of the time with my parents and reduce cost of care. While I made many inquiries, most agencies were only interested in their special area that related to some funding table, while others only wanted to talk about nursing homes. Finally in 2003, while at the mall getting a battery for my father's watch, a woman working at the kiosk and I started talking about health care costs. I said I didn't know how much longer I could afford my health insurance because I was taking care of my parents and it cost me $480.00 per month which, along with everything else, was breaking me financially. She said her sister took care of their parents and got health insurance and was paid to do so. She gave me the number to call for the state agency and from that point on we received help and information. Yes, I had called the county and state agency previously, but was only given misdirection and useless information.

Subsequently, I discovered that too many agencies had small qualifying focuses and an inability to understand where to direct people who may not fit their particular profile. Everyone is protecting their small piece of the pie and failing to provide cost effective solutions. Each agency has a set of rules which may conflict with others, causing more confusion as well as increased cost to those providing care and those getting care. This situation enables those prone to fraud, a lucrative playing field, which in turn reduces the availability of services. The conflicting regulations are a nightmare for both care recipients and administrators of the various programs. One example occurred in my home when a doctor ordered a blood draw after a hospitalization. The private agency's RN we hired could not do the blood draw because of Medicare restrictions from another agency whose RNs could not perform the task due to liability and some other restriction. It had to be done and the two agencies actually got into a fight over the rules and regulations they each work under with my mother caught in the middle. Not one tolerant of silliness when a person's health is at risk. I just hired a private nurse to come in and get the blood the doctor needed. Other options, proposed by the two agencies would have had adverse consequences for my parents, which both agencies agreed they did not want to see.

Addressing this issue is currently underway in Wisconsin, and is also one of the proposed goals for the Wisconsin Quality Home Care Commission. To this end, there have been many positive efforts in Wisconsin. Persuading any agency to work efficiently and cooperatively with other agencies (governmental, qusi governmental, or private) is a very difficult task to accomplish. If someone told you that merging the states of Oregon and Washington would save 10 million dollars a year and would improve the services to both states, but you would have to fine another job and could no longer control the money to the state, how fast would you jump on that band wagon? And how do you convince the law makers of Oregon that they should now use the laws of Washington?

I discovered several ways the county and state could cut cost and improve services. However, with the current protect your turf attitude, the majority of initiatives will continue to be layered costly fix after costly fix instead of real solutions. This will continue until the financial back is broken and the baby gets thrown out with the bath water in cut backs. I am very proud of the initiatives that have taken place in Wisconsin since I found myself in this life altering circumstance in 1997. People in this state now have better access to information. But there is so much more work to be done. The first paragraph of Charles Dickens' *A Tale of Two Cities* runs though my mind regularly when I reflect upon this unexpected phase in my life. While one of the most rewarding of my accomplishments, it has also been one of the most difficult. It is the conditions in which I found the elderly and the care givers which drive my conscience to help make things a little better. This world that I have adventured into is so far from who I am that I do stand in awe of those who have chosen this as a career path. I also pray they will at some point in time receive the recognition and assistance they so justly need and deserve.

When my job is finished here, I have the option to avoid the homecare field if I so choose, but I can't avoid getting old any more than you can. What caliber of person do you want in your home making decisions that could mean the difference between life and death?

SALLY BOWMAN'S RESPONSES TO SENATOR SMITH'S QUESTIONS

Question 1—Geriatric Education Centers and the Aging Network

In your written testimony you mention the great publications and information that OSU has worked on related to ensuring elderly consumers and their caregivers are aware of the options available to them.

Question 1. How do you ensure that seniors and their caregivers have access to this information, and do you work with the aging network, such as the State Unit on Aging and Area Agencies on Aging to ensure that the products are offered where seniors and their caregivers will have access to the information?

Answer. OSU Extension Service publications on aging are available for free on the OSU web site. They can also be ordered for a small charge. They are included in the next eXtension national Family Caregiving website located at www.extension.org. Because we are part of the national network of University Extension Services, other Universities also utilize our educational materials with their audiences.

In addition, our partners in the state, including the State Unit on Aging, AARP, Area Agencies on Aging, and our Oregon Geriatric Education Center partners, OHSU and PSU, distribute our publications at health fairs and trainings. We share our educational materials in these venues, and disseminate up-to-date lists of educational resources at events and conferences. We also actively co-teach with partners from other agencies, thus expanding our outreach. For example, we collaborated with AARP on a statewide Prepare to Care project, in which one of our activities was viewing the recent PBS special, *Caring for your Parents*, at selected locations around the state, followed by a panel of local and state experts.

Our OSU Extension faculty members with county assignments partner with the State Unit on Aging, regional Area Agencies on Aging, nonprofit agencies, and businesses to provide trainings in chronic disease self-management, tai chi, strong women, and family caregiving to older adults and their family members. Other workshops and events include medication management, optimal aging, aging in place, financial planning in later life, etc. These offerings are available in both urban and rural areas, although not in every county due to funding limitations for staffing.

Question 2—Federal Geriatric Programs

For Fiscal Year 2008 (FY08), Congress provided $31 million for geriatric programs. In FY07, Oregon received $390,000. Unfortunately, the President's FY09 budget zeroed out geriatrics programs, including the Geriatric Education Centers

Program, Geriatric Training for Physicians, Dentists, and Behavioral and Mental Health Professionals and Geriatric Academic Career Awards Program.

Question 2. In your testimony, you speak to the importance of Oregon's Geriatric Education Center to rural areas—how would you evaluate its success?

The Oregon Geriatric Education Center has fostered a collaborative relationship between OHSU, PSU, and OSU in the area of geriatrics and gerontology. One of the results of that collaboration is that we work together on developing train ing opportunities around the state. We provide a resource center of educational materials that are lent to professionals and to long-term care facilities. We develop curricula, if there is a gap in educational resources. The OHSU geriatrics physician who serves on the GEC is very active in providing geriatric training to other physicians around the state. In addition, we partner with geriatricians through their professional association. We report our activities and our outreach in the federal reports, and we are also working together this year to improve our evaluation of outcomes. In short, the Oregon GEC helps focus the energy of the three Oregon universities on working together on health programs and aging. It provides leverage that helps us respond to private foundation grant-related opportunities.

Follow Up: What other incentives could help induce physicians to pursue careers in geriatrics?

Answer. Financial incentives, such as scholarships and loan repayment programs, have been shown to be effective in recruiting health care providers, such as physicians and nurses, to practice in specific fields, such as geriatrics. Research also provides evidence that if you want to recruit health care providers to practice in rural areas, the greatest likelihood of success is if you recruit amongst students who grew up in rural areas. If you want to recruit health care providers to serve older adults from minority groups, the greatest likelihood of success is if you recruit amongst students from minority groups. If you want to recruit health care providers to work with older adults, the greatest likelihood of at some point in their life. These findings should inform the design of recruitment programs because they will contribute to their overall success.

Statement from National Center on Caregiving, Family Caregiver Alliance

To the Senate Special Committee on Aging
Hearing on April 26, 2008
"Caring for Our Seniors: How Can We Support Those on the Frontlines?"

The National Center on Caregiving at Family Caregiver Alliance (FCA) would like to thank Senator Herb Kohl, Chair of the Senate Special Committee on Aging, and Senator Gordon Smith, Ranking Member of the Committee, for holding the hearing on April 26, 2008 called "Caring for Our Seniors: How Can We Support Those on the Frontlines?"

FCA, founded 30 years ago in San Francisco, unites research, policy and practical services to support and sustain caregiving families. Our National Center on Caregiving works to advance the development of high-quality policies and programs for caregivers in every state in the country. FCA also offers direct services to family and friends as the Bay Area's Caregiver Resource Center (CRC) and serves as the Statewide Resources Consultant for California's CRC system.

Family caregivers are the backbone of our long-term care system. Most adults with long-term care needs want to remain at home or in the community, and they often rely on family and friends to provide the care they need. According to the Long-Term Care Financing Project at Georgetown University, more than three-quarters (78%) of adults age 18 and older who receive long-term care at home rely exclusively on informal care from family and friends. Another 14% of care recipients get assistance from both family caregivers and formal care providers, or direct care workers. Only 8% of care recipients depend on formal, paid care alone. This reliance on family caregivers makes them a tremendous economic asset. The value of family care is estimated to be $350 billion a year – more than the total annual U.S. expenditure for all formal long-term care, including institutional and home and community-based services.

As the population ages – bringing with it an increase in the number of people with chronic conditions or other long-term care needs, more spouses, adult children and other family members are expected to assume caregiving responsibilities. Family caregivers face increasing challenges and pressures as they try to balance work and family responsibilities, navigate the health, long-term care and social service systems, and deal with the stress of providing care to an ill or disabled family member. Family caregivers do all of this with little or no training or education on how to care for someone who is sick, disabled or has dementia, and they often lack access to services that could help them make decisions about caregiving arrangements and manage their care recipient's affairs.

Research shows that, compared to noncaregivers, family caregivers report higher rates of chronic conditions, disability and stress; lower levels of self-care; and they are more likely to lack health insurance. Adding to the physical and emotional burden, family caregivers face a financial burden, spending an average of $5,500 a year on caregiving expenses including household goods, food, transportation and health care. Without

appropriate support, family caregivers risk total burnout, resulting in increased strains on public resources and increased demand for formal care.

Assess and Address Family Caregivers' Needs

In order to continue effectively in their caregiving role, family caregivers' needs must be assessed and addressed. Therefore, it is critical that all family caregivers have the option of receiving a caregiver assessment. A National Consensus Development Conference on Caregiver Assessment was held in 2005, and participants agreed on this definition:

> *"Caregiver assessment refers to a systematic process of gathering information that describes a caregiving situation and identifies the particular problems, needs, resources and strengths of the family caregiver. It approaches issues from the caregiver's perspective and culture, focuses on what assistance the caregiver may need and the outcomes the family member wants for support, and seeks to maintain the caregiver's own health and well-being."*

To ensure a workforce competent in working with older adults and family caregivers, professional education and training curricula that include caregiver assessment should be developed for physicians, social workers, physical therapists, nurses and occupational therapists to be used in continuing education and student training programs.

In order to ensure that all family caregivers are able to receive an assessment regardless of their ability to pay, public financing should be available for caregiver assessment. Assessments of family caregivers should be required and reimbursed by Medicare and Medicaid when a beneficiary's care plan relies on a family caregiver to provided needed care and assistance. Not only is it in the care recipients' best interest that their family caregivers' needs be identified and met, but the government and taxpayers benefit when family caregivers remain in their caregiving role – largely at their own expense – and keep their relatives out of institutional care.

It is equally important that a caregiver assessment be followed up with the provision of caregiver services or, at the very least, referrals to appropriate caregiver supports, education and training. Addressing family caregivers' needs by giving them access to relevant programs and services, such as the National Family Caregiver Support Program (NFCSP), makes it possible for them to continue providing care.

Provide Skills Training for Family Caregivers and Direct Care Workers

Family caregivers and direct care workers are responsible for meeting a variety of home care and medical needs, sometimes quite soon after major medical procedures or diagnosis. Not only do they help with everyday tasks, such as bathing, eating, and providing transportation, but they are often charged with more complex tasks such as managing medication, changing bandages and using medical equipment. Yet both family caregivers and direct care workers tend to lack any formal training or education in providing care to an older adult or adult with disability. Certification requirements and the level of training offered to direct care workers are quite low. Federal law requires

less than two weeks of training for home health aides and no training for personal care assistants, although many states have slightly increased requirements.

Home care agencies and other employers, including state Medicaid programs, should provide more training for direct care workers to learn new skills and develop specialized competencies. Workers need to know clinical skills and how to provide safe and effective hands-on care, as well as how to communication effectively and help problem-solve. Greater skill development could increase workers' confidence and improve the quality of care they provide, which has the added benefit of reducing stress on family caregivers and improving their physical and mental health. In order to promote increased training for workers, the government could provide incentives to long-term care providers who invest in workforce development and trainings. Education and training programs should also be available and accessible to family caregivers, regardless of where they live, through the National Family Caregiver Support Program and other public programs.

Improve Working Conditions for Direct Care Workers

At the same time that family caregivers are facing increasing care burdens, the United States is experiencing a shortage of direct care workers for a number of reasons. Direct care workers face difficult working conditions, causing high turnover and an unstable workforce. Direct care workers often face a lack of respect, low pay, few fringe benefits, little opportunity for advancement and isolation. In 2005, the median annual wage was $17,710 for a personal care aide and $18,850 for a home health aide. Between 40% and 45% of home care aides lack health insurance.

Better working conditions for direct care workers would result in less turnover, more experienced workers and, ultimately, better quality of care. Increased wages, access to affordable health insurance and mandated worker protections would all serve to increase the status of direct care workers and to attract more potential workers to the field. FCA recommends the Department of Labor study working conditions for direct care workers, including home health aides, personal care attendants, and others working home and community-based settings, to see how the conditions can be improved.

Recruit and Train More Professionals in Geriatric Care

In addition to a shortage of direct care workers, there is a critical shortage of professionals, including physicians, nurses, social workers, physical therapists, and others, trained in working with and providing care to older adults. Efforts must be taken to recruit students into geriatrics and gerontology and to train professionals already in their fields to work with older adults. Legislation, such as the Caring for an Aging America Act (S. 2708), which provides loan forgiveness and career advancement to trained health care professionals and direct care workers dedicated to working with the growing population of older adults, is a step in the right direction.

Thank you for your interest in these issues. FCA looks forward to working with the Committee on efforts to provide more support and services to family caregivers.

STATEMENT
Of

The American Health Care Association
and
National Center for Assisted Living

Before
the
Senate Special Committee on Aging:
"Caring For Our Seniors: How Can We Support Those On The Frontlines?"
April 16, 2008
562 Dirksen Senate Office Building

On behalf of the American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL), I thank Chairman Herb Kohl, Ranking Member Gordon Smith, and all the Members of the Special Committee on Aging for taking the time to closely examine how we as a nation confront the current workforce crisis that leaves us without adequate staff in long term care facilities across the U.S.

Across the country, skilled nursing facilities serve approximately three million elderly and persons with disabilities each year – 80 percent of whom rely on government programs to pay for the cost of their care. Nationally, nearly two-thirds of nursing facility residents rely upon the Medicaid program to pay for their long term care needs, and nearly 14 percent have their skilled care and rehabilitative services covered by Medicare. Additionally, one million Americans reside in our nation's assisted living residences with nearly 10 percent of these residents relying on the Medicaid program to fund a portion of their care and services. Furthermore, nearly 100,000 individuals with developmental disabilities (DD) reside in intermediate care facilities for mental retardation (ICF/MR), and this increasingly aging population relies primarily on Medicaid to meet their care needs.

Assuring the highest quality of care for the millions of Americans who rely on critical long term care services is the driving force behind the advocacy efforts of AHCA/NCAL and its nearly 11,000 member facilities. The provision of quality long term care in our nation's nursing facilities, assisted living residences, and residences for people with DD truly is a partnership between the federal government and the profession that employs more than two million direct care workers caring for the nation's most vulnerable population.

Human contact is essential to treating long term care patients and residents, and you will never be able to replace the role that people play in providing long term care. AHCA/NCAL has long recognized that the provision of high quality long term care and services is dependent upon a stable, well-trained workforce.

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AHCA/NCAL is the nation's leading long term care organization whose member facilities are committed to enhanced quality through initiatives including Quality First, Advancing Excellence in America's Nursing Homes and the Center for Excellence in Assisted Living. AHCA/NCAL represents nearly 11,000 non-profit and proprietary facilities who employ millions of caring employees and provide care and services to millions of frail, elderly and disabled citizens in nursing facilities, assisted living residences, subacute centers and homes for persons with developmental disabilities. For more information on AHCA/NCAL, please visit ***www.ahca.org***

However, America's long term care system is currently suffering from a chronic supply and demand problem when it comes to our labor force. Addressing this challenge on both fronts is the only real means to sustain the provision of high quality long term care.

We are committed to partnering with Congress, the Administration, and other long term care stakeholders to ensure a qualified and well-trained staff is in place to care for our nation's elderly and disabled today – and in the coming years when the current crisis will hit epidemic proportions unless government intervenes. But as a first step toward this laudable goal, we agree with the *National Commission for Quality Long-Term Care* that there must be recognition that the long term care workforce is "a critical component of the nation's labor force – separate and distinct from the health care labor market." Today's hearing is a good step in recognizing that long term care has its unique staffing issues.

We want to take this opportunity to commend Senators Gordon Smith, Blanche Lincoln, and Susan Collins, members of this committee, for putting forward some of the most important regulatory reform concepts of the past twenty years – critical reforms that can help to build mutually beneficial partnerships, and undo an era of unproductive confrontation.

The *Long Term Care Quality and Modernization Act of 2007 (S. 1980)* represents an important step toward such a culture of cooperation – one that we enthusiastically embrace and endorse. In regard to the long term care workforce, this important legislation would:

- Require joint training and education of surveyors and nursing facility providers, and implement facility based training for new surveyors;

- Direct CMS to modify the definition of Substandard Quality of Care (SQC) so that factors not affecting quality of care or the training of nurse aides are eliminated, and amend current law to allow nursing facilities to resume their nurse aide training program when deficiencies that resulted in the prohibition of the training have been corrected and compliance has been demonstrated;

- Direct HHS to create a national nursing database of common data elements enabling the government and providers alike to forecast future supply and demand changes. The database should include workforce data across all provider settings, including nursing educators, for use in trend analysis and to create a pipeline/educational model to forecast workforce needs; and

- Amend the Nurse Reinvestment Act to require entities receiving assistance under the Act to submit an annual report to the Secretary of Health and Human Services. The report demonstrates how funds granted under the Act are being used to increase the number of nurses, nurse educators, and nursing education enrollment slots – including with respect to geriatric nursing.

On the front lines of care, Mr. Chairman, these proposals are significant and merit strong support.

Quality – AHCA/NCAL's First Priority

With "quality" as our watchword, it is important to note at the outset that the long term care profession has led the quality movement. Our sector's leadership has helped to improve and maintain the overall quality of care in our nation's nursing facilities and assisted living residences. Through the development of a private-public "culture of cooperation" long term care stakeholders are meeting the challenge of quality care head on, and this commitment has propelled the profession forward.

The Online Survey, Certification and Reporting (OSCAR) data tracked by the Centers for Medicare and Medicaid Services (CMS) clearly points to improvements in patient outcomes, increases in overall direct care staffing levels, and significant decreases in quality of care survey deficiencies in our nation's skilled nursing facilities. At the same time, an independent analysis confirms consistently high patient and family satisfaction with the care and services provided in nursing facilities.

Some examples of positive trends according to data tracked by CMS:

- Nationally, direct care staffing levels (which include all levels of nursing care: Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nursing Assistants (CNAs)) have increased 8.7 percent between 2000 and 2007 – from 3.12 hours per patient day in 2000 to 3.39 hours in 2007;

- The Quality Measure* tracking pain for long term stay residents vastly improved from a rate of 10.7 percent in 2002 to 4.6 percent in 2007 – more than a 50 percent decrease;

- The Quality Measure tracking the use of physical restraints for long stay residents dropped from 9.7 percent in 2002 to 5.6 percent in 2007;

- The Quality Measure tracking pressure ulcers improved for both low and high risk long stay residents – with hard to treat, high risk pressure ulcers reduced from 13.8 percent in 2002 to 12.8 percent in 2007; and

- For short-term stay patients (many of whom are admitted to the nursing facility with a pre-existing pressure ulcer) the Quality Measure tracking the incidence of pressure ulcers also improved, declining from 20.4 percent in 2002 to 17.5 percent in 2007.

- Substandard Quality of Care Citations as tracked by CMS surveys were reduced by 30 percent in five years – from 4.4 percent in 2001 to 3.1 percent in 2006.

Mr. Chairman, we remain committed to sustaining these quality improvements for the future. With your help, we will have the stable workforce necessary to build upon these improvements.

Long Term Care – A Workforce in Crisis

Despite the documented success on the quality improvement front through our participation in the collaborative *Advancing Excellence in America's Nursing Home* campaign, the federal Nursing Home Quality Initiative (NHQI), the *Center for Excellence in Assisted Living* and our profession's own *Quality First* program, our immediate concern is the need to sustain our progress in the face of a growing demand for care among the first wave of baby-boom retirees.

Last year *Congressional Quarterly* reported that nearly 70 percent of those who turned 65 in 2007 will eventually require long term care. Therefore, promoting and passing sound fiscal policies designed to strengthen our workforce and promote the continued improvement in seniors' care quality deserves to be a top national priority. The harsh reality is that while we will have a growing demand for long term care

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* **Quality Measures** track nursing facility residents who have and are at risk for specific functional problems needing further evaluation. Improvements in these measures indicate positive trends in patient outcomes, but it is important to clarify that the quality measures do not reflect a percentage of the entire population, rather the percentage of those who are at risk and have the condition.

services in the coming years, the population that must provide the care – at home or on the job in a facility – is not growing.

A recent report by the *National Commission for Quality Long-term Care* highlighted this impending catastrophe when it stated "even if we set the somewhat conservative goal to maintain the current ratio of paid long-term care workers to the current population of 85-year-olds, the long-term care workforce would have to grow by two percent a year — to the tune of 4 million new workers — by 2050."

The Department of Labor's Bureau of Labor Statistics indicated in a 2008 report that "in nursing facilities, the need for [licensed practical nurses] is expected to increase by 21 percent, from 193,241 in 2006 to 233,033 in 2016." The Bureau further stated that "nurse aides employed in nursing care facilities often are the principal caregivers, having far more contact with residents than do other members of the staff. Because some residents may stay in a nursing care facility for months or even years, aides develop ongoing relationships with them and interact with them in a positive, caring way." The typical resident in an assisted living setting will reside there for more than two years relying on caregivers to deliver their services.

The high demand for long term care workers is already documented by the federal government. A recent study by the Department of Health and Human Services (HHS) and Department of Labor (DOL) estimates the U.S. will need between 5.7 million to 6.5 million nurses, nurse aides, and home health and personal care workers by 2050 to care for the 27 million Americans who will require long term care – up more than 100 percent from the 13 million requiring long term care in 2000.

In addition, an AHCA study examining staff vacancy rates in our nation's nursing homes found approximately 52,000 CNAs are needed immediately – just to meet existing demand for care in nursing facilities alone. As CNAs perform almost 80 percent of direct patient care tasks, they are a vital part of assuring quality objectives within any given facility are achieved.

Vacancies and turnover in the long term care profession compromise sustained quality improvements and increase costs. In fact, a recent report from the *National Commission on Nursing Workforce for Long-Term Care* concluded that "efforts to recruit and train new nursing staff are estimated to cost nursing facilities over $4 billion each year – more than $250,000 annually for each nursing home in the nation.

While efforts to recruit and train new qualified long term caregivers are costly, our profession has been aggressively pursuing potential nurses and caregivers. An unfortunate truth exists that nursing education programs are forced to turn away well-qualified applicants for the sole reason that there are not enough nurse educators to train these potential caregivers. In fact, the American Association of Colleges of Nursing found in its annual survey that more that 40,000 qualified applicants were not accepted into nursing programs primarily because of insufficient nurse faculty for the 2007-2008 academic year.

Growing Demand for Care & Services

We have a current crisis with caregiver shortages in long term care. This will be exacerbated in the coming years. The most rapidly growing age group in America is those aged 85 years and older, which is expected to quadruple by 2050. These are the precise individuals who will require essential long term care services in the very near future.

These trends are further compounded by the impending care needs of the nearly 80 million baby-boomers who are set to retire in the not too distant future. Their retirements will not only signal the future care needs of this generation, but it will also signal the departure of our most experienced nurses and caregivers who are

currently employed in our nation's nursing facilities and assisted living residences. In 2001, 13 percent of RNs were 55 or older, while 31 percent were 45-54, which means that that by 2020 an estimated 45 percent of all RNs will be of retirement age, according to the Health Resources and Services Administration's National Center for Health Workforce Analysis.

The forecast is daunting. A March 2008 report from the National Investment Center for the Seniors Housing & Care Industry (NIC) indicates that the demand for long term care services will more than double by 2040. This increase in demand will require rapid and sustained growth of available and well-trained caregivers throughout the spectrum of long term care services.

In fact, the NIC study projected that "the use of paid home care will increase from 2.2 million people in 2000 to 3.9 million - 6.2 million in 2040, depending mostly on assumptions about disability rates. During the same period, the number of older people using nursing care will increase from 1.2 million to 2 million - 3.1 million."

Consequently, the need for long term care workers will increase. In 2000, 1.8 million Americans were employed as direct caregivers, and that number is conservatively estimated to jump to at least 6.6 million by 2050. It will become even more difficult for our profession to recruit workers because of the reality that the potential labor pool is shrinking – from a ratio of 77 possible employees within the labor force to each long term care position in 2000, to just 29 potential employees per position in 2050.

Looking to the future, we need to acknowledge the growing role that skilled nursing facilities play as providers of short-term post acute care. A recent United Hospital Fund report documents the growing role that skilled nursing facilities play as providers of short-term care for people continuing recuperation after a hospital stay. The report also found that the "number of patients staying in a nursing home for less than two months more than tripled," from 1996 to 2005 in New York. In addition to this rise in short-stay patients, the study further concludes that, "between 1996 and 2005, both long-term residents and short-term patients have become more disabled, and more of them are cognitively impaired." The authors indicate that the findings of this study are representative of national trends. In light of this shift, recruiting and retaining staff is especially critical, because caring for higher acuity patients with more cognitive impairments requires a more highly trained and educated workforce.

The Current Financing System Fails to Support Workforce Needs

Despite the growing demand for long term care, the current financing mechanisms rely heavily on public programs with Medicaid and Medicare funding the greatest portion of nursing facility care.

Although Medicare reimbursement rates do have a component that accounts for wage increases for skilled nursing facilities, there is a significant time lag between rising labor rates and increases in reimbursement rates. The Centers for Medicare and Medicaid Services (CMS), to our disappointment, has not yet developed a separate skilled nursing and long-term care index. Rather, they share a wage index with hospitals. This grouping of dissimilar care settings into a single index causes staff recruiting difficulties for the long term care profession.

Recruitment costs and increases in the federal minimum wage or other salary increases are often not represented in state Medicaid reimbursements. States are not obligated to adjust their reimbursement under Medicaid despite higher wage costs.

Clearly, this has the potential to create a still greater cost squeeze on facilities than is already the case, and places increased pressure on already strained state Medicaid programs and budgets.

An obvious and disturbing case in point relating to our profession's cost squeeze is an analysis of the nation's Medicaid financing system. An *Eljay, LLC*, study projected states would cumulatively under fund the actual cost of providing quality nursing facility care by $4.4 billion in 2007. The study further showed the average shortfall in Medicaid nursing home reimbursement was $13.15 per patient day in 2007 - a 45 percent increase from 1999.

Assisted living is also feeling the limitations by a stretched Medicaid program. According to a draft report titled "Residential Care and Assisted Living Compendium 2007," by the U.S. Department of Health and Human Services, while the number of licensed assisted living beds continued to grow from 2004-07, the number of assisted living residents covered by Medicaid declined over that same period from 121,000 beneficiaries to 115,000 beneficiaries.

How Can We Provide More With Less?

Nearly 70 percent of skilled nursing operating costs are labor-related. Ongoing funding shortfalls have a major impact on the front lines of care and negatively influence staffing, jeopardize intra-facility quality improvement efforts, and even may cost the jobs of the very staff that make a key difference in the quality of care and quality outcomes.

Therefore, when the federal government repeatedly propose drastic Medicare cuts for the care of our nation's elderly in skilled nursing facilities, providers are far less able to recruit and retain qualified direct care workers and health care professionals, modernize and refurbish aging physical plants and equipment, acquire and implement new technology – initiatives that are critical to meet the increasingly complex care needs of our aging population. AHCA is gravely concerned about the forthcoming CMS Rule regarding fiscal year 2009 Medicare payments for skilled nursing facilities. This anticipated proposed rule is highly likely to contain a regulatory change which will drastically reduce Medicare funds for the nursing and rehabilitation care of seniors in America's nursing facilities by $720 million in FY 2009 and $4.7 billion over five years.

So we ask you Mr. Chairman, how can dedicated providers of skilled nursing care meet the ongoing demands of the federal government for increased staffing levels and sustained quality improvements with reduced funding?

Reaction/Response to Institute of Medicine Workforce report

We applaud the Institute of Medicine (IOM) for addressing this critical issue in their report, *Retooling for an Aging America: Building the Health Care Workforce*, which was released earlier this week. AHCA/NCAL strongly agree that the rising number of older Americans, along with the demographic characteristics, health needs and care settings, necessitate immediate changes related to the education, training, recruitment and retention of the health care workforce now.

The report suggests a three-pronged approach to enhance the competence of all individuals in the delivery of geriatric care; increase the recruitment and retention of geriatric caregivers, and redesign models of care and broaden provider patient roles to achieve great flexibility. AHCA/NCAL is actively engaged in projects and initiatives that address each of these critical areas of need.

While we agree with the intent of this new workforce report, our initial analysis raises questions and concerns as to how the IOM envisions care and services should be provided to the frail, elderly and disabled in the coming years. The goals of the report are laudable as they raise awareness of the long term care sector of healthcare – a component that is too often underrepresented in national discussions regarding caregiver shortfalls.

Despite the good intentions of the IOM, we feel that the report does not go far enough in addressing all the underlying complexities that are unique to long term care. As well, we have specific concerns with two recommendations contained within the report – requiring substantial increases to direct care worker training hours, and mandating Medicaid wage pass-throughs.

AHCA/NCAL encourages Congress to fund a study which seeks to determine the positive measureable benefits of increased training supported by evidence based research. The results of this study would provide a better framework to establish optimal training requirements, including the ratio of classroom education and clinical training hours. This approach would create an informed perspective on the appropriate number of minimum training hours for direct care workers.

We agree that state Medicaid programs should fund long term care more appropriately, which we believe would better enable providers to increase salaries and wages to all employees. As indicated earlier, the disparity between the cost of providing nursing facility care, and the Medicaid rates paid by the states is growing annually with care underfunded nationally in 2007 by $4.4 billion. However, we believe that a Medicaid wage pass-through for direct care staff wages is not the answer to this problem and would have many unintended consequences. In fact, we agree with the IOM's assessment that "data for wage pass-throughs are limited and show mixed results, especially in terms of the effect on recruitment and retention." These wage pass-throughs are tied to fiscal year funding, and are therefore temporary. Without a federal mandate for ongoing stable funding of staffing costs, our workforce is vulnerable to the whims of each state budget process. From a practical standpoint, we also agree that there are numerous issues with implementing and overseeing these programs including "an inability to monitor how wages are actually transferred to the employees, and difficulty in separating the effects of the wage pass-through from other interventions."

We are hopeful that the legacy of this report, *Retooling for an Aging America: Building the Health Care Workforce*, will be to generate new dialogue and discussion as to how we prepare to meet the long term care needs of America's frail, elderly and disabled in the years to come. We commit to work collectively and collaboratively with Congress, the Administration, and the entire spectrum of long term care stakeholders to develop sound policy and initiatives that will build and sustain a well-trained, dedicated workforce.

The Future Long Term Care Workforce – Solutions & Strategies

From AHCA/NCAL's ongoing work with George Washington University, the Department of Labor's Employment and Training Administration, and its sponsorship and participation in the *National Commission on Nursing Workforce for Long Term Care*, our association has developed a variety of recommendations for this Committee's consideration:

- Create a broad long term care workforce commission of committed stakeholders, including national long term care organizations, nursing and professional caregiver groups, colleges and universities, nurse educators, and state and federal policy makers to support and encourage development of national policies and programs specifically addressing the long term caregiver shortage.

- Adopt critical components of the *Long Term Care Quality and Modernization Act of 2007* that would require joint training and education of surveyors and providers; implement facility based training for new surveyors; direct CMS to modify the definition of SQC so that factors not affecting quality of care or the training of nurse aides are eliminated; and amend current law to allow nursing facilities to resume their nurse aide training program when deficiencies that resulted in the prohibition of the training have been corrected and compliance has been demonstrated.

- Increase federal funding for training and development programs, which would enable all sectors of long term care – regardless of tax status – to attract and retain a highly-trained, compassionate workforce. Some programs which would provide near immediate benefits with additional funding are the Nursing Workforce Development programs under Title VIII of the Public Health Service Act – including the Nurse Reinvestment Act, The Workforce Investment Act and the Department of Labor's High Growth Training Initiative.

- The Agency for Healthcare Research and Quality (AHRQ) and other federal agencies should expand support for research on health care and long term caregiver and nursing workforce issues and solutions.

- Encourage and further develop appropriate leadership training programs, funded by state and federal governments, which will enhance leadership skills and competencies of long term care professionals in management positions. An example that has shown to be effective across the nation and would benefit from federal support is AHCA/NCAL's *Radiating Excellence* program. This program articulates the scope of management and leadership competencies essential for nurse leaders working in skilled nursing, assisted living, and residential service facilities for individuals with developmental disabilities.

- Develop ongoing funding from the state and local workforce investment boards (WIBs) to support partnerships and initiatives to improve recruitment and retention of the long term workforce. These activities may include CNA training, the development of career ladders, expansion of continuing education for long term care employees, and the promotion of interest in long term care careers.

We all agree that not only do consumers deserve the highest quality care and services across the spectrum of health care settings, but also employees deserve well-paid, positive work environments. As the profession responsible for the care of our nation's most vulnerable citizens, we are proud of the advances we have made in delivering high quality long term care services and we remain committed to sustaining these gains in the years and decades ahead.

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Statement

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Statement for the Record

Submitted to the
Senate Special Aging Committee

on

Caring for Our Seniors:
How Can We Support Those on the Front Lines?

April 30, 2008

The Association of American Medical Colleges (AAMC) welcomes the opportunity to submit this statement for the record on how to strengthen the health care workforce to care for an aging population. The AAMC represents all 129 accredited U.S. allopathic medical schools; nearly 400 major teaching hospitals and health systems, including 68 Veterans Affairs medical centers; and 94 academic and scientific societies. Through these institutions and organizations, the AAMC represents 109,000 faculty members, 67,000 medical students, and 104,000 resident physicians.

As educators of tomorrow's doctors and as providers of health care services, medical schools and teaching hospitals are keenly aware of the nation's changing demographics. Between 1980 and 2005, the U.S. population grew by more than 70 million people (31 percent), while medical school enrollment remained essentially flat. Advances in medicine have prolonged life expectancy and improved the quality of life for millions. As baby boomers age, the number of individuals over age 65 – who use twice as many physician services per capita as those under age 65 - will grow as well. By 2030, the number of people over the age of 65 will double from 35 million to 71 million.

The physician workforce also is aging; 36 percent of active physicians are over age 55, and most of these individuals are expected to retire by 2020. As a result, the number of physicians will grow less than 5 percent, while the 65 and over population will increase by 100 percent.

Based on these changing dynamics in both supply and demand, experts predict a physician shortage that most directly will impact the underserved and elderly populations. These shortages – coupled with shortages across all other health professions disciplines – are likely to exacerbate the existing lack of access for the 20 percent of Americans that live in government designated Health Professional Shortage Areas (HPSAs).[1] Furthermore, the changing needs of an aging patient population require a multifaceted approach that includes changes to the delivery, financing, and education systems.

The AAMC and its members are committed to promoting an adequate supply of well-educated physicians sufficient in number and competencies to assure access to high quality medical care in the future. Medical education is a complex and long process. While there are no "quick-fix" solutions to shifting the medical education paradigm, medical educators are taking steps to ensure that newly trained physicians are well-schooled in providing high quality health care for our seniors. To this end, this statement briefly summarizes some of the initiatives supported by medical schools, the federal government, and others.

Continuing Knowledge of Geriatrics for Our Graduates

Medical education takes place along a continuum, starting with four years of undergraduate medical education. In these years of medical school, students learn content – the knowledge,

1 http://bhpr.hrsa.gov/shortage/

skills, values and attitudes needed for the practice of medicine – and are exposed to clinical practice. They graduate as "undifferentiated" physicians. Medical school generally is followed by three to seven years of graduate medical education (GME) in a clinical setting. In their residency years, new physicians under faculty supervision with graded responsibility apply the content of undergraduate medical school to patients in clinical settings in their chosen discipline. As practitioners, physicians evolve their style of practice based on clinical experience and ongoing formal and informal education, including continuing medical education (CME) programs.

Opportunities to integrate learning about the care of older people abound along the entire medical education continuum and geriatricians play key roles in this teaching. Medical schools, teaching hospitals and a variety of other organizations have been devising and implementing new methods and approaches to change and improve the medical education process at all levels.

From 1999 - 2004, the AAMC coordinated and managed for the John A. Hartford Foundation a grants program to enhance the education of medical students about gerontology and geriatrics. Through the program, 40 U.S. medical schools each received a grant ($100,000 for two years) to develop and implement innovative curricula that reinforce the relevance and importance of gerontology and geriatrics throughout the four years of undergraduate medical education. The results of the development, implementation, and evaluation of the curricula were disseminated widely to all medical schools. Additionally, the supplement to the July 2004 edition of the journal *Academic Medicine* includes reports from each of the 40 grantees.

In July 2007, the AAMC hosted a consensus conference to develop competencies in geriatrics education. The focus of the conference was to confirm and expand what is known about geriatrics education in medical school and into the first year of residency. The primary goal was to reach consensus on a minimum set of medical student competencies that all graduating students should attain. The second goal of the conference was to identify existing and new mechanisms to introduce specific competency-associated topics in the curricula and ways to assess those competencies. The ultimate purpose of the conference was to develop a consensus about the evidence that supports the need for geriatrics education and to establish standards for assessing outcomes. The competencies defined as a result of the conference are listed in **Appendix A**, and a report on the conference is expected in June.

Progress in this regard is notable among graduating students. Since 1978, the AAMC has administered the Medical Student Graduation Questionnaire (GQ) to fourth-year medical students to assist the Association and medical schools in priority setting and program and policy development. The questionnaire assesses more than 200 items covering a wide variety of topics including: basic demographic data, educational experiences, specialty and career plans, and financial aid information. In addition, the GQ has focused on evolving areas of interest and concern. Examples of these topics include student mistreatment, the use of technology in education, evidence-based medicine, geriatrics instruction, and resident teaching skills.

In 2000, questions specific to student experiences in geriatrics were added to the GQ in order to determine the impact that the geriatrics programs were having on students' perceptions of geriatrics in the curriculum. The results of those questions are summarized in **Appendix B.** In general, there is a measurable increase in students' awareness of and comfort with geriatrics and the care of geriatric patients and this has been sustained beyond the life of the original Hartford grant period. These questions will remain on the GQ for at least another four years to continue to monitor the progress of the schools.

A second measure of the schools' sustaining programs in geriatrics was the highly successful "Senior Mentor" programs developed at many schools. These programs are detailed in the July 2004 supplement to the journal, *Academic Medicine*, where all 40 schools that received grants were highlighted.

Additionally, a variety of geriatrics resources are available to medical educators. Faculty invest significant time and effort in creating teaching materials and assessment tools. Peer-review and sharing of such tools encourages creation of high quality educational scholarship and promotes adoption of innovative materials in education. The AAMC developed the web-based MedEdPORTAL[2] to serve as a prestigious publishing venue and dissemination portal through which medical educators can share their educational works. MedEdPORTAL is a free, international service that was designed to encourage collaboration across institutions by facilitating the exchange of high quality peer reviewed educational materials and solutions. Examples of MedEdPORTAL publications include assessment instruments, tutorials, virtual patients, cases, and faculty development materials. MedEdPORTAL is being utilized in over 1,000 medical schools, teaching hospitals and other institutions in more than 20 different countries.

The chart included as **Appendix C** illustrates the current resources available in MedEdPORTAL. Geriatrics resources represent the second highest number of accepted submissions when organized by discipline, with 61 accepted resources. Only Family Medicine has more submissions, with 70 accepted resources.

Despite this progress, raising the visibility of geriatrics among medical students can be challenging given the current shortage of academic geriatric faculty, who serve as important role models for medical students. Further, emphasis on interdisciplinary learning as the health system shifts to team-based systems of care is critical, particularly in geriatrics. Interdisciplinary teams, in which health professionals from multiple disciplines apply their special skills, knowledge and values to achieve common goals, can enhance innovation, improve the quality of patient care, and strengthen academic-clinical ties and partnerships among institutions and settings.

Funding for the geriatrics programs authorized under Title VII of the Public Health Service Act and administered by the Health Resources and Services Administration (HRSA) has been

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2 http://www.aamc.org/mededportal

instrumental in confronting these challenges. The multidisciplinary geriatric education centers (GECs), geriatric training programs (GTPs), and Geriatric Academic Career Awards (GACAs) are effective in providing opportunities for health care personnel to develop skills for providing better, more cost effective care for older Americans. Affiliated with educational institutions, hospitals, nursing homes, community-based centers for the aged, and veterans' hospitals, GECs include short-term faculty training, curriculum, and other educational resource development, and technical assistance and outreach. GTPs provide fellowships for medical and dental faculty and provide for curriculum development, faculty recruitment, and the first three months of fellowship training. GACAs support career development of geriatricians in junior faculty positions who are committed to academic careers teaching clinical geriatrics. In FY 2008, funding for the Title VII geriatrics training programs was $31 million, compared to $31.6 million in FY 2005. The President's FY 2009 budget request eliminates funding for these programs. Increased support is necessary to allow the programs to continue to prepare the health care workforce to care for an aging population.

Other Title VII programs also contribute to a workforce that is better equipped to care for older patients. For example, the Area Health Education Centers (AHECs) facilitate placements in community-based training sites and emphasize interdisciplinary training, so that physicians train alongside public health professionals, physician assistants, nurse practitioners, behavioral and mental health providers, and other health care personnel. The Title VII allied health programs aim to expand enrollments in allied health professions whose services are most needed by the elderly, and provide support to develop allied health curricula that emphasize geriatrics, long-term care, home health and hospice care, among other goals. Funding for the Title VII primary care training programs also supports training in geriatric medicine. Yet, since FY 2006, the Title VII programs have struggled to recover from a 51.5 percent funding cut, and for FY 2008, funding for all programs remains below FY 2005 levels. The AAMC urges Congress to restore funding to the Title VII programs to at least the FY 2005 level of $300 million, as these programs work in concert with one another and other HRSA programs to strengthen the health professions workforce.

Medical schools and teaching hospitals are working actively to ensure that all physicians are prepared to care for seniors. Role models are necessary for students and residents to understand the gratification of caring for the elderly. Faculty are under considerable pressure to provide the best patient care, conduct research, and to teach, and federal funding is necessary to allow more faculty to devote time to teaching. Additionally, Medicare preferentially funds GME training in geriatrics by counting geriatric fellows as full-time equivalent positions, while counting all other subspecialty fellows as one-half a full time equivalent. Even so, few physicians choose the specialty. A recent "brief" of the Medicare Payment Advisory Committee (MedPAC) notes that physicians may view primary care specialties "less desirable" and "less profitable."[3] These findings suggest that the practice environment plays an important role in promoting interest in

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3 MedPAC March 5-6, 2008 Meeting Brief: Promoting the use of primary care. Available at: http://www.medpac.gov/transcripts/med%20home%20march%20cover.pdf

geriatrics.

Averting a Looming Physician Shortage

In addition to preparing physicians to care for an aging population, medical schools and teaching hospitals are grappling with an imminent physician shortage across all specialties. The number of graduates from U.S. medical schools has been virtually flat since 1980. As a result, a very large number of active physicians now are nearing retirement age. In 2005, a little more than 12,000 active physicians reached age 63; by 2017, this number will grow to more than 24,000. In addition to the large number of physicians approaching retirement age, there are growing reports that many of today's young physicians are choosing to work fewer hours than their older counterparts. As a result, the future physician workforce effectively may be 10 percent lower than their aggregate numbers may suggest.

While there are already shortages in many communities and for some specialties today, the potential for nationwide shortages looms in the future. It takes at least a decade to impact the supply of U.S. educated physicians, due to the time needed to develop additional capacity and the length of education and training. In its 2006 Statement on the Physician Workforce[4], the AAMC recommended that enrollment in medical schools accredited by the Liaison Committee on Medical Education (LCME) be increased by 30 percent by 2015. This expansion should be accomplished by increased enrollment in existing schools as well as by establishing new medical schools.

The AAMC's recommendation to increase enrollment has not gone unnoticed. The 2007 entering class to U.S. medical schools is the largest in the nation's history, with 17,800 first-year enrollees, a 2.3 percent increase over 2006. According to a 2007 survey of medical school deans, 100 of the 126-surveyed medical schools have increased their enrollment or plan to increase their enrollment by five or more students within the next five years, when compared to their baseline 2002-03 enrollment. It appears that AAMC member institutions will reach the 30 percent increase in enrollment goal from both existing and new schools by 2017.

Since all physicians must complete accredited graduate training to become licensed in the U.S., the number of GME positions is a critical choke point to increasing the supply of physicians. The AAMC strongly urge Congress to preserve Medicare and Medicaid support for GME. The AAMC has asked Congress to delay further action on a CMS proposed rule that would eliminate Medicaid GME funding. The AAMC also recommends that Congress eliminate the current limit on the number of Medicare funded residency positions. Such action is critical to increasing the supply of physicians available to care for older Americans whose health care services often are covered under both Medicare and Medicaid.

Additionally, existing federally-sponsored student loan repayment programs have been effective

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4 http://www.aamc.org/workforce/workforceposition.pdf

in placing physicians and other health care providers in communities where they are most needed. The National Health Service Corps (NHSC) has a proven track record of caring for the underserved in both rural and urban settings; 60 percent of its clinicians are located in rural areas, while the remainder serve urban populations in settings such as community health centers, health departments, and other critical access facilities. Since its creation, the NHSC consistently has received significantly more applications for positions than it is able to support with the funding provided by Congress. Funding for the NHSC has decreased by $47 million (27 percent) since FY 2003, when its budget was $171 million. Limited funding has reduced new NHSC awards from 1,570 in FY 2003 to an estimated 947 in FY 2008, a nearly 40 percent decrease.

The growing debt of graduating medical students is likely to increase the interest and willingness of U.S. medical school graduates to apply for NHSC funding and awards. The AAMC has recommended increasing annual NHSC awards by 1,500 to allow more graduates to practice in underserved areas. As a first step toward that goal, for FY 2009 the AAMC recommends a $200 million NHSC appropriation, which would restore funding to the FY 2003 level adjusted for inflation.

Coping with an Aging Veteran Population

As they age, veterans of World War II, Vietnam, and Korea also will require increasingly more medical care and VA resources. The median age of all veterans is 60 years, and nearly 50 percent of the veterans who use Veterans Health Administration (VHA) services are over the age of 65. VA projects that the veteran population age 85 or older will increase by 110 percent between 2000 and 2020 and that this group of elderly veterans will peak at 1.3 million in 2012. VHA acknowledges that this large increase in the oldest segment of the veteran population has had, and will continue to have, significant ramifications on the demand for health care services, particularly in the areas of chronic and long-term care.

Established in 1975, the VA's Geriatric Research, Education and Clinical Centers (GRECC) program increases the basic knowledge of the aging process, shares the knowledge with other health care providers, and improves the overall quality of health care received by elderly veterans. With the notable growth in the elderly veteran population in the past three decades, their significant health care needs and costs, and the undersupply of expertise, VHA's system of 21 GRECCs has proven itself a uniquely valuable resource for addressing a variety of important and pressing health care issues. The VA also maintains 121 geriatric evaluation management (GEM) programs across its system. Aimed at keeping the frail elderly out of nursing homes, these GEMs provide comprehensive health care assessments and other services to veterans with multiple medical problems and those with geriatric problems.

However, VA's FY 2006–2011 Strategic Plan does not identify the needs of an aging veteran population as one of the Secretary's priorities, and the plan has no specific objectives or performance measures directly related to long-term care. In concert with the recommendations

of the veterans service organizations' *Independent Budget*, the AAMC recommends that VA develop a more detailed comprehensive strategic plan for long-term care that meets the current and future needs of America's veterans.

Concerns about an aging veteran population are complicated by the nation's impending physician workforce shortage and difficulty recruiting and retaining physicians at the VA. On April 9, 2008, the AAMC testified on "Making the VA the Workplace of Choice for Health Care Providers" before the Senate Committee on Veterans Affairs.[5] In that testimony, the AAMC recommends $42.8 billion for VA medical care, $55 million for VA Medical and Prosthetic Research, and $45 million for VA research facilities improvement. This funding is crucial to the continued success of the primary sources of VA's physician recruitment and retention: academic affiliations, graduate medical education, and research.

Similar to the NHSC, the VA's Education Debt Reduction Program (EDRP) provides newly appointed VA health care professionals with educational loan repayment awards. However, the EDRP is limited to $49,000 spread out over five years of service. As the average medical education indebtedness has climbed to over $140,000 in 2007, the limited EDRP awards fail to provide an adequate incentive for most physicians.

The AAMC has had initial discussions with Senator Dick Durbin's (D-Ill.) office regarding the "Veterans Health Care Quality Improvement Act of 2007" (S.2377), which has been referred to the Senate Committee on Veterans Affairs for consideration. The AAMC is strongly supportive of the bill's proposed increases for VA physician educational loan repayment in exchange for at least three years of service in "hard-to-fill positions," as determined by the VA. Under this program, VA physicians would be eligible for up to $30,000 in loan forgiveness per year until their medical education debt had been repaid.

Today, the VA manages the largest GME training program in the United States. The VA system accounts for approximately 9 percent of all GME positions in the country, supporting more than 2,000 ACGME-accredited programs and 9,000 full-time medical residency training positions. Each year, approximately 34,000 medical residents (30 percent of U.S. residents) rotate through the VA and more than half the nation's physicians receive some part of their medical training in VA hospitals.

As our nation faces a critical shortage of physicians, the VA has been the first to respond. The VA plans to increase its support for GME training, adding an additional 2,000 positions for residency training over five years, restoring VA-funded medical resident positions to 10 to 11 percent of the total GME in the United States. The expansion began in July 2007 when the VA added 342 new positions. These training positions address the VA's critical needs and provide

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5 *Making the VA the Workplace of Choice for Health Care Providers Hearing Before the S. Comm on Veteran Affair*, 1010 Cong. (2008) (statement of John A. McDonald, M.D., Vice President for Health Sciences and Dean of the University of Nevada School of Medicine on behalf of the AAMC). Available at: http://www.aamc.org/advocacy/library/va/testimony/2008/040908.pdf

skilled health care professionals for the entire nation. The additional residency positions also encourage innovation in education that will improve patient care, enable physicians in different disciplines to work together, and incorporate state-of-the-art models of clinical care – including VA's renowned quality and patient safety programs and electronic medical record system. Phase 2 of the GME enhancement initiative has received applications requesting 411 new resident positions to be created in July 2008.

Conclusion

Medical educators are transforming our educational paradigm by adopting a broader focus incorporating responsibility for the life-long learning that physicians will need to maintain relevant knowledge and skills in a rapidly changing profession. The AAMC recognizes that increasing the number of geriatric physicians calls for action on at least two fronts: voluntary efforts by private sector organizations and government action to eliminate barriers that prevent the health care community from meeting the need. Medical schools, teaching hospitals and other private organizations will continue to work with governmental bodies to find and craft solutions for improving the health care workforce's ability to care for an aging population.

Appendix A

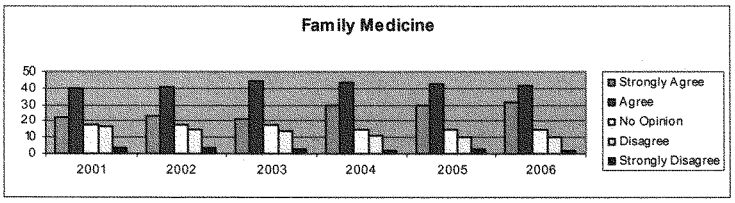
GERIATRIC COMPETENCIES for Medical Students	
The graduating medical student, in the context of a specific older adult patient scenario (real or simulated), must be able to:	
MEDICATION MANAGEMENT	
1	Explain impact of age-related changes on drug selection and dose based on knowledge of age-related changes in renal and hepatic function, body composition, and CNS sensitivity.
2	Identify medications, including anticholinergic, psychoactive, anticoagulant, analgesic, hypoglycemic, and cardiovascular drugs that should be avoided or used with caution in older adults and explain the problems associated with each.
3	Document a patient's complete medication list, including prescribed, herbal and over-the-counter medications, and for each medication provide the dose, frequency, indication, benefit, side effects, and an assessment of adherence.
COGNITIVE AND BEHAVIORAL DISORDERS	
4	Define and distinguish among the clinical presentations of delirium, dementia, and depression.
5	Formulate a differential diagnosis and implement initial evaluation in a patient who exhibits cognitive impairment.
6	Urgently initiate a diagnostic work-up to determine the root cause (etiology) of delirium in an older patient.
7	Perform and interpret a cognitive assessment in older patients for whom there are concerns regarding memory or function.
8	Develop an evaluation and non-pharmacologic management plan for agitated, demented or delirious patients.
SELF-CARE CAPACITY	
9	Assess and describe baseline and current functional abilities (instrumental activities of daily living, activities of daily living, and special senses) in an older patient by collecting historical data from multiple sources and performing a confirmatory physical examination.
10	Develop a preliminary management plan for patients presenting with functional deficits, including adaptive interventions and involvement of interdisciplinary team members from appropriate disciplines, such as social work, nursing, rehabilitation, nutrition, and pharmacy.
11	Identify and assess safety risks in the home environment, and make recommendations to mitigate these.
FALLS, BALANCE, GAIT DISORDERS	
12	Ask all patients > 65 y.o., or their caregivers, about falls in the last year, watch the patient rise from a chair and walk (or transfer), then record and interpret the findings.
13	In a patient who has fallen, construct a differential diagnosis and evaluation plan that addresses the multiple etiologies identified by history, physical examination and functional assessment.
HEALTH CARE PLANNING AND PROMOTION	
14	Define and differentiate among types of code status, health care proxies, and advanced directives in the state where one is practicing.
15	Accurately identify clinical situations where life expectancy, functional status, patient preference or goals of care should override standard recommendations for screening tests in older adults.

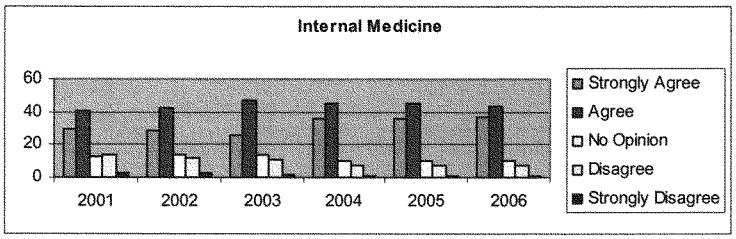
Appendix A

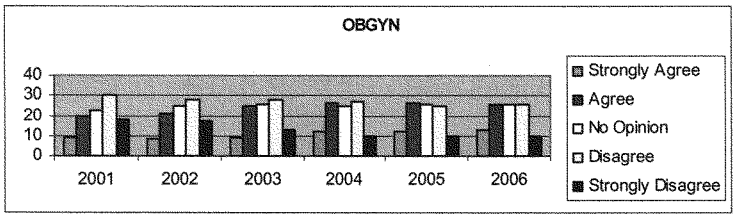
GERIATRIC COMPETENCIES for Medical Students	
The graduating medical student, in the context of a specific older adult patient scenario (real or simulated), must be able to:	
16	Accurately identify clinical situations where life expectancy, functional status, patient preference or goals of care should override standard recommendations for treatment in older adults.
ATYPICAL PRESENTATION OF DISEASE	
17	Identify at least 3 physiologic changes of aging for each organ system and their impact on the patient, including their contribution to homeostenosis (age-related narrowing of homeostatic reserve mechanisms).
18	Generate a differential diagnosis based on recognition of the unique presentations of common conditions in older adults, including acute coronary syndrome, dehydration, urinary tract infection, acute abdomen, and pneumonia.
PALLIATIVE CARE	
19	Assess and provide initial management of pain and key non-pain symptoms based on patient's goals of care.
20	Identify the psychological, social, and spiritual needs of patients with advanced illness and their family members, and link these identified needs with the appropriate interdisciplinary team members.
21	Discuss palliative care (including hospice) as a positive, active treatment option for a patient with advanced disease.
HOSPITAL CARE FOR ELDERS	
22	Identify potential hazards of hospitalization for all older adult patients (including immobility, delirium, medication side effects, malnutrition, pressure ulcers, procedures, peri and post operative periods, and hospital acquired infections).
23	Explain the risks, indications, alternatives, and contraindications for indwelling (Foley) catheter use in the older adult patient.
24	Explain the risks, indications, alternatives, and contraindications for physical and pharmacological restraint use.
25	Communicate the key components of a safe discharge plan (e.g., accurate medication list, plan for follow-up), including comparing/contrasting potential sites for discharge.
26	Conduct a surveillance examination of areas of the skin at high risk for pressure ulcers and describe existing ulcers.

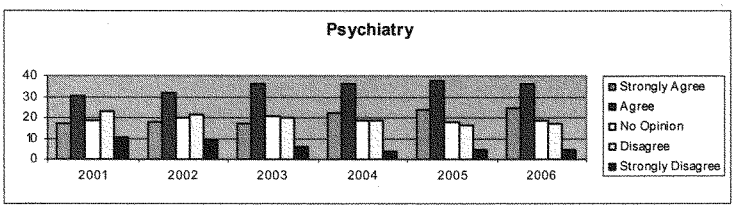
Appendix B

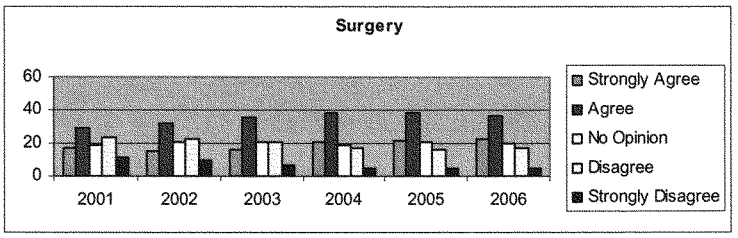
Graduation Questionnaire
Question: The clerkship included adequate geriatric/gerontology subject matter







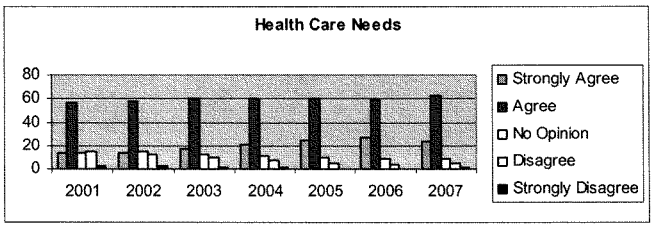




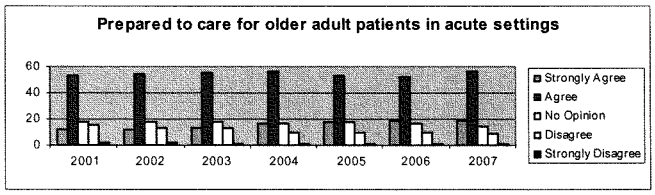
Appendix B

Graduation Questionnaire

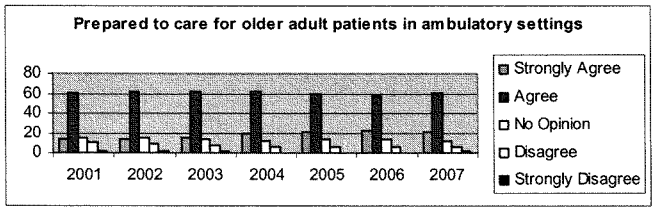
Question: I learned about the health care needs of healthy older adults during my medical training



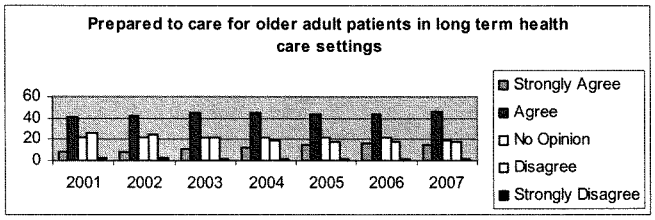
Question: I am well prepared to care for older adult patients in acute settings



Question: I am well prepared to care for older adult patients in ambulatory settings



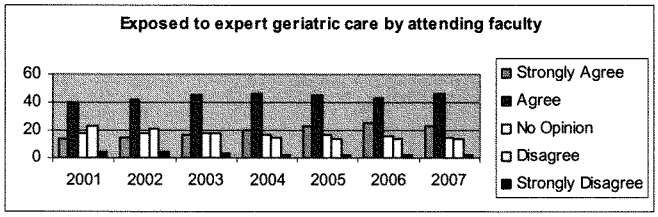
Question: I am well prepared to care for older adult patients in long term health care settings



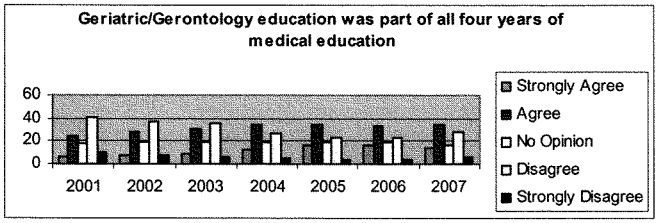
Appendix B

Graduation Questionnaire

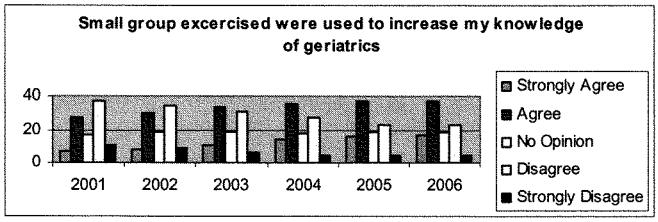
Question: I was exposed to expert geriatric care by the attending faculty of my medical program.



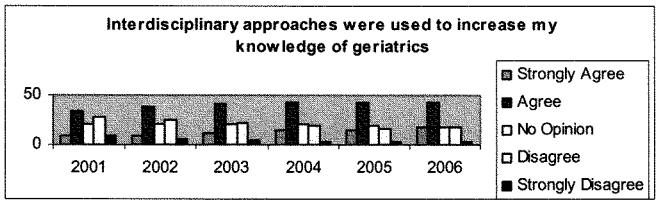
Question: Geriatric/Gerontology education was part of all four years of my medical education



Question: Small group exercises were used to increase my knowledge of geriatrics



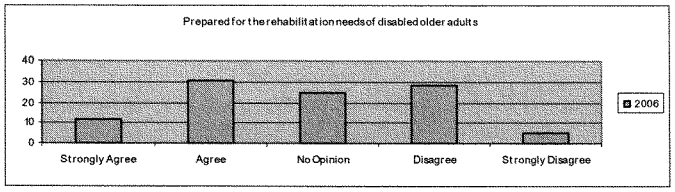
Question: Interdisciplinary approaches were used to increase my knowledge of geriatrics



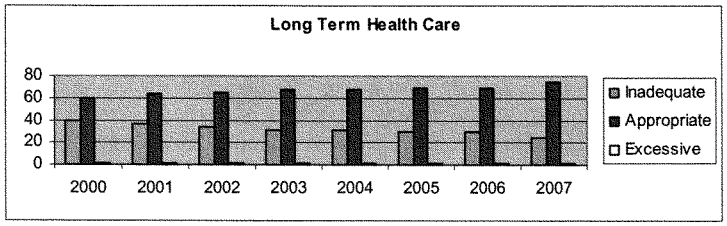
Appendix B

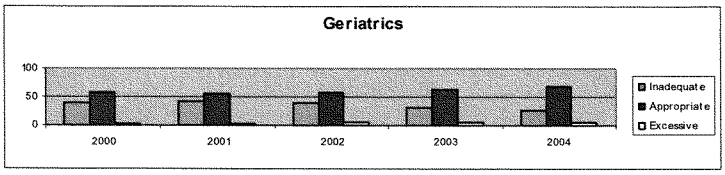
Graduation Questionnaire

Question: I am well prepared to care for the rehabilitation needs of disabled older adults (question added in 2006)



TOPICS





Inventory of Published Resources

Publications Grouped By Educational Level

Undergraduate Medical Education	292
Graduate Medical Education	135
Continuing Medical Education	96
Faculty Development Materials	27

Publications Grouped By Discipline/Specialty:

Anesthesiology	9	Medical Ethics	12
Basic Sciences Assessment	9	Microbiology, Immunology	8
Biochemistry/Cell Biology	25	Obstetrics and Gynecology	23
Biostatistics and Epidemiology	5	Ophthalmology	7
Clinical Exam	20	Orthopedic Surgery	6
Clinical Neuroscience	26	Otolaryngology	3
Clinical Sciences Assessment	15	Palliative Care	11
CNS/Neuroanatomy/Neuroscience	28	Pathology	14
Dermatology	12	Pathophysiology	10
Embryology	9	Pediatrics	43
Emergency Medicine	30	Pharmacology/Toxicology	12
Family Medicine	70	Physical Diagnosis	12
Genetics	9	Physiology	28
Geriatrics	61	Plastic Surgery	3
Gross Anatomy	12	Preventive Medicine	14
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Statement for the Record Submitted by the
American Association for Geriatric Psychiatry to the
Special Committee on Aging
United States Senate
Hearing on
Caring for Our Seniors: How Can We Support Those on the Frontlines?
April 16, 2008

The American Association for Geriatric Psychiatry (AAGP) appreciates the opportunity to offer its comments for the record of the Committee's recent hearing on "Caring for Our Seniors: How Can We Support Those on the Frontlines?"

The recent report of the Institute of Medicine, *Retooling for an Aging America: Building the Health Care Workforce*, concludes that, without changes at the national level, older Americans will lack access to affordable, quality health care – including mental health care. AAGP has long been concerned about the workforce in the area of late-life mental health care, particularly the declining numbers of doctors entering the field of geriatric psychiatry – those pursuing a research career, becoming clinician-educators, and entering clinical practice. The diminishing workforce in these areas will inevitably lead to inadequate access to quality mental health care for the aging Baby Boomers generation. There is a need for cadre of specialty-trained subspecialists to do research, teach and train others in graduate medical education and institutional and community based continuing education efforts, and to serve as clinical resources for consultation, community education, and tertiary care in communities. These needs require a robust pipeline of geriatric psychiatry fellows who will pursue various career paths in geriatric psychiatry and systematic efforts to assure that they are willing and able to continue their work in the field.

The IOM's report is the product of a project to examine the optimal health care workforce for older Americans in an aging society. The aim of the study was to determine the health care needs of Americans over 65 years of age, and address those needs through a thorough analysis of the forces that shape the health care workforce, including education, training, modes of practice, and financing of public and private programs. A committee of 15 experts, including AAGP's President-elect Charles F. Reynolds, III, MD, met over a period of 15 months to study the best use of the workforce, how the workforce (both generalist and specialist) should be educated, the most effective organization of health care delivery, and needed improvements of public programs such as Medicare and Medicaid.

AAGP lauds the IOM's comprehensive approach to meeting the workforce needs for an aging population in the United States, and for recognizing that this is an emerging public health crisis. The committee's leadership and expertise should ensure that the report will be received with the serious consideration the topic deserves.

However, we believe that additional time and attention is required to address the special workforce and clinical-service needs for older adults requiring mental health services.

Often medical-psychiatric-environmental factors conspire to diminish the quality of life for older adults, especially those with primary mental health conditions like depression, dementia and substance abuse disorders. A targeted report on these issues could greatly influence future policy and resource allocation decisions that will need to be made as the baby-boom generation marches through time.

Geriatric Mental Health Needs

The prevalence of mental illness among older adults and the compounding effects of mental illness plus other illnesses argue for legislative and regulatory changes to increase access to care. With 1 in 10 Americans over age 65 and nearly half of those over 85 suffering from Alzheimer's disease, one-third of people age 71 and older having some cognitive impairment, and upwards of 5 percent of the elderly in the community and 13 percent of those in home health care living with depression, greater investments into a quality mental health care system are sorely needed.

Today there are just 3.9 geriatric psychiatrists for every 10,000 Americans age 85 and older and just 1.1 for every 10,000 over 75 years of age, according to the Association of Directors of Geriatric Academic Programs (ADGAP). It is estimated the country needs 5,000 geriatric psychiatrists, and yet last year there were fewer than 1,600 board-certified geriatric psychiatrists in the United States, a number that has declined significantly since 1999, when there were 2,425. The data are clear, however, that most geriatric psychiatric services that are provided in this country are not from board certified geriatric psychiatrists, but are delivered by general psychiatrists in the community. It is also clear that the medical education pipeline in this country will never train sufficient board certified geriatric psychiatrists or geriatricians to meet the need or demand for geriatric mental health services. According to ADGAP, however, general psychiatrists are not prepared to meet the complex needs of older patients. Because these providers, of necessity, make a significant contribution, it is essential that policy makers and legislative bodies implement policies that promote enhanced geriatric expertise among general psychiatrists.

Deficiencies in the workforce of geriatric mental health practitioners already constitute a problem for consumer access to services, stretching across disciplines, and trends demonstrate that it is getting worse even as the baby boomer generation approaches late life. It is important to note that the problem extends to other specialists in mental health and aging. In social work, only about 1,115 (3.6 percent) of master's level social worker students specialize in aging and only about 5percent of practitioners at any level identify aging as their primary area of practice, even though the National Institute on Aging projected that 2020, 60,000-70,000 gerontological social workers will be needed. Among psychologists, only about 3 percent view geriatrics as their primary area of practice and only 28 percent of all graduate psychologists have some graduate training in geriatrics.

The fact that other mental health disciplines are similarly deficient in geriatric specialists indicates that, as it is already difficult for older adults to obtain competent, appropriate

treatment for mental illnesses, the problem will be greatly exacerbated in the next decade with the aging of the baby boom generation.

The precipitous drop in the numbers of geriatric psychiatrists clearly threatens to decimate the field of geriatric psychiatry. A larger issue than having board certified geriatric psychiatrists for treating individual patients is the possibility of losing the specialization entirely – which will mean that, in addition to treatment, both teaching and research will suffer. Physicians who treat, teach, and study in the area of geriatric psychiatry will be approaching the issues with less focus, through general psychiatry, or tangentially, through other disciplines (neurology, gerontology, geriatric medicine). Older adults with even mild to moderate mental illness diagnoses tend to have high rates of other illnesses. If these disorders are not properly treated, they can escalate into more serious mental conditions, complicate the treatment of physical health conditions, compromise patient outcomes, and increase the cost of care. Geriatric psychiatrists have the expertise that no other discipline has for addressing this complicated set of circumstances.

Disincentives for Geriatric Mental Health Practice

The IOM report acknowledges that "the costs associated with extra years of geriatric training do not translate into additional income, and geriatric specialists tend to earn significantly less income than other specialists or even generalists in their own disciplines." The problem is in many ways even more pronounced in the field of geriatric mental health. An important consideration for psychiatrists who are considering geriatric specialty training or for those already in practice who hope to continue to be able to see geriatric patients are numerous reimbursement disincentives to practice in the field. These barriers are myriad, but include out-of-date payment policies of government and private insurance that reflect obsolete models of practice not relevant to modern geriatric mental health services and that perpetuate long-held stigma and outdated ideas of treatment efficacy. The reimbursement issues for geriatric mental health are most blatantly apparent in Medicare's 50 percent coinsurance requirement for outpatient psychiatric services, a requirement that is a matter not of policy but of statute, dating to the inception of Medicare in 1965. Although efforts to repeal this inequity – all other Medicare outpatient doctors' visits are reimbursed at 80 percent – have recently made great strides with the passage of legislation in the U. S. House of Representatives and renewed interest in the issue in the Senate, there is still an uphill battle to win enactment.

Beyond insurance parity, more direct reimbursement problems disproportionately affect geriatric psychiatrists. For instance, in 2006, Medicare significantly increased reimbursement for evaluation and management (E&M) services performed by physicians. This increase was long sought and urgently needed by all geriatric practitioners whose practices involve complex office evaluations as opposed to the long established biases in the Medicare system favoring more procedure-based specialties. But for psychiatry, 2007 also brought a 9 percent reduction in reimbursement for psychiatric services as a

result of a five-year review of relative value units (RVUs). While geriatric psychiatrists are in some instances able to offset the loss of the latter by greater use of E&M codes, for geriatric practitioners in other disciplines, such as psychology and social work, this option is not available. While an across-the-board reduction in the physician fee schedule of a similar magnitude has been staved off by Congress year-by-year as it has searched for the means to finance a permanent correction, the additional reduction for mental health practitioners must also be addressed.

The coinsurance inequity and the reduction in psychiatric services reimbursement are just two examples of the disincentives for entering geriatric mental health field that compound the difficulties that generally face other geriatric specialties. At a time when the government ought to use Medicare policy to stimulate the growth in the numbers of geriatric mental health providers, current efforts to control healthcare spending may adversely affect geriatric mental health providers disproportionately more than other healthcare providers, producing the opposite effect.

Recommendations
AAGP recommends a number of legislative initiatives that would help to remedy the clear need for a stronger geriatric mental health workforce:

- Follow-up Study on Mental Health
  AAGP believes that the broad scope of the IOM's, while meeting a crucial need for information on the many issues regarding the health workforce for older adults, precluded the in-depth consideration of the workforce needed for treating mental illness. The study just completed should be followed by a complementary study focused on the specific challenges in the geriatric mental health field. This study should follow up the general IOM study in two specific ways: 1) It should examine the access and workforce barriers unique to geriatric mental healthcare services; 2) In discussing possible alternative models of geriatric service delivery (medical homes, PACE programs, collaborative care models, etc.) it should articulate the importance of integrating geriatric mental health services as intrinsic components.

- Loan Forgiveness Legislation
  AAGP strongly supports legislation to provide loan forgiveness for health care professionals who enter geriatric specialties. AAGP supports S. 2708, the Caring for an Aging America Act, which would create a new program for loan repayment for specialists across disciplines who enter geriatric specialties. AAGP also supports H. R. 2502, the Geriatricians Loan Forgiveness Act, which allow fellows in geriatric medicine and geriatric psychiatry to include fellowship training as part of their obligated service under the National Health Corps Loan Repayment Program.

- Title VII Geriatric Health Professions Program
  The geriatric health professions program, which has been administered by the Health Resources and Services Administration (HRSA) under Title VII of the

Public Health Service Act, has supported three important initiatives: the Geriatric Faculty Fellowship has trained faculty in geriatric medicine, dentistry, and psychiatry; the Geriatric Academic Career Award program has encouraged newly trained geriatric specialists to move into academic medicine; and the Geriatric Education Center (GEC) program has provided grants to support collaborative arrangements that provide training in the diagnosis, treatment, and prevention of disease. Weakening or even elimination of these programs, as occurred for one year in FY 2006, would have a disastrous impact on physician workforce development over the next decade, with dangerous consequences for the growing population of older adults who will not have access to appropriate specialized care. AAGP strongly urges reauthorization and increased funding for these programs.

- Medicare Reimbursement Issues
  AAGP strongly supports efforts to enact a long-term correction of the Medicare physician payment formula and to address other aspects of the Medicare payment system that discourage entry into geriatric mental health specialties, particularly the 50 percent copayment requirement for outpatient psychiatric treatment and the unacceptably low reimbursement rates for psychiatric services.

Summary

The small numbers of specialists in geriatric mental health care, including geriatric psychiatry, combined with increases in life expectancy and the growing population of those age 65 and over, estimated to be 20 percent of the U.S. population in 2030 (up from 12 percent in 2006), foretells a crisis in health care that will impact older adults and their families nationwide. Unless changes are made now, older Americans will face long waits, decreased choice, and suboptimal care. Consequently, AAGP urges Congress, the regulatory agencies, and leaders in health care policy to act upon the IOM's report and make the necessary changes to recruit and retain a skilled workforce in geriatrics and geriatric mental health care, and to adopt an efficient and effective organization of geriatric medical and mental health care services.

STATEMENT FOR THE RECORD

SUBMITTED TO THE

SENATE SPECIAL AGING COMMITTEE

ON

CARING FOR OUR SENIORS: HOW CAN WE SUPPORT THOSE ON THE FRONTLINES?

April 16, 2008

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On behalf of AARP's nearly 40 million members, thank you for holding this timely hearing today on the critical need for an adequate health and long-term care workforce. Without enough well trained health and long-term care workers – including family caregivers – it will be impossible to provide the services and supports that Americans need as they grow older. Access to quality health and long-term care depends on a strong workforce of individuals, in both paid and unpaid capacities, and on the tools and supports necessary to recruit, retain, and sustain these individuals.

Institute of Medicine (IoM) Report

AARP is pleased to be one of the sponsors of the Institute of Medicine (IoM) report released this week, ***Retooling for an Aging America: Building the Health Care Work Force***. We believe this comprehensive report and its recommendations will bring much-needed attention to these vital workforce and family caregiving issues and we urge that Congress take action to address these critical challenges facing this country. The IoM report focuses its recommendations in three areas: enhancing the geriatric competency of the workforce; increasing recruitment and retention of geriatric specialists and caregivers; and redesigning models of care.

AARP's testimony will also focus on these three key areas as well as the unique issues pertaining to the long-term care workforce.

Workforce Competency

The aging of the baby boom generation will create a greater demand for a competent and well trained health care workforce. Yet the IoM study found that the U.S. health care workforce receives little geriatric training and is not prepared to provide older patients with the best care. There is only one physician certified in geriatrics for every 2,500 older Americans and only one-third of baccalaureate nursing programs required a course focused on geriatrics in 2005. Even though Medicare is a primary source of medical education funding, most health care providers receive almost no formal training in geriatrics or gerontology and there are few incentives for them to get this training.

Older patients have unique needs – they are more likely to have multiple chronic conditions, use multiple medications, and have more complex health care needs than younger individuals. A well trained and competent workforce is vital to ensuring that these patients receive quality care. Training for residents in all settings including nursing homes, assisted living facilities, and patients' homes will give practitioners a greater understanding of their patients and enable them to better provide patient-centered care.

The IoM report also calls for better training opportunities for informal caregivers, and support for developing and promulgating technological advances that could enhance an individual's ability to care for older adults. When an individual is

released from a hospital or nursing home, training for the caregiver can be critical to a smooth recovery and continuity of care for the individual. And the report acknowledges, and AARP agrees, on the importance of increasing pay and fringe benefits for direct care workers, who provide care when family caregivers cannot do it all.

Recruitment and Retention of Geriatric Specialists and Caregivers

Recruitment and retention of qualified workers is one of the biggest challenges facing our health care system. By 2030, one in five Americans will be age 65 or older. The United States will need an additional 3.5 million formal health care providers – a 35 percent increase – just to maintain the current ratio of providers to the total population. This does not even count the increased need for these professionals due to the aging population. If there is not a sufficient number of providers trained to care for older adults, then older adults will be at risk for not getting the care they need. This in turn could lead to increased health care costs and poor patient outcomes.

To begin to meet increased demand, the IoM report recommends an increase in the number of geriatric specialists – both for clinical expertise and to help train the broader health care workforce in how to work effectively with older patients –

a recommendation AARP supports. The IoM report also recommends, and AARP supports, using incentives -- including through public and private payers -- to encourage individuals to pursue geriatric training and reward such training.

Beyond the IoM report, AARP is also pleased to endorse the Caring for an Aging America Act (S. 2708), sponsored by Senators Barbara Boxer (D-CA) and Susan Collins (R-ME). This bill would take some important first steps to help ensure that the workforce is more prepared to meet the needs of our aging population, and is consistent with recommendations of the IoM report. The loan repayment program created by the bill will help to encourage more physicians, physician assistants, advance practice nurses, social workers, and psychologists to seek specialized training in geriatrics or gerontology. By expanding the Nursing Education Loan Repayment Program to include registered nurses who complete training in geriatrics and gerontology, the bill could increase the number of nurses with this training who provide quality care in long-term care settings.

Improving Models of Care

The IoM also makes significant recommendations about redesigning models of care to provide and pay for effective and efficient care to older adults, testing new models of care in areas such as long-term care and palliative care, and flexibility in roles in the provision of care. The report concluded that a variety of models – rather than one single care model -- will be necessary to meet the targeted needs

of older adults. This finding underscores the importance of older adults having choices and a variety of approaches to meet their needs, so that if one model is not effective, an individual has other options. These options might include a medical home, a chronic care coordination program, or a Program of All-Inclusive Care for the Elderly site.

The IoM identifies common features that may contribute to the success of some models with the strongest evidence of success in improving care quality, health-related outcomes or efficiency:

- interdisciplinary team care;
- care management;
- chronic disease self-management programs;
- pharmaceutical management;
- preventive home visits;
- proactive rehabilitation;
- caregiver education and support; and
- transitional care.

These features are also important parts of efforts to test the medical home and chronic care coordination programs that could improve outcomes and patient satisfaction and potentially save health care dollars, especially for those with multiple chronic conditions.

Long-Term Care Workforce

The growing need for long-term care workers presents a unique set of workforce issues. Direct care workers, such as personal care assistants, home care and home health aides and certified nursing assistants, provide the vast majority of paid long-term care. They assist individuals with daily tasks such as bathing, dressing, meal preparation, and housekeeping. Compared to the general workforce, direct care workers are more likely to be women (about 90 percent of the direct care long-term care workforce), non-white, and sole providers for their children.

Direct care workers are often paid low wages with limited or no benefits and have high workloads, unsafe working conditions, inadequate training, a lack of respect, and limited opportunities for advancement. All these factors contribute to the high turnover rate among these workers, in some cases more than 100 percent.

Long-term care workers should receive:

- adequate wages and benefits;
- necessary training and education, including opportunities for mentoring and advancement;
- more input into care planning and provision;
- more respect for the work they do; and
- safer working conditions.

These issues should be addressed across all settings, whether HCBS or institutional. Addressing these issues will not only strengthen the long-term care workforce, but also improve the quality of care and continuity of services for consumers. Improvements in recruitment and retention of staff could also help improve disparities in care.

Expanding existing career ladder programs to focus on specialty training in long-term care services for nursing personnel and direct care workers in all settings would help ensure that staffs are better trained to meet the unique and often complex needs of individuals.

Further, culture change, a movement to transform institutions into more resident-centered, homelike settings, can also improve working conditions and empower direct care staff in long-term care facilities and other settings. Facilities that have undergone culture change generally have much lower staff turnover rates that undermine quality and morale in most long-term care institutions.

Finally, the recent report of the National Commission for Quality Long-Term Care (NCQLTC), a nonpartisan, independent body charged with improving long-term care in America, made recommendations and identified the workforce as one of four key areas to address in long-term care, along with quality, technology, and financing.

Family Caregiving

No discussion of health and long-term care workforce issues would be complete without taking into account the family caregiver. Family caregivers – the informal workforce – play an important role in health care processes and are important members of the care team for individuals, especially those with multiple chronic conditions. The contributions of America's family caregivers – relatives, partners, friends and neighbors – are currently the foundation of the nation's long-term care system. These unpaid caregivers provide the majority of home and community-based services (HCBS) for persons with disabilities of all ages and are critical to helping people remain at home.

Family caregivers provide a wide range of assistance and often become both the de facto care coordinators and care providers when their loved ones are discharged from hospitals, nursing homes, or home health care, with little or no preparation for their complex responsibilities.

The "typical" caregiver in the U.S. is a 46-year old woman who works outside of the home and spends more than 20 hours per week providing unpaid care. Caregivers face multiple challenges -- financial, emotional, and physical. Many caregivers experience significant economic losses due to changes in work patterns, including lost wages, loss of health insurance and other job benefits, and lower retirement savings. And according to a recent AARP Public Policy Institute

analysis, the contributions of unpaid caregivers represent an important component of the U.S. economy, with an estimated economic value of about $350 billion in 2006.

Often because of a lack of training and support, caregivers' own physical and mental health may be placed at risk. They are more likely than non-caregivers to have chronic health conditions, including depression, as well as medical bill problems or medical debt. The health of the caregiver also impacts the health of the care recipient. All of this underscores the importance of recognizing the role of the family caregiver in the health and long-term care system and using preventive and other interventions with the caregiver to ultimately benefit the caregiver and the care recipient.

Family Caregiver Assessments and Training

Family caregivers can benefit from supports such as training, respite care, education, counseling, and financial assistance that enable them to address their own needs and continue to care for their loved ones. A good way to determine what supports a family caregiver needs is through an assessment. A family caregiver assessment is a systematic process of gathering information that describes a caregiving situation and identifies the particular problems, needs, resources, and strengths of the family caregiver. An assessment also approaches issues from the caregiver's perspective and culture.

While it is standard practice to assess an individual who needs long-term services and supports and develop a care plan to meet that individual's needs, it is not yet routine to conduct a family caregiver assessment and, based on the assessment, help connect the caregiver to or provide identified supports that are needed, such as training. Several states are using caregiver assessments, including California, Idaho, Massachusetts, Minnesota, Pennsylvania, and Washington. But currently no single, universal standard for a state assessment tool or protocol for caregiver assessment exists. However, substantial guidance on good assessment is available in the Agency for Healthcare Research and Quality's National Guideline Clearinghouse.

Family caregiver assessments in Medicaid HCBS programs could help achieve the important goals of connecting caregivers to essential supports, improving quality, and enabling individuals to remain in their homes longer – possibly saving public dollars. That is why AARP and several other national family caregiving and aging groups support the creation of a Medicaid family caregiver assessment demonstration program. States that choose to participate in this demonstration would offer family caregiver assessments to primary caregivers when the Medicaid beneficiary's care plan could not be administered without the caregiver. Needed supports that are identified could be provided through a variety of public and private sources. This demonstration approach is one step that Congress could take to expand and build upon the work that several states have done on caregiver assessments and meeting the needs of caregivers.

Family Caregivers and Other Health and Long-Term Care Providers

We also encourage Congress to find ways to help identify and connect family caregivers of Medicare and Medicaid beneficiaries to needed training, resources, information, and supports. For example, family caregivers interact with physicians, nurses, social workers, and direct care workers in hospitals, home health and nursing home settings, providing continuity of care and essential information to both care recipients and the various providers. Family caregivers need to be integrated as full partners into the care team. Transitions from one setting to another, such as hospital to home, are especially important opportunities to provide information and support to family caregivers, so they can help ensure quality and continuity of care for the care recipient, especially for individuals with multiple chronic conditions who require additional care coordination.

Providers, such as nurses and social workers, can play a critical role in supporting family caregivers. A major private sector initiative is currently underway to encourage better support of family caregivers by nursing and social work professionals, in a unique collaboration among the AARP Foundation, the American Journal of Nursing, the Council on Social Work Education, and the Family Caregiver Alliance. However, the private sector alone cannot do it all. Professionals often face many barriers in providing family caregiver support in the current health care environment, including lack of time and dedicated resources, which must be addressed in partnership with the public sector.

There are steps that the Centers for Medicare and Medicaid Services could currently take to educate Medicare and Medicaid providers about existing authorities under these programs that enable the support of family caregivers. For example, physicians and other providers can provide education and training for family caregivers as part of visits under specific Medicare and Medicaid billing codes. Providers need to know what they can currently do under these programs for family caregivers and family caregivers also need to know about these services.

There are some current initiatives to help train and support caregivers and keep them on the job as part of the health and long-term care workforce.
These include:

- **The National Family Caregiver Support Program under the Older Americans Act:** This program provides information and assistance, respite care, counseling, support groups, training, and other supplemental services to family caregivers. AARP supports the full authorized funding level of $173 million for fiscal year 2009.

- **Lifespan Respite Care Act:** This program would expand access to respite care, train and recruit workers and volunteers, and improve local coordination of services and assistance to caregivers. The bill was enacted with broad bi-

partisan support in 2006, but has yet to be funded. AARP urges funding at the full authorized amount of $53.3 million in fiscal year 2009.

Conclusion

This Committee has taken an important step today in calling attention to the need to build a more robust health and long-term care workforce, including family caregivers. AARP urges Congress to take the next step by beginning to enact some of the IoM recommendations. Serious, effective, and sustainable efforts are necessary to recruit, retain, and support a workforce adequate to meet the current and future health and long-term care needs of our population. AARP looks forward to working with members of this Committee and your colleagues on both sides of the aisle to act on these important caregiving and workforce issues.

Strengthening Wisconsin's Long-Term Care Workforce

Final Report

from the

Direct Care Workforce Issues Committee

WI Council on Long Term Care Reform

June 2005

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Executive Summary

The Direct Care Workforce Issues Committee was created in the spring of 2004 by the Wisconsin Council on Long Term Care Reform, which advises the Department of Health and Family Services (DHFS). The committee was charged with recommending public policy changes that DHFS could make to foster a stable and well-trained workforce of direct care workers and growth of the workforce to meet current and future needs of consumers. The Committee's work and this report focus on "direct care workers," the non-licensed professionals who provide personal care, housekeeping, home management tasks, vocational counseling, supervision and emotional support to people with chronic illness and disabilities of all ages, in all settings.

Direct care workers are the backbone of the long-term care system, providing 70 to 80 percent of paid, hands-on care. Conservatively estimated, there are at least 80,000 of these workers in Wisconsin – accounting for one out of three of all health care jobs. They work independently, as well as in hundreds of small and large organizations in every community in the state. These are fast-growing occupations; personal and home care aide jobs, for example, are projected to rank eighth among *all* jobs in terms of predicted growth rate between 2000 and 2010.

Wisconsin, like most other states, is experiencing a shortage of direct care workers in many long-term care settings, placing pressure not only on the formal (paid) system, but also on family caregivers. Without serious intervention, the shortage will worsen as the population ages. Causes of the workforce shortage are multifaceted and interacting, but they are mainly due to high turnover rates and/or low retention rates.

High rates of vacancies and turnover in this workforce has consequences for all four key stakeholder groups within long-term care.

- Consumers and their families may experience inadequate and sometimes unsafe care;
- Workers have higher levels of injury and stress and less supervisory and training support;
- Providers have high costs both to mission and to bottom line; and
- Payers, including taxpayers, make substantial payments for costs that detract from, rather than add to, the quantity and quality of care actually provided.

A growing body of research is concluding that the reasons for workers quitting add up to a failure of employers, supervisors, society as a whole, and sometimes even consumers, to adequately respect and value them and the work that they do. Among the factors associated with recruitment and retention are:

- Hierarchical organizational structure and poor communication and relationships between worker and supervisor
- Low pay and insufficient benefits
- Few opportunities for career advancement
- Poor public image of this work
- Inadequate training, job orientation and mentoring
- Lack of involvement in care planning for their clients and other work-related decisions
- Emotionally and physically hard work and unreasonable workloads

The bottom line is that valuing frontline caregivers can reduce turnover. Demonstration of that respect can take many forms, including better compensation, benefits and career ladders, better training, and improved working conditions that include team approaches to work-related decisions.

Without a sufficiently large, stable and well-trained workforce of people providing hands-on care, other efforts to reform the long term care system will fail. The quality of long-term care is dependent on quality caregivers. Public and employer policies should contribute to an environment in which direct care workers can deliver high quality care.

Areas of recommendation

All of our recommendations are based on a review of research and recent efforts in Wisconsin and a number of other states. Some of them would require some upfront investment, but improved retention will save money and improve quality of care in the longer run. Many others are directed toward spending currently available funds more efficiently and effectively. Taken together, we believe they would move Wisconsin toward a more stable and better trained workforce of direct care workers, with the capacity for the growth that will be needed.

Underlying values and principles
We have developed and recommend that DHFS, service providers and other stakeholders in long-term care adopt a statement of principles related to the direct care workforce. These principles are the underpinning for all our other recommendations, and we make specific recommendations to DHFS about how to incorporate these principles in policies and programs.

Data collection, analysis and dissemination
Consistent data about this workforce, including turnover and retention rates, across all long-term care settings and across time is necessary to pinpoint problem areas, focus public and private efforts to resolve problems, and test the extent to which those efforts have a real impact. These data are needed to effectively implement many of the recommendations in this report. We make several specific recommendations for improving the collection, analysis and dissemination of workforce information across settings.

Quality assurance and improvement
A number of studies have shown that a sufficiently large, stable and well-trained direct care workforce is directly correlated with quality of care and quality of life for people receiving long-term care services. We make a number of recommendations, including:

- Integration of workforce-related quality indicators into all DHFS-administered long-term care programs
- Facility licensing requirements that would better assure sufficient staffing
- Better care planning processes to assure that staffing levels meet consumer needs
- Redirection of funds from forfeitures to quality improvement efforts
- Improved county contracting processes
- Improved consumer information about available services

Reimbursement mechanisms
Increased funding is not the only answer to resolving direct care workforce issues, but it is an important goal. Even within current public spending levels, steps can be taken to improve quality of care and job satisfaction of workers, leading to lower turnover rates and higher retention rates. Reimbursement methodologies should reward and promote quality, including a sufficient, well-trained and stable workforce. Our recommendations include:

- A stepped approach to analyzing and revising existing rate structures
- Revision of state and county rate-setting to incorporate incentives for better staffing

Wages and benefits
Research shows that low wages are correlated with high turnover among frontline caregivers and that, in some cases, benefits are even more important than wages in affecting turnover. Given the current shortage and the coming demographic realities, it is imperative that we do all we can to make direct care work in long-term care an attractive career. Investments in wages and benefits – and in other efforts to make these better jobs – are at least partially offset by reducing the costs associated with high turnover. We make a number of recommendations in this area, including:

- Renewed efforts to improve health insurance coverage for workers
- Improved access to benefits, including Workers Compensation, for independent workers

Training, certification and career ladders
Inadequate training leads to higher turnover. Current training requirements for workers vary widely by setting and job title and appear to be inadequate. Workers need opportunities for ca-

reer advancement so that these are not dead end jobs. We make many recommendations related to training, certification and career ladders, including:

- Making initial worker training requirements stronger, more consistent and more portable
- Creating advancement opportunities
- Better in-service training for workers and supervisors
- Ways that DHFS could better support good training opportunities

Working together

Resolving the direct care workforce crisis calls for partnerships among groups with a stake in resolving the problem. The complexity of the problem means that no single person, organization, or sector can resolve the long-term care labor crisis on its own. We recommend several ways that DHFS and counties can encourage multi-stakeholder approaches to working on this issue.

Respect, recognition and teamwork

Many studies have found that a lack of respect and recognition for their work is an important factor in turnover rates of direct care workers. In one study, the degree of nurse aide involvement in resident care planning was superseded only by the condition of the local economy as a factor affecting turnover. To find and keep direct care workers, it is also important to improve the image of this work with the public. We make several recommendations to improve:

- State and county support for provider efforts to better integrate frontline workers into care planning processes
- Support for improving the public image of direct care work

Worker support and safety

Because of their low wages and frequent lack of adequate benefits, direct care workers often need supports. These jobs are also physically demanding, often requiring moving patients in and out of bed, long hours of standing and walking, and dealing with clients who may be disoriented or uncooperative. These jobs have among the highest rates of on-the-job injury, much higher than the construction industry. We recommend a number of strategies for improving worker supports and safety, including:

- Information for workers on public programs they may be eligible for
- Improved supports for independent workers
- Efforts to improve health and safety practices for workers, especially in homes and small residential settings.
- Dissemination of best practices

Self-directing consumer issues

We have included a section on the special issues that arise when consumers self-direct their care and supports, hiring workers directly instead of through an agency. These arrangements can expand the available pool of workers, since some workers may be willing to work for someone they know, but are not interested in agency employment. But these arrangements also raise issues that need attention. We include a number of recommendations, including:

- Strengthening self-directed care mechanisms in county-managed programs
- Improved training for workers, care managers and consumers
- Improved supports for independent workers in these situations

Conclusion

There is no quick fix to the direct care workforce shortage, but progress can be made with small, practical steps, over time, on a number of fronts. With sustained and focused effort, Wisconsin can improve the current situation and avert future crisis. Our recommendations are intended to point the way toward developing a committed, stable pool of frontline workers who are willing, able and prepared to provide quality care to people with long-term care needs.

Introduction

The Committee on Direct Care Workforce Issues was created in the spring of 2004 by the Wisconsin Council on Long Term Care Reform[1], which advises the Department of Health and Family Services (DHFS). The committee was charged with recommending public policy changes that DHFS could make to foster a stable and well-trained workforce of direct care workers and growth of the workforce to meet current and future needs of long-term care consumers. The committee met monthly from June 2004 to February 2005 to develop a draft report which was reviewed and discussed in several forums, including an invitational discussion involving more than 70 stakeholders, a meeting of the Wisconsin Long Term Care Workforce Alliance, and a large event sponsored by the Milwaukee Aging Consortium. The Committee then met again in June 2005 to finalize its report. Committee members included representatives of service providers, workers, consumers and their advocacy groups, counties, researchers, and others with expertise in workforce issues.[2]

The Committee's work and this report focus on "direct care workers," the non-licensed professionals who provide personal care, housekeeping, home management tasks, vocational counseling, supervision and emotional support to people with chronic illness and disabilities of all ages in any setting. In keeping with our charge (see Appendix 1), the report is also limited to public policy issues which can be impacted by DHFS and the counties with which they contract for long-term care services.

Who are direct care workers?

Direct care workers are the backbone of the long-term care system. After unpaid family members, direct care workers are the most essential component in helping people with long term care needs to maintain function and quality of life. They provide 70 to 80 percent of the paid hands-on long term care and personal assistance received by Americans who are elderly, chronically ill, or living with disabilities (Dawson and Surpin 2001). They have many job titles, including nurse aide, nursing assistant, home health aide, home care aide, personal care worker, personal care attendant, residential aide, supportive home care worker, adult day care aide, rehabilitation aide, and others.

In May 2003, the U.S. Bureau of Labor Statistics (BLS) counted about 68,000 direct care workers in Wisconsin. (US BLS 2003) This number likely seriously underrepresents the actual size of this workforce, particularly in the home care and personal care attendant categories (Turnham and Dawson 2003). For one thing, it does not include independent workers who are self-employed or who have a fiscal agent as an employer of record. The total number of independent workers is not known, although one national study estimates that 29% of the workers providing assistance to Medicare beneficiaries in the home are self-employed (Leon and Franco 1998). We do know that there are at least 4,200 of these independent workers serving participants in Wisconsin's Community Options Program and its related Medicaid waiver programs (WI DHFS 2004b), and an additional unknown number in Family Care and Partnership programs. Thousands more are hired directly by consumers paying privately.

Direct care workers are a substantial segment of the state's health care economy. In 2003, BLS reported that Wisconsin had a total of about 225,000 health care workers. From the same count, about 68,000 – nearly one out of three of these workers – held positions as nurse aides, attendants, home health aides, personal care aides or other direct care workers. (US BLS 2003) A recent study using the PUMS/Census data estimated four times as many home care aides than were identified in previous studies (Montgomery et al, 2005).

It is also a fast growing occupational field. The BLS predicts dramatic growth for all of the key frontline caregiving occupations within health care between 2000 and 2010: nursing aides, orderlies, and attendants projected to grow at a rate of 24 percent; home health aides up 47 percent;

[1] For more information about the WI Council on Long Term Care Reform and its various committees, see http://www.wellc.state.wi.us/.

[2] See Appendix 1 for the full Committee charge and member list.

and personal and home care aides projected up 63 percent over the decade (Center for Health Workforce Studies 2002; US BLS 2001). Personal and home health aides rank eighth among *all* jobs in terms of predicted growth rate between 2000 and 2010, and nursing aides rank 12th. Health care jobs will grow twice as fast as all jobs. (US BLS, 2001)

Direct care workers work independently, as well as in hundreds of small and large organizations in every community in the state. The formal relationship between the consumer and the worker varies. In some cases, the worker is hired directly by the consumer and functions explicitly at his or her direction. In others, the worker is employed by an agency or facility, which directs and is responsible for the worker. Employers include adult day programs, adult family homes, Community Based Residential Facilities (CBRF), Residential Care Apartment Complexes (RCAC), Home Health Agencies (HHA), Hospice programs, Nursing Homes (including facilities for the developmentally disabled, known as ICFs/MR), Personal Care Agencies (PCA), and Supportive Home Care (SHC) Agencies.

Nationally, nine out of ten direct care workers are women. Their average age is 37 in nursing homes and 41 in home care. Slightly over half are white and non-Hispanic; about one-third are African-American and the rest are Hispanic or other ethnicities. Compared to the general workforce, direct care workers are more likely to be non-white, unmarried, and with children at home (GAO, 2001). The typical direct care worker is a single mother aged 25-54. Over 40% of home care workers and half of those in nursing homes completed their formal education with a high school diploma or a GED. Another 38% of those in home care and 27% of those in nursing homes attended college. Although we do not have comparable data for Wisconsin, several local studies lead us to believe that the demographics of Wisconsin workers are not very different from those of the national workforce, except perhaps for ethnicity in more rural parts of the state.

Dimensions of the problem

Wisconsin, like most other states, is experiencing a shortage of direct care workers in many long-term care sectors, placing pressure not only on the formal (paid) system, but also on family caregivers. Without serious intervention, the shortage of workers is likely to worsen over coming decades. Due to medical advances that allow people with chronic illnesses and disabilities to live longer and the aging of the Baby Boom generation, an unprecedented increase in demand for long-term care will occur over the next several decades. Between 2005 and 2030, the number of Wisconsin residents age 85 and older, those most likely to need long-term care, is projected to grow by nearly 50% percent, from 108,000 to 158,000. At the same time, the population of those who traditionally provide that care (primarily women between the ages of 25 and 54) is projected to decline by about 8,000. In other words, there will be a proportionally far smaller pool of potential workers to support our elders and others with long-term care needs.

Pressure on the paid workforce will be exacerbated by the fact that the current and future generations of older people have fewer adult children available to provide unpaid care than in the past. And more of those adult children are in single-parent and dual-income households, so that they are less available for significant levels of informal (unpaid) caregiving.

Retention is key

Causes of the workforce shortage are multifaceted and interacting, but they are mainly due to high turnover[3] rates and/or low retention[4] rates. Turnover rates for direct care workers in long-term care tend to fluctuate with the economy, going up when the economy is good and people can readily find other jobs. Many long-

[3] The turnover rate measures how many workers are replaced during a given time period, and is usually calculated as the number of workers hired as a percentage of all workers in that category.

[4] The retention rate measures how long workers stay, usually by calculating the percentage of all workers who have worked for an employer for more than a year.

term care providers have a stable core of workers, but suffer from a continuous "revolving door" among new hires. While a certain amount of turnover is inevitable and even healthy, many parts of the long-term care sector experience very high rates that create serious problems.

In Wisconsin, only nursing homes routinely report turnover and retention data. In these settings, rates have been improving in the most recent years for which data are available (2002 and 2003). It is unclear whether this improvement is related to the downturn in the economy in those years or signals a longer-term trend. Both turnover and retention rates tend to be better in facilities for the developmentally disabled than in nursing facilities, and in government-owned facilities, where wages and benefits are better. The highest turnover rates are in for-profit nursing facilities, where turnover of full-time nurse aides was 57% in 2003 and turnover of part-time aides was 84%. In for-profit nursing homes, two-thirds of full-time aides and just over half of part-time aides had worked at the same home for more than one year. Comparable retention rates for government-owned homes were 93% (full-time) and 72% (part-time). (WI DHFS 2004c and 2004d)[5]

> *"We trained 35 people since last year and none are still there." Direct Care Worker*

Information about turnover and retention rates at other types of facilities is sketchier. Various recent Wisconsin studies have found the following:

- Residential Care Apartment Complexes (RCACs): median turnover rate of 22.2% (range from 0% to 100%). Rates are lower in more well-established RCACs. (WHEDA and DHFS 2003)
- Community-based agencies providing vocational and residential services to people with developmental disabilities: an average of 8% of workers had left these agencies in the month previous to the survey. About 58% or surveyed agencies had vacancies at the time of response. (Mulliken 2003)
- Community Based Residential Facilities (CBRFs): Range of turnover rates from 60% to 143%. (Data for 46 facilities.) (Sager 2004)

High turnover rates make recruitment more pressing and retention even harder. High rates of vacancies and turnover in this workforce has consequences for all four key stakeholder groups within long-term care (Dawson and Surpin 2001a, Stone 2001, Turnham and Dawson 2003).

Consumers experience care without continuity, inadequate and sometimes unsafe care, and reduced access to care. (Wunderlich et al. 1996) In turn, these problems place more physical and emotional burden on unpaid family caregivers and create anxiety for those who are trying to arrange formal care. Families with loved ones in nursing homes and assisted living are augmenting the care provided in facilities because of the worker shortage (Stone 2001).

Workers have higher levels of injury and stress and less supervisory and training support when they work in a short-staffed environment. Turnover is directly related to heavy workloads, low wages and benefits, poor working conditions, and other factors (U.S. DHHS/CMS 2001, Harrington et al. 2003). The result is a spiral of instability as more workers leave a workplace that is ever less attractive to potential new staff (Harrington et al. 2003).

Providers have high costs, both direct and indirect. Turnover among direct care staff in long-term care costs U.S. employers about $3,500 per employee, or more than $4 billion a year. (Seavey 2004).

Payers, including the taxpayers who pay the highest proportion of long-term care costs, are making substantial payments for costs that de-

[5] For more specific information about turnover and retention rates in nursing homes, see Appendix 3.

tract from, rather than add to, the quantity and quality of care actually provided.

Implications for taxpayers
Public payers contribute the majority of funding for long-term care in Wisconsin and the country. In 2002, Medicaid accounted for 47% of national long-term care spending, while Medicare accounted for 17% (Georgetown 2004). Of those costs, 50 to 70 percent are for direct labor costs (Turnham and Dawson 2003).

In Wisconsin, state taxpayers purchase long-term care services through Medicaid fee-for-service, the Community Options Program and its related home and community-based waiver programs, Family Care, and Partnership programs. The total cost of these programs in 2004 was over $2 billion in state and federal funds. This means that taxpayers paid about $1 billion to $1.4 billion on labor costs in long-term care, mostly for direct care workers. Reductions in turnover could produce real savings that could be better used to improve quality (including jobs with better wages and benefits) and serve more people.

Counties also pay for long-term care, through Community Aids and county tax levy, especially for services for people with developmental disabilities. One recent estimate put the annual county contribution at about $70 million.

What causes high turnover?
The causes of turnover in this workforce are complex. A growing body of research is concluding that the reasons for workers quitting add up to a failure of employers, supervisors, society as a whole, and sometimes even consumers, to adequately respect and value them and the work that they do. Workers repeatedly say that they value their relationships with the people they support and that their work is important. But the work is often very hard and other rewards are few. The committee believes that workers in long-term care should have high quality jobs in good work environments.

A review of the research highlights a variety of factors associated with recruitment and retention problems among this workforce. These include:

- Hierarchical organizational structure and poor communication and relationships between worker and supervisor
- Insufficient benefits
- Low pay
- Few opportunities for career advancement
- Poor public image of the work
- Inadequate training
- Inadequate job orientation and lack of mentoring
- Little or no opportunity for continuing education and development within the position
- Lack of involvement in care planning for their clients and other work-related decisions
- Short staffing; unreasonable workloads
- Emotionally and physically hard work
- Workplace stress and burnout
- Personal life stressors, such as problems with housing, child care and transportation
- Lack of respect from clients' families

The bottom line is that valuing frontline caregivers can reduce turnover.

The relative importance of these factors will vary from individual to individual. People don't usually leave a job for only one reason, but because of general dissatisfaction resulting from multiple causes. Strategies to reduce turnover and increase retention need to address many of these factors to achieve significant change. (Stone 2001, Stone and Wiener 2002, Jervis 2002, Bowers et al. 2003, Eaton 2001, Harahan et al. 2003, Sager 2004, Lageson 2003, Dresser 1999, Landsness 2004, WI DHFS 2004a, and others)

The bottom line is that valuing frontline caregivers can reduce turnover. Demonstration of that respect can take many forms, including better compensation, benefits and career ladders, better training, and improved working conditions that

include team approaches to work-related decisions.

Recommendations for change

There is no quick fix or single solution to the direct care workforce shortage. But progress can be made with small, practical steps, over time, on a number of public policy and provider practice fronts. Our review of research in this area and strategies employed by many other states indicate that with sustained and focused effort, Wisconsin can improve the current situation and avert future crisis. Increased funding is not the only answer to resolving direct care workforce issues, but it is an important goal. Some investment in proven retention strategies is needed up front, but improved retention will save money and improve quality of care in the longer run. And we can spend currently available funds more efficiently and effectively. Within current public spending levels, steps can be taken to improve quality of care and job satisfaction of workers, leading to lower turnover rates and higher retention rates. Our recommendations are intended to point the way toward developing a committed, stable pool of frontline workers who are willing, able and prepared to provide quality care to people with long-term care needs in Wisconsin.

There is no quick fix or single solution to the direct care workforce shortage. But progress can be made... Our recommendations are intended to point the way toward developing a committed, stable pool of frontline workers who are willing, able and prepared to provide quality care to people with long-term care needs in Wisconsin.

Given our charge, the committee's recommendations are limited to public policy issues within the purview of DHFS. During the course of our deliberations, we learned about promising practices that can and should be considered by private service providers to improve their turnover and retention rates; these are listed in Appendix 10. For ease of reading, our recommendations are divided into a number of policy areas, several of which overlap.

Underlying values and principles

Early in its work, the Committee developed a statement of direct care workforce values and principles. The statement served as a framework for guiding the deliberations of the Committee. We believe its principles would also improve public and private policies and practices if adopted by the Department of Health and Family Services, service providers and other stakeholders in long term care.

This statement was reviewed, modified and adopted unanimously by the Committee's parent Wisconsin Council on Long Term Care Reform in October, 2004. In her response to the Council, Secretary Nelson stated that she would direct Department staff to incorporate appropriate elements into the DHFS Guiding Principles for Long Term Care Redesign. The following statement has been added to these principles under "design" and published on the DHFS web site: "Address labor force issues such as availability, salaries, benefits, and training needed." In addition, the Secretary said that she would direct staff to identify ways that the principles could be incorporated into program operations for a number of programs and proposals. She also promised to share the statement of principles with other state agencies, including the Departments of Workforce Development, Commerce and Public Instruction and the Wisconsin Technical College System.

The statement, as adopted by the Council, is shown below:

Statement of Direct Care Workforce Principles

The Wisconsin Council on Long Term Care Reform recommends that the Department of Health and Family Services, providers and other stakeholders in long term care adopt the following statement of principles as a framework for ensuring that public and private long term care policies and practices promote a sufficient, stable and competent workforce. The Department has a responsibility to promote the creation of good jobs with the long term care funding it administers. These principles should be the basis for any policy that affects paid caregivers for adults and children, including those providing care to a family member.

1. The quality of long-term care is dependent on quality caregivers.
2. Without a sufficiently large, stable and well-trained workforce of people providing hands-on care, other efforts to reform the long term care system will fail. Even in difficult economic times, efforts to increase and stabilize this workforce must be a high priority, and all other reform efforts must incorporate and support this goal.
3. Direct care work and the people who do it deserve the respect of public officials, employers, consumers and society.
4. The foundation of direct service work is the relationship with the consumer and his or her family members and/or guardian. Public policies and employers should support these relationships, encouraging continuity and stability of care. Workers and supervisors should be diverse and culturally competent to meet the diverse needs of consumers.
5. Direct care workers should receive a living wage, adequate and affordable health insurance and other benefits. Wages for this work should enable financial self-sufficiency, while reducing dependency on other public programs (such as W-2, food stamps and Medicaid). Restrictions on these other programs should not discourage direct care workers from full participation in this workforce.
6. Workers should have clear opportunities for specialized training and advancement in long term care, including cross-sector career ladders/lattices. Workers should be recognized and rewarded for their skills and experience.
7. Direct care workers and supervisors should receive the training (including training in diversity issues), mentoring, peer support and supportive supervision that will enable them to handle multiple situations.
8. Public and employer policies should contribute to an environment in which direct care workers can deliver high quality care. As the quality of jobs improves, expectations of workers can increase.
9. Direct care workers should be an integral part of the care team. They should have opportunities for input into care planning, and must be included in implementation of the care plan.
10. Direct care workers are the most important source of ideas for resolving the workforce crisis. Direct care workers will be consulted about public and employer policies and practices that impact their work.
11. People who wish to do so should be able to make direct care work a career.

Recommendations

The Department of Health and Family Services, in consultation with affected organizations, workers and consumers, should incorporate items 1 and 4-9 of the statement of principles into the following policies and processes:

- Contracts between DHFS and the various organizations operating Family Care, PACE, Partnership and SSI Managed Care programs, including reporting requirements.
- Family Care and Partnership program reviews, outcome evaluations, and quality improvement projects, including technical assistance from DHFS.
- The Community Options Program (COP) update process.
- Monitoring criteria for program reviews of COP and its related waiver programs: Community Options Program-Waiver (COP-W), Community Integration Programs (CIP IA, CIP IB and CIP II).
- Licensure and certification requirements for all facilities and agencies employing direct care workers, including nursing facilities, community based residential facilities, home health agencies, personal care agencies, licensed adult day care centers, and licensed adult family homes.

In addition, all of these principles should serve as the underpinning of all follow-up work recommended in following sections of this report.

Improving the collection and use of information about the workforce

Although available information indicates a widespread and serious shortage and instability of the direct care workforce, we cannot quantify the problem precisely. The US Bureau of Labor Statistics collects information about the number of direct care workers in broad categories, and their wages. Wisconsin currently collects detailed, consistent and longitudinal data only about nurse aides in nursing homes (nursing facilities and ICFs-MR) and, to a lesser extent, home health agencies. Through the DHFS annual nursing home survey and Medicaid cost reports, we systematically collect and analyze information from nursing homes that allows us to know:

- Number of employees in various categories, by full and part-time
- Turnover rates (for full- and part-time workers)
- Retention rates (for full- and part-time workers)
- Wages and benefits

We have more limited, although consistent and longitudinal data from home health agencies.

Without similar data about workers in other residential and community-based settings, it is difficult to pinpoint problem areas, focus public and private efforts to improve the sufficiency and stability of the direct care workforce, and test the extent to which those efforts have a real impact. Most importantly, these data are needed to inform the development of workforce-related policies that improve the quality of care in all settings. Some of our policy recommendations are fairly general; implementing these as specific policies will require better information than is currently available.

Several other states have begun to collect and analyze data from a variety of providers. North Carolina, for example, annually collects and analyzes basic turnover data on direct care workers in nursing homes, adult care homes and home care agencies, using a standard set of questions. This effort was initiated in 2001.

Recommendations

1. Working with providers, workers, consumers and other stakeholders, DHFS* should determine a minimum set of data elements that would be necessary to track the number of workers (head count and FTE) in various worker categories and settings, wages and benefits, and turnover and retention rates.

* We encourage DHFS to work collaboratively with the Department of Workforce Development in designing and implementing strategies recommended under items 1, 2, 3, 5 and 6.

2. Working with these stakeholders, DHFS* should develop uniform questions to be asked across employer types and uniform methodologies to be used to analyze data (e.g., turnover calculations). This effort should include uniform definitions of worker categories, so that comparable information can be collected across settings, where job titles may differ.

3. Once developed and field-tested, data should be collected, analyzed and published annually by DHFS* from at least the following providers: nursing homes, home health agencies, community based residential facilities, licensed adult family homes, residential care apartment complexes, personal care agencies, and licensed adult day care centers.

4. Similar data should be collected by counties from certain agencies with which they contract, including supportive home care agencies, fiscal agents who are the employer of record for independent personal care and supportive home care workers, supported living providers, and vocational programs such as sheltered workshops and job coaches. This collection effort should involve agencies for which DHFS does not have a mechanism for collecting information. County collection of data should augment, not duplicate DHFS efforts. These data should be forwarded to DHFS by counties and then incorporated into the overall picture of the direct care workforce published under item 3 above.

5. All data collection and analysis activities should be coordinated across public and private organizations, to minimize duplication of effort for both the collectors and the providers of information. Further, both raw data and analysis of it should be shared widely to make it useful to all stakeholders*.

6. DHFS* should work with the federal Department of Health and Human Services and Bureau of Labor Statistics to explore the possibility of Wisconsin serving as a pilot for the nation in uniform collection and analysis of this information on direct care workers, to assist with the effort to make these data comparable across states.

Quality assurance and quality improvement

A number of studies have shown that a sufficiently large, stable and well-trained direct care workforce is directly correlated with quality of care and quality of life for people receiving long-term care services. While there is little empirical evidence to establish causal links, anecdotes and qualitative studies suggest that problems with attracting and retaining frontline workers may translate into poorer quality and/or unsafe care, major disruptions in the continuity of care, and reduced access to care (Wunderlich et al. 1996). Several studies have observed that inadequate staffing levels are associated with poorer nutrition (Kayser-Jones and Schell 1997). Inadequate staffing has been associated with inadequate feeding assistance, poor skin care, lower activity participation, and less toileting assistance (Spector and Takada 1991; Kayser-Jones 1996, 1997; Kayser-Jones and Schell 1997). More recently and closer to home, a study of nursing homes in south-central Wisconsin found that homes with high staff turnover rates received more complaints and are cited for many more violations and deficiencies than are low-turnover homes. (Hatton and Dresser 2003)

> *"You know the families are paying a fortune, and the people aren't getting the care." CNA*

High turnover disrupts the quality of relationships that are critical to both the client and caregiver, creating "needless opportunities for mistakes and [removing] from the client a sense of dignity and control over herself and her environment" (Dawson and Surpin 2001a). Consumers consistently cite the rapport between themselves and their direct care workers above other potentially important measures of quality care (Wilner 1998).

There is debate over whether quality is best assured through state-imposed, standardized criteria, through the development of an internal quality plan by each facility or agency, or some combination of these. While some basic standards should be uniform, other requirements may be specific to each organization. Many people agree that an approach that centrally defines outcomes and allows regulated entities to develop their own approaches to meeting those outcomes is preferred.

Current state licensing requirements for long-term care providers contain a number of items related to staffing. For example, there are statutory minimum nursing staff-to-resident ratio requirements for nursing homes[6] and a requirement that homes have sufficient staff to meet the needs of residents. The federal requirement that long-term care facilities have "sufficient staff available" is not defined. To determine whether a facility is adequately staffed, surveyors usually look at resident outcomes. Nursing homes are required to post detailed weekly staffing schedules.[7]

> *"I have had many people ask me, 'Why don't you go on to school to be a nurse, why stay "just" a CNA? You are so smart.' To which I reply: 'The work that I do, and the people that I have cared for complete me. They have been my friends, my mentors, my guides, and I have been their legs, their hands, and sometimes their eyes. But never am I "just" their CNA." Beth Hadley, CNA*

Uniform staffing ratio requirements for congregate settings are difficult to establish, since the optimum number of available staff should vary by several variables, including: the needs of the residents, the skill levels of staff, worker responsibilities for non-direct care tasks, assistive technologies that are available and functional, the extent that a team approach to staffing is in place, and regional economic and workforce variables. However, the state should set minimum staffing standards for all facilities and assure that facilities have a plan, available to the public, for staffing levels that will meet the needs of their residents.

Individual care planning, whether by facilities, agencies or counties, should address the staffing needs of each consumer. Direct care workers, despite being closest to the consumer, are not often involved in on-going care planning processes. Questions and information may go from the worker to her supervisor to the care manager and responses back through the chain. It should also be noted that if funding is insufficient to provide all the services that people need, or prior authorization does not allow it, then care plans cannot allow for sufficient staffing and providers cannot meet staffing requirements.

Much of the home and community based long-term care in Wisconsin is purchased by county and other local agencies. The state contracts with counties for administration of the Community Options Program and its related waivers, and with the Family Care and Partnership programs. These local entities, in turn, purchase care through contracts with licensed providers and from those not required to be licensed, and are thus in a position to demand good quality. In addition, care managers in these programs are responsible for helping consumers to choose which agencies will provide care to meet their individual needs, whether in congregate or home care settings.

A policy established by DHFS in 2002 required that county agencies administering the Community Options Program (COP) and the COP and CIP II Waivers incorporate quality standards in their contracts with CBRFs. Model quality performance standards and measures and a checklist for the evaluation of quality in CBRFs were developed by a state-county workgroup and distributed to counties. Some of the quality indicators in the model relate directly to staffing. Counties began incorporating these standards in CBRF contracts in 2003. Objective and consistent criteria and evaluation processes are needed

[6] s. 50.04(2)(d), Wisconsin Statutes
[7] s. 132.63(3)(d), Wisconsin Statutes

within and across counties in order to meaningfully enforce these standards.

Other county efforts are also underway to develop objective tools for measuring the quality of assisted living settings with which they contract. One county, for example, is developing a model using a more objective measurement tool for all populations and all assisted living settings. The Family Care program, operating in five counties, is developing performance-based contracting with service providers. Specific standards, including those related to staffing, are being developed and baseline data collection is underway. Developing and implementing a contracting system that is fully performance-based may take from 3 to 5 years. Efforts are also currently underway in DHFS, through the federally funded Quality Close to Home project, to make quality processes in Family Care and all the waiver programs similar.

When forfeitures are assessed for violations of licensing codes by nursing homes and CBRFs, funds are deposited in the state's School Fund. This constitutionally mandated requirement is premised on the idea that regulators should not benefit from assessing penalties, for example by using these funds to support surveyor salaries. As a result, the current system precludes the use of these funds to improve quality in these or other facilities. A coalition of groups is advocating changing state statutes to allow penalty collections to be used for quality improvement purposes.

To make wise choices about long-term care, consumers need good information about the quality of facilities and agencies, especially information about quality indicators. The California Healthcare Foundation provides a web-based free public service providing comprehensive, consumer-friendly, comparative information on the more than 1,400 nursing homes, 834 home health agencies, and 172 hospice programs in California[8]. In appearance, content and usability, it is said to outperform the CMS system, including pop-up explanations of various terms and functions and comparative ratings across provider type. Depending on the type of long-term care, the site includes information on many factors shown to have an impact on quality of care, including:

- Staffing levels, turnover, and wages;
- Quality measures;
- Complaint, deficiency, and citation rates; and
- Finances and costs.

The federal Centers for Medicare and Medicaid (CMS) provides some information about nursing home and home health agency quality on its web sites respectively titled Nursing Home Compare[9] and Home Health Compare[10] Information includes citations for three years (without detail about seriousness of violations), the degree to which homes meet certain quality measures, and nursing staff hours per day per resident. The Wisconsin DHFS Bureau of Quality Assurance's web pages include considerable information about individual nursing homes, including staffing levels, turnover and retention rates, and citation histories, although navigation is somewhat difficult. Provider profiles are under development for CBRFs, AFHs and RCACs that will include three-year citation histories. Links to consumer checklists for choosing facilities are also available on the DHFS web site, and on the site of the Board on Aging and Long Term Care.

Additional recommendations related to improving quality can be found in the section of this report related to reimbursement mechanisms.

Recommendations

1. Workforce-related outcomes and quality indicators related to a quality workforce should be integrated into all Department-administered long-term care programs (institutional and community-based), including contracts between the Department and counties and other providers. All stakeholders, including providers, workers and consumers, should be actively involved in the development of these indicators. Because data is currently available for Medi-

[8] http://www.calnhs.org/

[9] http://www.medicare.gov/NHCompare/Home.asp

[10] http://www.medicare.gov/HHCompare/Home.asp

caid-funded nursing homes and (to a more limited extent) the Community Integration Program, efforts should start with these programs. As data collection and analysis is expanded as recommended in the data collection section above, efforts can expand to additional programs. Outcomes and indicators should recognize regional workforce and other variables and should include:

- Turnover rates
- Retention rates
- Skill levels of workers and supervisors
- Use of pool staff
- On-the-job injuries
- Extent of overtime required of workers

2. Licensed long-term care facilities should be required through the regulatory process to have a specific process for determining adequate staffing to meet the needs of their residents, taking into account the appropriate use of technology to assist staff and residents. This process should be linked to outcome-based quality assurance processes and should be reviewed and approved by the Bureau of Quality Assurance as part of the initial and renewal licensing process. It should also be publicly available in a format useful to consumers and their families, county care managers, and Aging and Disability Resource Centers. To transition to this requirement, a pilot approach is recommended, to test the variables that should be used and documented.

3. Community Based Residential Facilities, licensed Adult Family Homes and Certified Residential Care Apartment Complexes should be required to post weekly staffing schedules, as nursing homes are already required to do.

4. DHFS should review current minimum staff-to-resident ratio requirements in regulations governing nursing homes, CBRFs and other facilities to assure their adequacy and propose statutory and/or rule changes as needed.

5. DHFS should explore possible changes to assessment and care planning processes required of providers and counties that would more effectively assure adequate staffing levels in all settings to meet consumer outcomes. DHFS should require that care managers in the Community Options Program, the Community Integration Program, Family Care and Partnership consider staffing levels and individual consumers' needs in all placement and contracting decisions. Counties and providers should also involve direct care workers in care planning processes.

6. The committee supports an approach to quality assurance that allows for alternatives to monetary penalties for licensed facilities. We recommend that statutory changes be pursued that would eliminate forfeitures for violations by nursing homes and Community-Based Residential Facilities and allow instead for collection of assessments. Funds from these assessments should be used for grants for quality improvement projects in these facilities and/or for rewarding high quality performance. We further recommend that the state share of recoveries from personal care audits under the Medicaid program be re-directed to quality improvement efforts.

7. DHFS should continue to provide information and technical assistance to counties and work with them to develop meaningful measures and processes for contracting for quality, including workforce quality.

8. DHFS should require that counties incorporate quality standards, including standards related to staffing, into contracts with residential service providers, as has been done under the Community Options Program, COP-Waiver and CIP II.

9. DHFS should incorporate into its Quality Management Plan, currently under development, strategies for insuring that worker feedback is a part of quality improvement

strategies in provider and care management agencies.

10. DHFS should explore the feasibility of providing comprehensive, consumer-friendly, comparative information about nursing homes and other long-term care providers on a web site similar to the one that the California Healthcare Foundation provides. The web site under development through the Comprehensive System Change project would be a good location for a link to this information. Information about the web site should be made available through Aging and Disability Resource Centers, and distributed by a variety of local means such as doctors, hospital discharge planners, and county agencies.

Reimbursement policies

Increased funding is not the only answer to resolving direct care workforce issues, but it is significant. If providers do not receive funding sufficient to pay their workers living wages and provide decent benefits, they will be unable to attract and retain many of those who might otherwise be attracted to this workforce. Moreover, rates must be high enough to enable staffing levels that will promote good quality of care and quality of life. (See quality section.)

Under the current system of reimbursement, substandard providers are often paid the same as excellent ones.

Reimbursement methodologies should reward and promote quality, including a sufficient, well-trained and stable workforce. Under the current system, substandard providers are often paid the same as excellent ones.

Moving toward a system that rewards quality would require careful consideration of a number of factors. Consensus would need to be developed on what indicators of quality would be used. A number of variables would have to be incorporated into the system, including the proportion of Medicaid residents in a given facility, the availability of private foundation funds to supplement lower rates, the varying levels of resident needs, and others. It should also be noted that, unless new funds are added to the system, there would be the potential for decreasing quality of care even further in poorer performing facilities/agencies. Without new funds, rates for poorer performers would need to be decreased in order to reward high performers. However, a reimbursement system that recognized different levels of consumer need and provider performance would provide assurance to citizens and policy-makers that we are purchasing outcomes, not just paying for services.

Medicare-certified home health agencies (HHAs) are reimbursed under a prospective payment system that utilizes data from the Outcome and Assessment Information Set (OASIS). These data elements are core items of a comprehensive assessment for an adult home care patient and also form the basis for measuring patient outcomes for purposes of outcome-based quality improvement.

Most institutional long-term care and some home and community based care in Wisconsin is purchased under the Medicaid fee-for-service program. For most providers, standard reimbursement rates are established by the state for specific covered services, and providers are reimbursed per unit of service provided. Nursing homes are reimbursed under a formula that incorporates a number of factors.

Wisconsin's nursing home reimbursement formula contains no factors directly related to the adequacy or stability of direct care staff. The direct care allowance portion of the formula is based on a facility's historic costs, creating a disincentive to hiring more staff or increasing pay or benefits for existing staff. In addition, reimbursement rates for initial nurse aide training and testing have not been increased since the early 1990's and there is no reimbursement for in-service training.

Other states have begun to revise their nursing home formulas to tie quality measures, including those related to a sufficient and stable workforce, to reimbursement. Iowa, for example, uses ten accountability measures, including nursing hours provided and high employee retention rate, in determining rate increases. Homes can qualify for up to a 3% reimbursement increase (over the direct-care and non-direct-care component median rates) for meeting these measures. Minnesota is considering a more complex system that incorporates seven tiered quality measures, four of which relate directly to staffing: nursing hours per resident day, staff turnover, staff retention, and use of pool staff. Alaska, Michigan, North Carolina and Vermont are also considering nursing home reimbursement strategies to tie quality to reimbursement levels. Arkansas uses a cost based methodology that is responsive increased staffing levels and salary increases for direct-care workers. (PHI and NCDHHS 2004; Minnesota DHS 2004)

Other states provide "bonus" payments for nursing homes that meet certain quality criteria. In 2003, California's Quality Awards Program, for example, began to distribute up to $1500 per employee as staff bonuses to nursing homes that meet or exceed certain quality benchmarks. South Carolina has a Quality Initiative grant program, one requirement for which is monthly submission of data including facilities' turnover rates.

In addition to state efforts in this area, two bills are pending in Congress that would revise Medicare payment mechanisms to reward nursing homes for providing higher direct care staffing levels and better care. H.R. 5403 proposes to develop and test ways of rewarding facilities with higher pay for high performance on certain quality indicators, including higher than average direct care staffing levels. Companion bills S. 2988 and H.R. 5393 would provide an increase of 1 percent in Medicare payments to skilled nursing facilities that performed in the top 20 percent on quality measures. Homes in the top 10 percent would get a 2 percent increase, while those in the bottom 20 percent would get 1 percent less.

In Wisconsin, a large proportion of community-based long term care is purchased by counties using state, federal and county funds under the Community Options Program and its related waiver programs, and through Family Care. Counties purchase assisted living, vocational supports and in-home services from a wide variety of local providers. Community based providers report that current funding levels make achieving quality supports very difficult. Some programs operate under standard rates per client paid by the state; the CIP IB rate has been flat for years and most counties supplement it with county funds. For the most part, county rates are based on standard rates set by providers. Providers receive, and workers are paid, the same rate regardless of the intensity of need of each client. Quality of care differences among providers are not often recognized in these reimbursement systems.

Community Care of Portage County has begun using measurements of the sufficiency of staffing in CBRFs with which it contracts for services to its Family Care members. As in most Family Care programs, rates are individualized, based on each member's needs as documented in the functional screen. Adjustments to these rates are tied to several indicators of quality relating to staffing patterns, with facilities meeting all staffing standards receiving a higher daily rate.

Recommendations

1. DHFS should analyze current rates for providers in all public long-term care programs to determine their adequacy to support an adequate staff-to-client ratio as well as sustaining wage levels and adequate benefits for workers. The most significant problem areas should be identified and ways to improve them recommended. Since data are already available for all nursing homes and some community providers serving people with developmental disabilities, analysis should begin with nursing home and CIP IB rates. Other analysis can be conducted as better information is available from other providers.

2. State rate-setting methodologies should incorporate mechanisms to encourage sufficient and stable staffing, including rewarding high retention and low turnover rates. In developing these methodologies, DHFS should review those being adopted or under consideration in other states.

3. County rate-setting methodologies for contracted service providers should reward a sufficient, stable and well-trained workforce.

4. While rate setting methodologies that reward providers for having a sufficient and stable workforce are being developed, DHFS and counties should explore ways to provide other kinds of public recognition for high-performing providers.

Wages and Benefits

To stem the tide of nursing assistants and other frontline workers leaving the long-term care sector, surveys conducted by Cushman and colleagues (2001) suggest that more competitive wages are needed. In Wisconsin, the federal Bureau of Labor Statistics reported the following median hourly wages in November 2003 for broad categories of direct care workers[11] in both acute care and long-term care settings:

- Nursing aides, orderlies and attendants: $10.66
- Home health aides: $9.44
- Personal and home care aides: $9.14

Even the highest of these was 21% below the median hourly wage of $13.51 for all occupations in the state for that year.

Workers in nursing homes tend to make more per hour than those in home and community settings, as demonstrated by the following information.

- In Milwaukee County (2003): mean hourly wages of $9.83 for workers in home care, $10.58 in nursing homes, and $10.55 in other community care settings. Range in wages of from $5.15 to $15.00 per hour across settings. (Lageson, 2003)
- Nurse aides in nursing homes (statewide in 2003): Median average hourly wage of $11.15. (WI DHFS, 2003)
- Workers providing community services to people with developmental disabilities in 2003: Mean hourly wage of $8.81 in residential services; $9.93 in vocational services. (Mulliken 2003)
- Workers in CBRFs: Mean hourly wage of $8.40 to $8.62 (Sager 2004)
- Independent workers providing services to participants in COP and related Medicaid Waiver programs in 2004 (statewide for responding counties providing mechanisms for consumers to employ their own workers): Mean low wage of $6.85 per hour to mean high wage of $10.50 per hour. (WI DHFS 2004b)

> *Quality care means a living wage, so we don't have to work two and three jobs to make ends meet, robbing us of our strength so we can't deliver our best care. – John Booker, CNA*

Hourly wage rates can be deceiving because many of these workers cannot work full time; statewide, about half of nursing home workers are part-time. A study conducted by the Milwaukee Aging Consortium in 2003 across all long-term care provider types found that 38% of workers fit the BLS definition of part-time (less than 35 hours per week). Home care workers worked the fewest hours (mean of less than 31 hours per week). Nearly 26% of all workers in the study had total annual incomes under $15,000, and another 35% had incomes between 15,000 and 25,000. (Lageson 2003) Another study (Montgomery, et al 2005) found that only 34% of home care workers nationally work full-time and year-round.

[11] See Appendix 3 for BLS definitions of these worker categories.

"I like my work but I don't want to always depend on help from the government to make ends meet."
CNA

Even if they can work full time, the wages for most workers are not at a level that can provide a self-sufficient income for a family. The self-sufficiency standard, calculated by the Wisconsin Women's Network for all Wisconsin counties in 2004, offers a realistic measure of the monthly income required to have a safe, decent, basic standard of living. It defines the income that working families need to meet their basic needs without public or private assistance and is calculated using the real costs of goods and services purchased in the regular marketplace. Only basic needs, including a thrifty food plan with no restaurant or take-out meals, are included. The cost of providing basic family needs varies widely by family size and geography. For one adult with a pre-school age child, the self sufficiency wage ranges from $1,364 ($7.75/hour) in Buffalo County to $3,060 ($17.38/hour) in Waukesha County. (Lewis 2004)

The wages of direct care workers tend to fall short of the self-sufficiency standard. For example, in Milwaukee County, a single parent of one preschool-age child would need to work full-time at $15.72 per hour to meet the self-sufficiency standard. Actual mean hourly wages range from $9.83 to $10.58, depending on the setting. Half of the workers surveyed in the Milwaukee Aging Consortium's study had children under the age of 18 living with them and 22% reported caring for other adults in the family. (Lageson 2003) Almost a third of all frontline caregivers in nursing homes (and a quarter of those in home health care) are not married but have children, meaning that they are the household's primary breadwinners (Hatton and Dresser 2003).

Many direct care workers are among the "working poor." They are twice as likely to receive government benefits – such as cash assistance and Food Stamps – as workers in other job categories because their wages are so low. (Citizens for Long Term Care 2003, GAO 2001). In the late 1990s, nursing home aides and home care aides were more likely to be in poverty (16 percent and 22 percent, respectively) than the average population (12-13 percent) (ASPE 2004).

Nationally, one-third of frontline caregivers in nursing homes and one-quarter of their counterparts in home health agencies do not have health insurance, compared to 16 percent of all workers (GAO 2001). More than a quarter (27.5%) of workers from a variety of settings surveyed in Milwaukee County reported having no health insurance. Only 36.5% of workers had health insurance paid by their employer. About 20% had coverage through a spouse's policy or another source, while 12.3% had coverage under Medicaid. (Lageson 2003) In Wisconsin nursing homes, health insurance coverage and other benefits are much better in government-owned facilities. Part of the reason for low health insurance coverage rates is that is difficult for employers to find insurers who will cover their many part-time workers.

"You can't make a career out of something where you don't have benefits." Direct Care Worker

Uninsured direct care workers are less likely to have a regular health care provider, more likely to avoid medical care because they cannot afford it, and report lower health status than their insured co-workers (Hams 2002). Even when health insurance is provided, given the rapidly rising costs of liability and health insurance, employers have to choose between raising wages and continuing current levels of contribution to health care coverage. And many workers are finding the employee share of premiums and co-pays to be overwhelming (Hams 2002).

Most nursing homes and home health care agencies do not offer pension coverage, and only 21 to 25 percent of aides in these settings are covered (GAO 2001). Information about benefits other than health insurance and pensions is lim-

ited. In the Milwaukee Aging Consortium Retention Survey, workers reported having the following benefits other than health insurance: vacation days (63.5%), paid holidays (63.1%), personal days/paid time off (49.2%), sick days (49.2%), dental insurance (33.6%), life insurance (23.8%), shift differential (23%), retirement benefits (18.9%), flexible scheduling (12.7%), and unpaid days off (11.9%). Ten percent or fewer reported having a variety of other benefits. (Lageson 2003) In a recent statewide survey, agencies providing residential and vocational services for people with developmental disabilities reported providing the following benefits other than health insurance: mileage (92% of agencies), savings plans (17%), employee assistance program (28%), 125 plan for pre-tax benefits (55%), car allowance (6%), use of care (16%), tuition reimbursement (38.5%), on-site or off-site child care (5%), and wellness/fitness (12%) (Mulliken 2003).

National research shows that low wages are correlated with high turnover among frontline caregivers (DCA 2002a, Massachusetts Health Policy Forum 2000, Dawson and Surpin 2001a) and that, in some cases, benefits are even more important than wages in affecting turnover (Brown 2002). Data on turnover among frontline caregivers in South Central Wisconsin nursing homes provide further evidence for this point. A 2003 study found that the average hourly wages at high-turnover nursing homes were nearly $1 less than wages at low-turnover homes, and nearly $3 less when benefits were included (Hatton and Dresser 2003). A large wage increase for publicly-funded homecare workers in San Francisco County, California also correlated with reduced turnover and substantial increases in the number of people drawn to these jobs (Howes 2002). And a study of agencies in New York State providing residential care to people with developmental disabilities found that workers stayed longer at agencies with higher rates of insurance coverage (Duffy 2004).

Independent workers may make less than agency-employed workers, and may not have access to any employer-provided benefits. Of particular concern is that they may not be covered by Workers' Compensation to cover medical expenses if they are injured on the job. Another frequent problem is that there is no mechanism in place to provide respite or even back-up if they are ill or have other pressing personal needs. A survey of counties conducted by DHFS in 2004 found that nearly 4,200 independent providers serve COP and waiver participants who hire the workers directly in the 66 responding counties. Of these, 1,585 (38%) are paid family members of the participants. (Wisconsin DHFS 2004b) There is a statutory requirement for the Community Options Program and all its related waiver programs that all counties offer self-directed supports and the opportunity for consumers to hire independent workers through a fiscal agent, but not all counties currently meet this requirement. Counties who do not do so are concerned about liability issues. However, other counties have resolved the liability issue through a number of mechanisms, including assisting to form agencies to act as the employer of record, and helping independent workers to form cooperatives. In other states, efforts have been made to create cooperatives in which both consumers and independent workers are owner-members.

"I haven't seen a pay raise in fifteen years." - Direct Support Professional

Just over half the states (26), including Wisconsin, have funded a wage or benefit pass-through or other increase to benefit direct-care workers (PHI and NCDHHS 2004). Data on the impact of wage pass-through programs on direct care worker recruitment and retention are limited and inconsistent. Findings across the few evaluations completed to date – and the lack of an appropriate comparison group in these studies – do not support the efficacy of wage pass-through programs or of a particular type of wage pass-through approach (PHI 2003). It should also be noted that when pass-throughs are provided in Medicaid fee-for-service rates, they are available only for those hours that are billable to that funding source; the time of many community-based workers is billed to several different

sources during a given time period. If this strategy were used in Wisconsin again, documentation that funds had indeed been used for wages and benefits should be required and funds recouped if this were not demonstrated. Moreover, data should be collected and analyzed to determine the effect on turnover and retention rates.

Some research with CNAs suggests that wage increases may need to be targeted, i.e. to those who stay longer or as rewards for providing good care (Bowers, et al. 2003). Workers in the WETA study reported that they liked their jobs but felt underpaid and underappreciated, especially when their wages had not increased over long years with the same employer (Sager 2004). Workers in the Milwaukee Aging Consortium study who were dissatisfied with wages indicated that a very reasonable increase would suffice. They also wanted to be rewarded for longevity and experience, rather than making about the same as a newly hired worker. (Lageson 2003) The WETA study found similar results (Sager 2004). In Wyoming, a mandated wage increase for direct care workers in developmental disability community based programs required differential minimum wages for new staff and those with 12 months of experience. Increases for full-time staff were substantial (a 51% increase over several years from an average of $9.08 to $13.74 per hour). A study of the impact of these increases found that turnover dropped by nearly one-third in a three month period, from 52% to 37%.

When employees have the resources for basic needs – food, housing, childcare, health care and reliable transportation – their stability in the profession increases. They are less likely to miss work or to leave the profession altogether. Wages and benefits are not the only reason, and sometimes not even the primary reason, that people take and leave jobs, but they are an important factor in job satisfaction. Given the current shortage and the coming demographic realities, it is imperative that we do all we can to make direct care work in long-term care an attractive career. Investments in wages and benefits – and in other efforts to make these better jobs – are at least partially offset by reducing the costs associated with high turnover.

Recommendations

1. DHFS should take a more active role in improving health insurance coverage for direct care workers and other low-income uninsured people. This should include taking a leadership role in forming a multi-agency task force on health insurance reform to analyze current proposals for reform and advising DHFS, the Department of Workforce Development and the Office of the Insurance Commissioner on strategies for broadening coverage. The Paraprofessional Healthcare Institute has offered informally to provide staff assistance with such an effort.

2. DHFS should monitor the progress and success of health insurance cooperatives and pools as potential models for containing health insurance costs and broadening coverage for workers.

3. As outlined in the training section of this report, workers should have opportunities for advancement within the long-term care field, including opportunities for wage and benefit increases.

4. DHFS should continue to encourage and support models such as worker cooperatives and worker-consumer cooperatives that allow independent workers access to better pay and benefits, including Workers Compensation.

5. DHFS should explore ways to improve the availability of respite and back-up for independent workers, including paid family members.

6. DHFS should renew efforts to resolve the issue of liability for counties when they offer consumer-directed services through independent workers who have a fiscal agent as employer of record. When this is resolved, counties should take responsibility for providing workers compensation coverage for independent workers serving participants in their long-term care programs.

7. DHFS should analyze current reimbursement mechanisms to determine the current percentage of rates going into wages and benefits for workers and the amount of new funding that would be needed to provide sustaining wage levels and adequate benefits. The most significant problem areas should be identified and ways to improve them recommended. Since data are already available for nursing homes and community providers serving people with developmental disabilities, analysis should begin with nursing home and CIP IB rates. Other analysis can be conducted as better information is available from other providers.

Training, certification, career ladders and workforce flexibility

From several perspectives, strengthening training for direct care workers is an important strategy in resolving the workforce crisis. People receiving long-term care are living longer with more severe disabilities and workers need the skills, knowledge and confidence to provide good care in a variety of settings. People living in CBRFs and other community settings today have a level of disability at least as severe as those who lived in nursing homes a decade ago. And nursing home residents have a much higher average acuity level (i.e., more complex and serious illness and disability) than in years past. Training that is relevant, meaningful and practical can give workers the tools they need to do a good job, as well as bolstering their investment in this work. There is evidence to suggest that some direct care workers may not be receiving the training they need to do their jobs effectively (PHI 2005).

A growing body of research supports the hypothesis that inadequate training leads to higher turnover (PHI 2005). One national literature review on this subject found that, in general, higher levels of training for direct care workers helped employers find, and especially, keep employees (Pennsylvania 2001). Several studies have found that effective in-service training can improve turnover and retention rates (McCallion et al. 1999, Taylor 2001, Noel et al. 2000).

Although research on the extent to which training impacts quality of care is limited, most providers, consumers and direct care workers would argue that there is a direct connection. Several consumer advocacy groups, including the National Citizens' Coalition for Nursing Home Reform, the Alzheimer's Association, and the World Institute on Disability, have issued calls for higher or different training standards. (PHI 2005)

> *"Training makes it a profession."*
> *DCW*

Current initial and in-service training requirements for workers in Wisconsin vary widely by setting and job title. Specific hourly requirements range from 75 (for certified nurse aides or CNAs) to no specific requirement for many other categories. Requirements for training content range from very specific to very general. Oversight of training is also quite varied. Training requirements and oversight tend to be most stringent in settings that are the most regulated, supervised and "public." They are the loosest in settings that are least regulated and supervised and where workers are often making decisions on their own. Many workers have training beyond the minimum required to work in a particular setting or agency type. (See Appendix 4 for details.)

Turnover prevention begins with initial training. If people entering the field are treated with respect by trainers and adequately trained to perform the "real" job, they are more likely to stay. Many workers say that current training is not "reality based." They say that classroom training is not effective without sufficient clinical training. They especially find on-the-job mentoring, by people who are trained in mentoring, to be very effective. Not only do they learn from experienced workers, but it helps them to build relationships with the organization and other workers. Peer support of this kind helps to build teamwork and workers' confidence in their

skills. Especially in home care, consumers may also serve as mentors.

Mentoring strategies were part of the Iowa CareGivers Association Project (Iowa CareGivers Association, 2000). Evaluation found that facilities that provided CNA in-service trainings, support groups, and CNA mentorship opportunities had an average length of CNA employment of 18.96 months, which was significantly higher than the control group average of 10.01 months. The CNAs in the treatment group also reported greater job satisfaction.

CNAs

About 176,500 CNAs are listed in Wisconsin's nurse aide registry. Of these, 58,500 meet federal requirements to work in a nursing home, home health agency or hospice program. The remaining 117,500 are either working in another long-term care setting or a hospital or are no longer working as a nurse aide. In order to become a CNA, the State of Wisconsin requires 75 hours of training, including 16 hours of clinical experience; this is the minimum required under federal rules. Although the federal Omnibus Budget Act of 1987 raised the training requirements of frontline caregivers in nursing homes and home health agencies, federal regulations for caregiver training still fall short, according to the Direct Care Alliance. In fact, federally mandated training hours for school crossing guards, cosmetologists and even dog groomers are greater than those required for entry-level CNAs and home health aides (Hatton and Dresser 2003).

A 2002 report from the Office of the Inspector General in the U.S. DHHS found that nurse aide training has not kept pace with 1) the medical and personal care needs of today's nursing home residents; or 2) nursing home practices and new technologies. Forty of 49 State Nurse Aide Training and Certification program directors believe that 75 hours of nurse aide training is not sufficient to prepare nurse aides for their first day on the job. Twenty-six states have extended their nurse aide training programs beyond the 75 hours required by Federal law; new requirements range from 80 hours to 175 hours. Wisconsin is one of 21 states with training requirements at the federal minimum of 75 hours. Wisconsin also is among the lower tier of states with respect to requirements for the clinical experience portion of training. At least 27 other states require more than the federally mandated 16 hour requirement, ranging from 24 to 100 hours. (U.S. DHHS/OIG 2002)

The 2002 DHHS/OIG study also found that teaching methods used in initial training programs are often ineffective, and that clinical exposure is too short and unrealistic. They found that training focuses on acquiring skills needed to pass the State exam. Other skills needed for the job may receive only limited coverage during their initial training. In the same study, CNAs, ombudsmen, and other experts had a low opinion of most in-service training, saying the content was often repetitious, not directly relevant, or signed off on without being absorbed.

All initial training programs for CNAs in Wisconsin are approved by the DHFS Bureau of Quality Assurance (BQA). BQA's Office of Caregiver Quality reviews and approves curriculum, instructor qualification, and training site. Training and experience in a non-approved nurse aide training program (e.g., in a CBRF) does not count toward CNA training. The number of approved nurse aide training programs in Wisconsin has declined recently from 230 to 120 programs. A large percentage of facility-based programs are no longer active, and about half of all new CNAs now are trained at technical colleges. The Office of Caregiver Quality does not review and approve curricula for in-service training.

Other worker categories

Training requirements for workers in settings not requiring nurse aide certification range from non-existent to modest (see Appendix 4). Training for workers in home and community settings is often provided by employers, either directly or through contract with another agency. BQA reviews and approves curricula for workers in CBRFs, but not those for workers in other home and community settings. Competency testing is not currently required for workers in any of these settings. In addition to CNA courses, the Wisconsin Technical College System offers courses in other health and long-term care occupations,

including CBRF Caregiver and Community Developmental Disabilities Associate. However, these are offered at only a few campuses. (See Appendix 5.)

> *"When I asked for training on Parkinson's/ Alzheimer's, they told me to just go to the library and get a book." DCW*

Sometimes training in one setting is portable to another setting and sometimes not. Training in any program that has not been approved by BQA for nurse aide training does not count at all toward CNA training. CNA training may or may not count toward training required for other settings. This inconsistency and lack of portability hinders movement of workers from one type of program to another, as well as the flexibility of providers of more than one service to utilize workers across settings. Further, workers who move across settings may be trained over and over on the same topics if they change jobs, using resources that could be better used on enhancing their knowledge and skills. In-service training is often duplicative, with workers funded through several funding sources required to take essentially the same training multiple times in the same year.

Many states are increasing training and staffing requirements for assisted living facilities. A recent (2005) analysis by the National Center for Assisted Living identified several trends:

- There is a general increase in training and continuing education requirements for both administrators and direct care staff;
- More states are permitting trained, supervised, unlicensed staff to administer medications; and
- There continues to be an increase in training and staffing requirements when care is provided to individuals with Alzheimer's disease in a secured or specialty care section.

Higher training requirements in community settings could help make liability insurance more accessible and affordable for employers. At the same time, distinctions should be made between workers in settings where there are many consumers with differing needs, and those who work with only one or two clients in their own homes. Rather than (or in addition to) a set curriculum of classroom training, workers in the latter category may benefit more from shadowing experienced workers and/or receiving training from consumers and family members about each person's needs and preferences.

Consumers who direct their own care sometimes prefer to train their own workers; however, their objections to formal training programs are often based on the way that training is currently conducted. Some states have developed curricula for personal assistants who deliver services under the self-directed model. San Francisco's In-Home Supportive Services public authority, for example, offers a free, voluntary 25-hour initial training for personal assistants serving self-directing consumers. The curriculum addresses communication, health, safety, nutrition, and job readiness (PHI 2005).

Training and testing costs

Part of the reason that turnover is expensive is that training and testing new employees is costly. A recent study reported average CNA training costs of $1,066 at privately operated facilities and $1,604 at government-operated nursing homes, which generally provide substantially more hours of training per student (Pennsylvania 2001).

CNA training is partially funded through the Medicaid program. Under federal Medicaid rules, CNAs who pay for their own training privately are supposed to be reimbursed for their costs if they start work or receive an offer of employment at a nursing home within a year of being certified. The state is supposed to reimburse the worker, through the facility, and facilities are allowed to require that the worker stay a certain amount of time in order to be reimbursed. (PHI 2005) In Wisconsin, the required competency testing for certification as a CNA costs

$100. Often this is paid for by providers, but may be borne by individual CNAs. Wisconsin's nursing home reimbursement rates for initial nurse aide training and testing have not been increased since the early 1990's. The maximum payment for a nursing home for initial training and testing is $286.50 ($225 for training and $61.50 for testing). The facility receives a percentage of this capped amount based on the percentage of resident days that are covered by Medicaid. Even though they receive a reduced payment, facilities are required to reimburse the CNA no less than the full $286.50. Many CNAs who meet the qualifications, however, are never repaid, and even when they are, the payment may not cover all their costs (U.S. DHHS/CMS 2001).There is no similar reimbursement mechanism to cover facility costs for in-service training.

Apart from CNAs in nursing homes, there is no requirement for Medicaid or other public funding reimbursement of training and testing costs for workers. Some states, including Washington, Kansas and Oklahoma, cover the cost of training other kinds of workers, either directly or through their per diem rates for providers. The Massachusetts Extended Care Career Ladder Initiative has promoted collaboration between workforce development agencies, community colleges, and long-term care providers to offer free or subsidized training. The New York State Department of Health has allocated $100 million in surplus TANF funds to educate certain direct care workers. California used $25 million in combined WIA and TANF funds to improve training and retention of frontline workers in long-term care. The U.S. Department of Labor's new High-Growth Job Training Initiative, which targets health services as one of nine fast-growing sectors, is another promising source of support.

Our government needs to start looking at being a nurse aide as career choice and not a dead-end job. - Jennifer Craigue, nursing assistant

Consistency, portability and advancement opportunities

Although much work would be needed to move toward portable credentials and the "universal worker" concept, we could start by making training requirements more portable than they currently are, across settings and funding sources. With the caveat that some flexibility may be needed for family caregivers, basic training for all worker categories could be consistent. Modules could be added for specific skills needed for a particular client population and/or setting, and more advanced skills and specialty needs (e.g., dementia care). Once a worker had received training and demonstrated competency in a particular module, s/he would not have to repeat it to work at a different work site. Instead, training and worker resources could be devoted to expanding knowledge and skills.

Ohio is identifying key core skill competencies for direct-care workers across systems of care, work settings and consumer populations (e.g., nursing homes, MR/DD, home health, physically disabled, etc.) to develop standardized requirements and institute state credential programs for workers. In Pennsylvania, a broad coalition of groups is working to design and test a comprehensive core-training package for direct-care workers across the continuum.

Creating opportunities for advancement would help decrease the shortage of workers, improve job satisfaction, make the job more attractive, and increase diversity. (Salsberg, 2003) Lack of career mobility may make care work a dead-end occupation, both in the perception of potential employees and in fact. Career ladders can take many forms. Tying extended training to career ladders would provide opportunities for advancement that could help keep experienced workers in long-term care. Making training more portable from one long-term care setting to another would also increase opportunities for workers within the field.

The Wisconsin Education, Training and Assistance (WETA) project (Sager 2004) studied the effectiveness of tying expanded training opportunities for workers in CBRFs to increased wages and/or bonuses in their current jobs. North

Carolina's Workforce Improvement for Nursing Assistants: Supporting Training, Education, and Payment for Upgrading Performance program (WIN A STEP UP) provides financial incentives to workers for completing training modules and staying with an employer for a specified period. The program also provides financial incentives to nursing homes for their participation. It is funded by civil monetary penalty fines collected from nursing homes, which are earmarked for use in improving nursing home quality. (University of North Carolina 2004) Although evaluation is not complete, these approaches show promise for improving turnover and retention rates.

For workers in the developmental disability field, the National Alliance of Direct Support Professionals has developed a national credentialing program based on the Community Support Skills Standards, a group of 12 broad knowledge and skill sets needed by workers. By completing courses through the Internet-based College of Direct Support, workers can advance through several stages, becoming a support professional assistant, licensed support professional, certified direct support professional and then supervisor, while earning first an associate's and then a bachelor's degree. Two initial evaluations of this new program have been positive.

A few states have credentialing programs of their own. The Massachusetts Department of Mental Retardation, for example, offers a 21-credit Direct Support Certificate Program, which is taught at community colleges. Workers who complete the course get an increase in pay. (PHI 2005) The federal Department of Labor has recently approved an apprenticeship program for home health aides, which is being tested in three pilot programs in Michigan, Indiana and Pennsylvania. It will provide a structured career path for career development.

Some states, including Delaware, Colorado, Massachusetts, New York, North Carolina, Virginia, Pennsylvania and Illinois, have or are experimenting with two or three levels of nurse aides. There are several potential benefits to these types of structures. First, they can give CNAs incentives to stay in their jobs by offering higher pay to CNAs in higher tiers. Second, to advance to the next tier, additional training is required, which will result in a larger population of well-trained CNAs. Having CNAs who have an incentive to continue in the profession and receive additional training, has the potential to decrease the high turnover rate and increase the quality of care received by residents. Career ladders are also being developed designed to facilitate movement from nurse aide to higher paying positions, such as LPN or RN.

Some career ladder opportunities may take workers into areas related to, but not direct care work. For instance, one Wisconsin county identified some direct care workers serving COP clients who were particularly skilled at helping people take advantage of educational, recreational, religious and social opportunities. They were given the opportunity to become care manager assistants and county employees, doing community integration work that care managers and direct care workers might not have time to do.

Promising models of training

The Committee reviewed several training models for direct care workers and supervisory staff that have received positive reviews from multiple agencies in Wisconsin. These included (1) training developed by the Wisconsin Council on Developmental Disabilities and the DHFS Bureau of Developmental Disability Services, (2) training done by the Wisconsin Education, Training and Assistance (WETA) project, and MetaStar's Leadership Development training. Summary and contact information about these models is included in Appendices 5-7.

Recommendations

1 Worker categories, career ladders and workforce flexibility

   a Current direct care job categories should be clarified and clustered. Create more flexibility in training requirements and worker categories. Training beyond the basics should be tailored to the setting in which the worker will provide service,

and the needs of the population(s) with which s/he will work.

b Training requirements should be more consistent and portable across care settings. All workers should have the same basic level of training and competency, and once they have demonstrated competency in a particular skill set, should not have to repeat training in that area when they move to another setting or funding source. Elements of this core training should include:

- Safety (worker and consumer)
- Dealing with emergencies
- Universal precautions (infection control)
- Resident/client rights
- Confidentiality
- Communication between:
  - Caregiver and client
  - Health care providers
  - Caregiver and facility/agency
  - Caregiver and nurses/supervisors
- Life skills
- Activities of daily living (ADLs) and instrumental activities of daily living (IADLs)
- Natural aging vs. disease and disability
- Challenging behaviors
- Balancing workload/coping strategies
- Family involvement and dynamics
- Ethics and boundaries between caregivers and consumers

c Additional modules of training for advanced or special skills should be available and as consistent as practicable across settings serving similar target groups. Completion of these modules and/or equivalent additional experience should result in wage increases and/or bonuses.

d More consistent training could result in the "universal worker" who could follow a consumer from one setting to another. Training for workers in various job categories and settings should be made much more consistent in terms of:

- The number of hours of training required
- Curriculum approval by the state
- Requirements for instructor qualifications
- Competency testing (written test with the option of an oral test when needed, and skills demonstration), conducted by a person or entity other than the trainer

e As a first step toward making training more consistent and portable, DHFS should identify all current training requirements across all settings and funding sources, including those in the Medicaid Waiver Manual, state statutes, administrative rules and federal rules, and develop a work plan for making a transition to a more uniform system.

f To create advancement opportunities, two (or more) levels of nurse aide should be created, with statewide standards and portability. Guaranteed wage increases should be associated with advanced certification. Similar efforts to create career ladders within long-term care should be explored for other worker categories.

g DHFS should explore ways in which providers could be more flexible and efficient in the deployment of staff, so long as quality of care is not compromised.

2 <u>Adequacy of initial training</u>

a DHFS, in cooperation with provider associations, direct care workers and consumers, should invest in improving current training programs for all direct care workers in all long-term care settings.

- Training should focus not only on health and clinical aspects but also worker and consumer safety, communication, problem-solving, critical thinking, individualizing care, interpersonal skills, listening and relationship building, especially for those new to the workforce.
- Training should use adult-centered teaching methodologies and the content should be immediately applicable and practical. Training should demonstrate and expect professionalism on the job.
- Training and testing requirements should relate to state and county expectations for provider quality.
- Training should focus not only on the needs of employers, but also on the needs of workers.
- Training should consider all needs of consumers, not just their health care needs.
- Ensure that those providing the training for entry level workers in all worker categories (not just CNAs) have adequate credentials and experience. Various methods are possible, including rating trainers based on student evaluations, test results and observation of trainees on the job.
- Ensure that sufficient clinical training follows classroom training.

b All current training requirements should be considered bare minimums. Requirements for workers typically employed by Residential Care Apartment Complexes, Supportive Home Care Agencies, Adult Family Homes and Adult Day Care Centers are particularly low or even non-existent and should be strengthened.

c Both classroom and clinical requirements for CNA training should be increased.

d Training for workers in assisted living and in-home settings should provide more emphasis on medication assistance.

e Training for individuals working in consumers' homes should be specific to the individuals for whom they will work and should include training related to each individual's particular needs and preferences This training should take place with that consumer. A worker who is going to work with just one or a few people in their homes may need less generalized classroom training and more instruction from consumers and family members and/or shadowing experienced workers.

f DHFS should encourage and work with providers and other stakeholders to develop a peer mentoring program for direct care workers.

3 <u>In-service training for DCWs and supervisors</u>

a DHFS should review current in-service training requirements for all direct care worker categories to assure that:

- Required hours are adequate
- Content is relevant to actual job duties of workers
- Requirements for trainer qualifications are adequate
- Employers are accountable for providing the training and workers are accountable for taking it
- Requirements for annual training in universal precautions are consistent, so that workers do not have to repeat it to satisfy various funding source requirements.

b DHFS should establish a requirement that in order to maintain active status in the nurse aide registry, CNAs or their employers must provide documentation of completion of required in-service training.

c DHFS should establish requirements or incentives for training of supervisors, with the content emphasis on team-

building, mentoring and problem-solving.

d Training and other efforts are needed to remove cultural barriers (e.g., age, language, ethnicity, literacy levels) between direct care workers and supervisors. This is an essential component of good communication, team-building and job satisfaction in many organizations.

4 Support for training improvement

a DHFS should take a leadership role and designate staff to develop, identify and recognize excellent training for workers and supervisors.

b DHFS should work with researchers to evaluate initial and in-service training for direct care workers and disseminate the results.

c State and county rate-setting methodologies should provide incentives for providers to cover the cost of ongoing training.

d A State-sponsored training initiative should be considered. (A train-the-trainer approach could be employed.) Training approaches used in Wisconsin and other states that should be considered include:

- The training developed and provided for residential and vocational providers of developmental disability services by the Wisconsin Council on Developmental Disabilities and DHFS
- Leadership Development middle management training for nursing homes and home health agencies developed and provided by Meta-Star
- Worker and supervisory training developed and provided in the Worker Education, Training and Assistance (WETA) project.
- Mentor training programs such as those developed by the Iowa Care-Givers Association project, the Wisconsin Regional Training Partnership, and elsewhere.

e The state should explore ways to fully or partially subsidize the costs of training and testing, as well as other supports such as child care and transportation needed for workers to attend. A revolving loan fund for initial and/or in-service training for workers and supervisors is an alternative approach worth considering.

f DHFS should work with the Department of Workforce Development to increase the use of Workforce Investment Act funds for long-term care worker training and to strengthen apprenticeship programs to make them useful for long-term care workers.

g The state should develop a continuing education curriculum, on-line courses or other training opportunities for administrators, managers and supervisors, and direct care workers, incorporating information about best practices.

The complex interplay of market forces, industry practices, and public policies means that no single person, organization, or sector can resolve the long-term care labor crisis on its own.

Working together

There are no easy solutions to long-term care workforce problems. The complex interplay of market forces, industry practices, and public policies involved in making such changes means that no single person, organization, or sector can resolve the long-term care labor crisis on its own. This calls for partnerships among groups with a stake in resolving the problem. When providers, consumers and workers from both the institutional and the community sides of the long-term care system come together to work collectively on the workforce issue, they can and

have made a difference. (Better Jobs Better Care 2003)

In Wisconsin, the Wisconsin Long Term Care Workforce Alliance is a coalition that includes providers, workers, consumer representatives, educational organizations and state and county governments. Local coalitions with similar representation also exist in several counties, many of them initiated with support from the Community Links grants. The Alliance has received a grant from the Helen Bader Foundation to assist additional counties to form workforce coalitions and to strengthen existing ones.

Recommendations

1. DHFS is encouraged to continue to support, through the Community Links grant program, statewide and local collaborative models of planning and implementation of efforts to improve the direct care workforce. In particular, support is encouraged for the Wisconsin Long Term Care Workforce Alliance and local coalitions of stakeholders working on these issues.
2. DHFS should evaluate and disseminate information about lessons learned from past Community Links projects and continue funding of these projects to support local efforts to address workforce issues and needs.

Respect, recognition and teamwork

Many studies have found that the lack of respect and recognition for their work is an important factor in turnover rates of direct care workers. When frontline caregivers talk about feeling unsupported on the job, they often cite the lack of respect and recognition for the difficult work they do on a daily basis. (Dresser et al. 1999, Hatton and Dresser 2003, Stone 2001, Bowers et al.2003, Eaton 2001, Pennington 2003, Sager 2004, and others) A recently published study found that organizational culture was the strongest predictor of organizational commitment on the part of workers in assisted living facilities. Employee characteristics such as age, gender, and educational level play little if any role in how committed employees are to their employers. High levels of commitment are linked to low rates of turnover. (Sikorska-Simmons 2005)

Demonstrating that workers are valued by their employers, their colleagues, their clients and the broader society can take many different forms. Many of these are in the purview of the private sector, and not a focus of this report.[12] But some concepts are relevant to public policy and practice.

"I love working with the people I care for. I think that of all the jobs out there, this one fits me best."
Direct support professional

"I like the fact that I can make a difference in someone's life. . ."
Direct support professional

"I feel like I'm a millionaire every time I walk through those doors and it has nothing to do with the money." CNA

Caring and compassionate people are drawn to these jobs, and many find the work rewarding because of the relationships they develop with clients and families (Mulliken 2003, Dresser 1999, Hatton and Dresser 2003, Lageson 2003, Sager 2004 and many others). Two keys to retention are to foster those relationships and to involve frontline workers in the planning and management of care. In one study, the degree of nurse aide involvement in resident care planning was superseded only by the condition of the local economy as a factor affecting turnover. For example, in facilities where nursing staff were perceived to accept aides' advice and suggestions or simply discussed care plans with aides, the turnover was lower than in those facilities where aides were not involved in care planning. (GAO 2001, Banaszak-Holl 1996)

[12] Selected information about promising practices for provider organizations is provided in Appendix 10.

"The case manager spends 10 minutes in a home and makes an assessment. They don't ask us. The case manager thinks, 'We are educated and they (direct care workers) aren't.'"
Direct Care Worker

A number of training programs for middle management in provider organizations emphasize and encourage team approaches to caregiving that involve direct care workers. Three of these that the Committee reviewed are summarized in Appendices 5-7. The training section above also includes several recommendations related to improved training for supervisory staff that can lead to better recognition and involvement of direct care staff.

To find and keep direct care workers, it is also important to improve the image of this work with the public. Iowa, North Carolina, Arkansas, Massachusetts, Pennsylvania, Maryland and Ohio are among the states that have undertaken public recognition and image campaigns. In Wisconsin, several counties have conducted such campaigns, and the WI Long Term Care Workforce Alliance has received a planning grant from the Retirement Research Foundation to design a research project to evaluate the efficacy of this approach. They plan to apply for funds to implement and test several campaigns. See Appendix 9 for sample materials from recent county coalitions' campaigns.

Recommendations

1. DHFS is encouraged to continue to support the efforts of the Wisconsin Long Term Care Workforce Alliance to implement and evaluate campaigns to improve the image of direct care workers among workers, supervisors, employers, consumers and the general public.
2. Publicly funded long-term care programs should include requirements for consumer-centered care planning processes. Direct care workers' input into care planning should be required, to the extent that consumer preferences about how and when that occurs can be met.
3. DHFS should involve direct care workers in all policy and implementation committees or task forces related to long-term care.
4. DHFS, counties, providers and other stakeholders should actively pursue grants and other funding opportunities to encourage innovative projects and demonstration programs designed to flatten hierarchical structures, involve direct care workers in care planning and other workplace-related decisions, and encourage relationships between workers and clients.

"Quality care means respect from our supervisors and other administrative personnel, to help us feel good about the work and the quality of care that we give, and to give us the support we need to do it right." - John Booker, CNA

Better worker support and safety

Because of their low wages and frequent lack of good benefits, direct care workers often need supports to be reliable in their jobs. DHFS-administered Community Links grants have been used to support county efforts to provide worker supports such as child care and transportation to support people during training. Many employers also provide supports; some promising practices in this area are listed in Appendix 10.

Peer support, continuing education and advocacy are sometimes available to workers through direct care worker associations and unions. These connections can be especially important for independent workers. Maine has used grant funds to establish the Personal Assistance Worker Guild. Pennsylvania is assisting to sup-

port a direct care worker association. Worker cooperatives, such as Waushara Cooperative Care, can provide peer support as well as other tangible benefits.

States can also support workers by providing outreach to inform them about benefits that low-income working families may be eligible for. When people register as CNAs in North Carolina, for example, they are automatically placed on a mailing list to receive information about that state's equivalent of Badger Care.

Studies have identified the physical demands of nurse aide work and other aspects of the workplace environment as contributing to retention problems. Nurse aide jobs are physically demanding, often requiring moving patients in and out of bed, long hours of standing and walking, and dealing with patients or residents who may be disoriented or uncooperative. Nursing homes have one of the highest rates of workplace injury, 13 per 100 employees in 1999, compared to the construction industry with 8 per 100 employees (GAO 2001). Workers cite short-staffing as the leading cause of worker injury; when only one worker is available to do a job that should be done by two people, the chance of injury is greatly increased. Direct care workers in other settings also face high risk of injury, especially in home settings, where often only one worker is present and no equipment is available to assist with transfers.

"What I'd really like them to do is stop giving me 6-foot-tall people when I'm under 5 feet tall. Someone's going to get hurt." Home Health Aide

Workers in private homes are also exposed to a variety of other potential safety issues. Clients may be unable to keep walks and driveways cleared of ice and snow or live in high-crime neighborhoods. Pets, guard dogs and wildlife may pose a danger. Individuals other than the client may be present. The client and/or others in the home may be drinking or using illegal drugs. Sexual harassment is another potential threat to worker safety.

The Select Committee on Health Care Workforce Development, a multi-agency group involving key stakeholders and staffed by the Department of Workforce Development, has identified reduction of injuries related to lifting as a top priority. To date, their efforts have focused primarily on institutions and larger residential settings. Considerable attention is given to worker safety issues in larger facilities because of OSHA regulation; less attention has been focused on worker safety in home and small community settings. A faculty member at the University of Wisconsin Extension is working on a project to develop and evaluate promising interventions (training, technology, practices and procedures) to reduce injuries among home care workers (DeClercq 2005). Special one-time grants under the Community Options Program have been used in the past for technology to improve worker safety, as well as consumer safety and independence. For example, grants have been used to purchase lifting devices, cell phones to improve communication and assure safety of workers on the road, and electronic monitoring devices to allow staff to be available only to respond only when needed.

Some workers choose to work overtime in order to increase their income. In other cases, overtime may be required, because another worker does not show up, because of overall vacancies and staff shortages, or because an employer requires overtime in lieu of hiring additional workers. Worker fatigue and/or preoccupation with childcare or other personal conflicts can create unsafe conditions for both workers and consumers if overtime is extensive.

Recommendations

1. As noted in the self-directing consumer issues section of this report, we recommend that DHFS monitor the results of local projects to create registries to match independent workers and consumers. If these prove to have benefits for consumers and for workers, the Department should encourage ex-

pansion to other localities, perhaps through the Community Links grant program.

2. The long-term care sector should be represented on regional Workforce Development Boards and direct care work in long-term care should be a priority for these Boards. Counties should work with these boards and with local Job Centers to assist, where necessary, those workers who are displaced by closure or downsizing of facilities and agencies to transition to other jobs.
3. Current state and local funding for the development of technology to reduce worker injuries should be preserved.
4. DHFS should maintain and systematically disseminate information to long-term care providers about public programs available to low-income families, such as Badger Care and subsidized child care, which could benefit their employees.
5. DHFS should continue to encourage and support the creation of worker associations, worker cooperatives and worker-consumer cooperatives that can provide supports and other concrete benefits for independent workers. DHFS is also encouraged to consult with the UW Extension Small Business Development Center to explore additional ways that workers could organize.
6. DHFS should consult with stakeholders and experts to develop an inclusive set of best practices to improve worker health and safety across all long-term care settings.
7. DHFS is encouraged to work with the Department of Workforce Development and the University of Wisconsin Extension to form a task force to develop and oversee implementation of recommendations to improve safety and supports for worker in home and small residential settings.
8. DHFS should work with the University of Wisconsin Extension on their project to investigate ways to improve the health and safety of home care workers.
9. DHFS should work with providers, workers and other stakeholders, including the Department of Workforce Development, to build the capacity to make training in worker health and safety more available.
10. DHFS should work to develop training curricula that address the unique worker safety issues that are associated with service delivery to consumers in their private homes.
11. DHFS should encourage wider availability of home safety inspections and advice for consumers, which could improve safety for both consumers and workers.
12. DHFS is requested to study the extent to which overtime, especially mandatory overtime, is creating unsafe conditions for consumers and/or workers.
13. All stakeholders, including researchers, providers, workers, counties and DHFS, should work together to better prepare for and coordinate grant applications and other opportunities to demonstrate, evaluate and disseminate information about projects to strengthen and support the direct care workforce.

Self-directing consumer issues

Many of the recommendations in previous sections of this report relate to the majority of publicly funded consumers, who receive services from workers employed by facilities and agencies. There is another group of consumers who direct their own care, using a variety of funding sources including COP and its related waiver programs, Family Care and private funds. (Medicaid fee-for-service funded services must be provided by agencies certified to receive these funds.) These consumers hire, train, supervise and fire the people who support them, and often the workers are self-employed.

Self-directed support mechanisms can broaden the direct care workforce, since people may be willing to work for one or more individuals whom they know, but are not interested in being employed by an agency to serve multiple individuals. But independent workers may earn less than agency-employed workers, and may not have access to any employer-provided benefits.

Of particular concern is that they may not be covered by Workers' Compensation to cover medical expenses if they are injured on the job.

Mechanisms are needed to connect consumers who are looking for workers and workers who are looking for jobs. Special training issues arise in these situations, for consumers, workers and care managers. Other issues that arise include the frequent lack of peer mentoring opportunities for workers and mechanisms for mediating issues between consumers and workers.

Nearly 4,200 independent providers serve COP and waiver participants who hire the workers directly in the 66 counties responding to a recent survey (Wisconsin DHFS 2004b). There is a statutory requirement for the Community Options Program and all its related waiver programs that all counties offer self-directed supports and the opportunity for consumers to hire independent workers through a fiscal agent who acts as the employer of record, but not all counties currently meet this requirement. More specific information about this issue is included in the wages and benefits section of this report.

Additional information and recommendations relating to independent workers are covered in the sections of this report on wages and benefits, training, and worker supports and safety.

Recommendations

1 Support and strengthen self-directed care mechanisms in public homecare programs, to bring in independent workers (family members, neighbors, etc.) who may be willing to work for someone they know. DHFS should enforce the current requirement that all COP and waiver participants have a self-directed care option and the opportunity to hire independent workers through a fiscal agent. In addition, DHFS should help clarify the legal exposure or liability that consumers have as employer of record and work with counties to resolve the issue of county and consumer liability. Counties should provide workers compensation coverage as recommended in the wages and benefits section above, with the infrastructure in place to protect counties, workers and consumers.

2 DHFS should encourage and offer technical assistance to counties to help them develop and provide training to consumers who wish to self-direct their services and perform employer-related tasks themselves. In addition to training, counties or their fiscal agent organizations could set up payroll systems for individual consumers to help them prepare to manage taxes and other employer tasks.

3 Long-term care funding programs should provide mechanisms for continuing to pay consumer-employed workers during short term interruptions in care (e.g., hospital stays).

4 DHFS should explore ways to improve the availability of respite, back-up and peer mentoring support for independent workers, including paid family members. One option might be to expand the role of fiscal agent organizations to include these services.

5 DHFS should encourage and offer technical assistance to counties for creation of mediation mechanisms, perhaps through care managers, of issues that may arise between self-directing consumers and the independent workers they employ.

6 In addition to the recommended improvements in training for workers and supervisors in the training section of this report, specialized training is needed in self-directed support situations:

   a to instruct caregivers about working for people with disabilities, including training on assistive technology as appropriate;

   b to instruct caregivers about the particular needs and preferences of the individuals whom they will be supporting, including training by consumers and their family members;

c to educate case managers about implementing self-directed care programs and about recognizing signs of abuse and neglect; and

d to educate consumers about managing their own care.

7 Training for workers who will be working with one individual should include training related to that consumer's particular needs and preferences. This training should take place with that consumer.

8 DHFS and counties should develop training resources and opportunities for publicly supported consumers, especially those who manage their own care, to help them build skills as an employer/supervisor as they recruit, hire, supervise and evaluate workers. Consumer training should also incorporate interpersonal skills, problem solving, listening and relationship building.

9 DHFS should encourage and offer technical assistance to Aging and Disability Resource Centers, Independent Living Centers and advocacy organizations to provide training resources and opportunities for both public-pay and private-pay consumers, especially those who manage their own care, as outlined in recommendation 8 above.

10 DHFS should monitor the results of local projects to create registries to connect and match independent workers and consumers. If these prove to have benefits for consumers and for workers, the Department should encourage expansion to other localities, perhaps through the Community Links grant program.

"Most people don't know what CNAs really do. They tell you "anybody can be an aide, it takes no brains and no skills. You just have to be able to handle the smells." Oh, does this make me boil!" - Richard J. Sojka, CNA

"There aren't that many jobs where you can get eight thank-you's in a day. I get a paycheck every day and a stipend every two weeks." -CNA

Appendix 1 – Committee Charge and Membership

Preamble: Without a sufficiently large, stable and well-trained workforce of people providing hands-on care, other efforts to reform the long term care system will fail. Even in difficult economic times, efforts to increase and stabilize this workforce must be a high priority, and all other reform efforts must incorporate and support this goal. The Department of Health and Family Services creates many jobs through its substantial funding of various long term care programs and has a responsibility to ensure that those jobs are good jobs.

Charge: After review of current and recent efforts to address issues related to the direct care workforce in long term care, and with a focus on retention issues, develop recommendations to the full Council, within the constraints of tight fiscal conditions, on public policy changes that the Department of Health and Family Services could make to foster a stable and well-trained workforce of direct care workers and growth of the workforce to meet current and future needs of consumers.

Issue areas to be addressed:

1 A recommended statement of principles that could be adopted by the Department, providers and others, explicitly recognizing the value of direct caregivers and their work, and providing a framework for evaluating whether long term care policies and practices support the goal of a sufficient, stable and competent workforce.

2 Describe the current workforce in various care settings, including demographics, and the percentage paid by Medical Assistance and other public sources. Analyze the factors that contribute to high turnover. Analyze options for improving the stability and skill of direct care workers that utilize existing funds or that leverage small amounts of new funding.

3 Quality assurance and improvement programs for facilities and agencies employing direct care workers that include measures of the stability and quality of their direct care employees.

4 Reimbursement policies and methodologies for publicly funded programs that will support and encourage a stable, well-trained workforce of direct care workers.

5 Identify gaps in data collection about the extent and nature of the workforce shortage as it relates to specific settings and populations; make recommendations about how to improve the collection and use of data to tailor remedies to specific problems.

6 Training for supervisors, workers and consumers, and certification requirements for direct care workers that encourage competency, flexibility in the workforce and retention of qualified workers.

7 Strategies for encouraging innovation, culture change and team approaches to care and care management that increase the involvement of direct care workers.

8 Strategies for providing support to direct care workers.

9 Strategies for making the work less physically demanding

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The Committee benefited from the expertise of a number of individuals who regularly attended meetings and contributed information. These included:

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Many other individuals presented information that was of great use to the Committee.

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Appendix 3 – Size and stability of the Wisconsin direct care workforce

Selected Information

In May 2003, the U.S. Bureau of Labor Statistics (BLS) reported about 68,000 direct care workers in Wisconsin, in three categories[13]:

- Nursing Aides, Orderlies, and Attendants – 40,900
- Home Health Aides – 11,680
- Personal and Home Care Aides – 15,160

The number of nursing aides, orderlies and attendants includes some working in acute care and psychiatric hospitals, although it consists mainly of nurse aides in long-term care settings.

These numbers do not count thousands of independent workers who are not employed by facilities or agencies. Nearly 4200 independent workers are funded through COP (WI DHFS, 2004). One national study estimates that 29 percent of the direct care workers providing assistance to Medicare beneficiaries in the home are self-employed (Leon and Franco, 1998).

As of February, 2005, about 176,500 CNAs are listed in the nurse aide registry. Of these, 58,566 meet all federal requirements to work in a federally certified nursing home, home health agency or hospice program. The remaining 117,514 are either working in another long-term care setting or a hospital, or are no longer working as a nurse aide.

[13] Nursing aides, orderlies and attendants: Provide basic patient care under direction of nursing staff. Perform duties, such as feed, bathe, dress, groom, or move patients, or change linens.
Home Health Aides: Provide routine, personal healthcare, such as bathing, dressing, or grooming, to elderly, convalescent, or disabled persons in the home of patients or in a residential care facility.
Personal and Home Care Aides: Assist elderly or disabled adults with daily living activities at the person's home or in a daytime non-residential facility. Duties performed at a place of residence may include keeping house (making beds, doing laundry, washing dishes) and preparing meals. May provide meals and supervised activities at non-residential care facilities. May advise families, the elderly, and disabled on such things as nutrition, cleanliness, and household utilities.

Turnover Rates[14] of Nurse Aides in Nursing Facilities (NF) and Facilities for the Developmentally Disabled (FDD)
Wisconsin, 2003[15]

	NF		FDD	
Full-time aides				
All facilities	43%		24%	
Government		10%		5%
Nonprofit		43%		46%
For-profit		57%		16%
Part-time aides				
All facilities	61%		33%	
Government		41%		26%
Nonprofit		51%		36%
For-profit		84%		39%

Retention Rates[16] of Nurse Aides in Nursing Facilities (NF) and Facilities for the Developmentally Disabled (FDD)
Wisconsin, 2003[17]

	NF		FDD	
Full-time aides				
All facilities	74%		84%	
Government		93%		95%
Nonprofit		74%		71%
For-profit		67%		89%
Part-time aides				
All facilities	64%		74%	
Government		72%		77%
Nonprofit		66%		67%
For-profit		56%		82%

[14] The turnover rate is calculated as the number of employees in a given category hired during the year as a percentage of all employees in that category.
[15] WI DHFS, 2004c.
[16] The retention rate is the percentage of all employees in a category who have worked there for more than one year.
[17] WI DHFS, 2004d.

Annual turnover rates in selected Community Based Residential Facilities, 2000-2002. CBRFs participating in Worker Education, Training, and Assistance Program (WETA) training and control facilities. (Sager, 2004)

	Pre-WETA	During WETA	Post-WETA
Comparison Facilities	135%	143%	126%
Training Facilities	84%	74%	60%

Appendix 4 – Summary of Current Wisconsin Training Requirements

Job title/setting	Wisconsin training requirements	Accountability	Actual training levels (as known)
Certified nurse aides (CNAs) Nursing homes (including ICFs/MR) Home Health Agencies Hospice Programs	Initial training: Minimum of 75 hours, including at least 16 hours of classroom instruction and 16 hours in a clinical setting. Very specific curriculum requirements, including basic nursing skills, personal care skills, basic restorative services, rights of clients and dementia care. In-service training: Minimum of 12 hours required every 12 months. Federal requirement that training address each CNA's strengths and weaknesses.	Standardized written and skills competency testing required. (Contracted through Promissor.) DHFS/BQA licenses these organizations, assures compliance with federal regulations, approves all initial training programs, including curriculum, teacher training and experience, and training site, and oversees the nurse aide registry. BQA does not track in-service training.	Except for feeding assistants, all direct care workers in nursing homes, home health agencies and hospice programs must meet at least nurse aide training requirements, pass competency test and be in nurse aide registry. Most facility-based programs offer 80-90 hours of initial training. Technical colleges offer several different training models, including 120-hour, 140-hour and 160-hour.
Medication Aides (CNAs with experience and advanced training) Nursing homes	Initial training: CNA plus individualized training and supervision In-service training Instructor qualifications specified.	Competency testing (challenge test) required. BQA licenses facilities, ensures compliance with federal regulations and oversees training.	Must have CNA training – see above – plus individualized medication aide training.
Feeding Assistants Nursing homes (limited to feeding and hydration assistance)	Initial training: Minimum 8 hours of instruction in one of 3 standardized and approved curricula with specified topics. In-service training: Minimum 1 hour annually.	Standardized, state-approved written and skills exam. BQA licenses facilities and approves training for workers.	
Community Based Residential Facility (CBRF) Workers (5 or more adults; ranges from 5 to 257)	Initial training: Minimum 45 hours specified in 6 modules over 6 months. Instructor qualifications not specified. In-service training: Minimum 12 hours annually relevant to job responsibilities.	Competency currently not required. (May change after HFS 83 rule revisions underway.) BQA licenses facilities and approves training, often provided by facilities.	Nearly half of all CBRF workers are CNAs (Sager, 2004)

Job title/setting	Wisconsin training requirements	Accountability	Actual training levels (as known)
Licensed Adult Family Home Workers (3-4 beds)	Initial training: Minimum 15 hours within first 6 months of providing care. Broad topics specified. Qualified training organizations specified. In-service training: Minimum 8 hours annually approved continuing education on specified, broad topics.	No competency test. BQA licenses homes.	
Certified Adult Family Home Workers (1-2 beds)	Initial training: No specific requirements. In-service training: No specific requirements.	No competency test. Counties certify homes.	
Residential Care Apartment Complex (RCAC) Workers (5 or more adults in apartment units with services) (Requirements shown are for certified RCACs)	Initial training: Minimum hours and instructor qualifications not specified. Topics are specified. In-service training: Not specified.	RCACs self designate. Those serving only private pay tenants may simply register with DHFS/DDES. Certification by BQA is required to qualify for reimbursement from COP/CIP.	Over 60% of workers in RCACs are CNAs. 46% received training provided by RCAC consisting of a median of 40 hours of job shadowing/on-the-job training, 8 hours of classroom training, and 4 hours of other training. (WHEDA and DHFS, 2003).
Adult Day Center Workers (Group adult day service providers)	Initial training: Workers must receive training on specified topics within 90 days of employment. Minimum hours and instructor qualifications not specified. In-service training: Minimum of 10 hours annually after first year of employment.	No competency test. Program certified by BQA, but only if at least one participant is funded through COP/CIP waiver program.	
Family Adult Day Care Workers (Up to 6 adults, depending on severity of disability, served for less than 24 hours per day)	Initial training: Minimum training hours and instructor qualifications not specified. Topic areas are identified. Workers have up to 6 months to obtain training. In-service training: No requirements.	No competency test. Program certified by BQA, but only if at least one participant is funded through COP/CIP waiver program.	

Job title/setting	Wisconsin training requirements	Accountability	Actual training levels (as known)
Personal Care Workers Home Health Agencies Personal Care Agencies (must be county agency or Independent Living Center)	Initial training: *Current rules:* Minimum 40 hours training, at least 25 hours of which in personal, restorative care, or 6 months equivalent experience. Topics specified. *Proposed rules:* No minimum hour or trainer qualification requirements. Topics specified. In-service training: *Current rules:* None specified. *Proposed rules:* Ongoing instruction and evaluation as appropriate to needs of recipient.	RN supervisor to evaluate competency of worker. BQA licenses Home Health Agencies. Bureau of Health Care Financing oversees Personal Care Agencies and conducts periodic audits. Under proposed rule changes, agencies are accountable for assuring that workers have appropriate training.	
Supportive Home Care Workers	Initial training: Minimum 16 hours classroom training, plus minimum 1 hour in home of consumer. Person often is matched with specific client and additional one-to-one training provided. In-service training: None specified	Sign-off by trainer, who may be consumer, that worker is trained and competent. COP-Waiver manual specifies training requirements.	

Appendix 5 – LTC courses in the WI Technical College System

Technical College	Nursing Assistant	Physical Therapy Assistant	Occupational Therapy Assistant	Medication Assistant	CBRF Caregiver	Community Developmental Disabilities Associate	Human Services Associate
Blackhawk	X	X	X	X			
Chippewa Valley	X			X			
Fox Valley	X		X				
Gateway	X	X	X	X			X
Lakeshore	X						
Madison Area	X	X	X	X			X
Mid-State	X			X			
Milwaukee Area	X	X	X				X
Moraine Park	X			X			
Nicolet Area	X			X			
Northcentral	X			X	X		X
Northeast WI	X	X		X			
Southwest WI	X						X
Waukesha Co.	X	X					X
Western WI	X	X	X			X	
WI Indianhead	X		X	X			

Appendix 6 – WCDD/BDDS Training Summary

This training was developed by the Wisconsin Council on Developmental Disabilities and the DHFS Bureau of Developmental Disabilities for staff of agencies providing residential and vocational services. It is designed to support organizations that want to develop a competent and committed workforce. Several different modules provide perspectives on making direct support work more interesting and meaningful by strengthening relationships between direct support workers, the people they assist, and people's families and allies. The various modules allow organizations to explore their work from different angles, and perhaps to discover practices that will improve outcomes for people with developmental disabilities while offering better conditions for the emergence of valued support workers.

The training is designed as a resource for use by organization managers in the course of their everyday work. Each activity takes one to two hours and can be done within a staff meeting. Activities can be sequenced to support a staff retreat or a more intensive training workshop. All the materials to support the activities are included in the module in the form of PowerPoint shows, reproducible instruction manuals, and reproducible handouts. Each activity invites participants to identify specific action steps that will improve the quality of direct support work. An agency team learns to use the module with the guidance of a more experienced leader and then implements the module in its own workplace.

Good work: Finding Meaning in Providing Direct Support. Based on an approach developed by psychologists Howard Gardner, Mihaly Csikszentmihalyi and William Damon, this module invites organizational teams to discover the sources of meaning and the resources for coping with dilemmas and disappointments available to workers. Its ten activities offer a choice of ways to reflect on and celebrate what matters about direct support work.

We Can! Supporting People to Seek Ambitious Goals. Based on the research of Albert Bandura, this module offers a way to encourage people to pursue ambitious goals. It defines the concept of self-efficacy in the context of direct support work and invites participants to review their organizations to identify and strengthen practices that build a sense of competency to achieve goals that require learning and perseverance.

Learning from High Reliability Organizations. Based on organizational psychologist Karl Weick's synthesis of research into organizations that perform effectively when both the human stakes and uncertainty are very high, this module provides four windows for organizational self-assessment focused on the mindful management of risk. It defines ways of organizing that allow staff to avoid failure and detect and make the most of opportunities for success.

Making Sense of Disability. The activities in this module invite participants to think about the ways that beliefs about disability shape the life prospects of the people they assist and the sort of satisfactions available in direct support work. The module uses a variety of historical materials as case studies to build understanding of the roots of the exclusion of people with disabilities and the importance of commitment to acting on better understandings of disability.

Promoting Resiliency. Based on a growing body of research in developmental psychology and sociology, this module focuses on an approach to dealing with health and safety issues by adopting practices that will strengthen people's ability to cope with difficult life events. The module calls for a resiliency check-up that inventories the protective resources available to a person and identifies actions that will improve resiliency.

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Appendix 7 – MetaStar Training Summary

This Leadership Development training was developed by MetaStar, the Quality Improvement Organization (QIO) for Wisconsin. It is being piloted with members of the Kenosha County Long Term Care Workforce Alliance and will be evaluated.

The training, which uses a train-the-trainers approach, is focused on leadership development for middle management of nursing homes and home health agencies. The curriculum consists of four sessions of about 2 ½ hours each, with homework between sessions. MetaStar will provide free assistance with organizing this training for any group of nursing homes and/or home health agencies. Because of the limits of MetaStar's contract with the federal government, they cannot provide training assistance to other types of service providers; however, curriculum materials are free to anyone in Wisconsin who would like to have them.

Module I: Communication

- Communication PowerPoint
- Group Activities related to communications

Module II: Problem Solving and Conflict Management

- Problem solving and conflict management PowerPoint
- Several group activities related to conflict management and effective problem solving

Module III: Leadership: Developing Skills as a Leader

- Developing skills as a leader PowerPoint
- Group activity: Conflict management tools
- Group activity: Leadership styles orientation
- Caught in the act activity sheet

Module IV: Developing Coaching and Mentoring Skills

- Coaching and mentoring skills PowerPoint
- Several group activities related to coaching and mentoring skills

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Appendix 8 – WETA Training Summary

This training was developed, along with related strategies for retention, by the Wisconsin Education, Training, and Assistance Program, a project of the Wisconsin Alzheimer's Institute. The training is no longer available from this source, but the curriculum is available upon request.

Level I Sessions:
Joint sessions for supervisors and direct care workers:

1. Communication and problem solving: "The Power of Perspective: Communication, Problem-Solving and Personalities
   Communication skills' responding to conflict; approaches to interacting with other people
2. Dementia care: "Creating a Caring Environment"
   Understanding of dementia; philosophy of person-centered care; models of effective care
3. Building teams: "Working Together to Meet the Mission: Creating a Cohesive Team"
   Characteristics of effective teams; team roles and stages of development; benefits of teamwork

Sessions for supervisors:

1. Quality of work life: "Creating a Supportive Environment Through Self-Investment"
   Role modeling; stress and time management; staff recognition; fostering teamwork
2. Manager's role in staff performance: "Connections: Positive Management and Staff Performance"
   Effective methods for hiring, orienting, training, performance reviews, and staff feedback
3. Personal and professional development: "Genuine Leadership"
   Leadership strategies; managing change; developing trust between staff and supervisor

Sessions for direct care staff:

1. Quality of work life: "Believe, Resolve, Take Care!"
   Improving self-esteem; conflict resolution; dealing with aggression; stress management
2. Personal and professional development: "Growing and Becoming Positive, Personal and Professional"
   Accountability; productivity; decision-making; time management; goal setting
3. Caregiver's role in quality of care: "Quality of Care: You Make the Difference"
   Techniques for providing quality care; working cooperatively with families; diversity

Level II Sessions
For supervisors:

1. "Digging Deeper into Communication Skills"
   More in-depth training on communication, including communication across generations and cultures
2. "Developing Leaders"
   More in-depth training on leadership skills
3. "Creativity in the Workplace"
   More in-depth training on developing and supporting creativity

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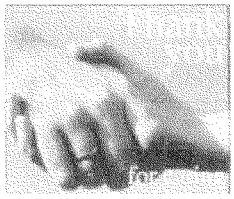
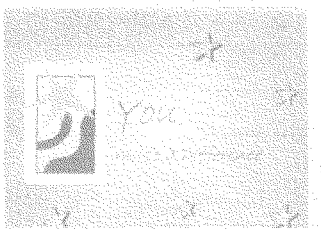
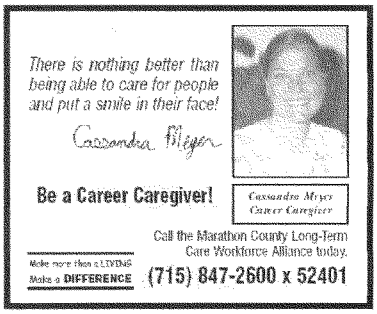
Appendix 9 – Local Image Campaigns

Several local coalitions have conducted public campaigns to improve the image of direct care workers and the work they do. A few selected images from the Kenosha County LTC Workforce Alliance and the Marathon County Long-Term Care Workforce Alliance are shown here.







Appendix 10 – Promising Provider Practices

Although the Committee's charge was to review and make recommendations about public policy within the purview of DHFS, we learned about a number of strategies for improving retention that provider organizations may want to consider. Promising practices that were brought to the attention of the committee and appear to be supported as effective by research include the following. The following is only a beginning list of strategies that employers can undertake to improve retention of workers.

- Improve morale and retention rates by recognizing the valuable contribution of direct care workers to your customers and your organization:
  - Involve workers, who know the consumer best, in care planning.
  - Build respect for frontline workers into organization policies and practices.
  - Thank individual workers for good performance, with words, small gifts, and public praise.
  - Have formal and informal recognition events to reward workers for dedication and quality of care.
- Tie pay and some benefits (e.g., vacation days) to experience, performance and level of training.
- Provide initial and in-service training for all employees that is effective, non-repetitive, and practical. Check to make sure it is absorbed by the trainee.
- Provide training for supervisors in communication, leadership and team-building skills. (Summaries of three of many models are provided above.)
- Relational skills should be supported and nurtured, for both direct care workers and supervisors.
- Encourage continuity in worker assignments within home care and facility-based settings.
- Good screening of workers and good matching of workers with consumers is important to both worker retention and consumer satisfaction.
- Agencies policies should encourage, as much as possible, consumers' choice of home care workers and workers' choice of consumers.
- To assist workers and reduce absenteeism, work with other local organizations and government to make available supports such as child care, health screenings, or a nearby bus stop.
- Consider joining together with other long-term care stakeholders in your community or county to work jointly on direct care workforce issues.
- Keep statistics about your workforce and analyze turnover and retention rates. Try to tie changes in these rates over time to specific strategies you have used, so that you know what works.
- Keep track of the costs of turnover; try to invest some funds in proven strategies for retention, which can be recouped through lower turnover costs.

Appendix 11 – Resources

- The **National Clearinghouse on the Direct Care Workforce** is a web site with a wealth of information about strategies for improving retention, research in this field, and other items of interest. Subscription to their e-newsletter *Quality Jobs/Quality Care* is also available through this site. Links to sponsoring organizations lead to additional information. The address is: http://www.directcareclearinghouse.org/index.jsp

- The **Better Jobs Better Care** web site and e-newsletter also provide timely information, including issue briefs, reports and articles. Connect at http://www.bjbc.org/.

- The **Wisconsin Long Term Care Workforce Alliance** is a statewide coalition across the spectrum of stakeholders, whose mission is to improve the stability and public recognition of the direct care workforce. It also supports local coalitions to work at the community level. Their web site, at http://www.wiworkforcealliance.com/ also includes a news and events section focused on Wisconsin, links to contact information about local coalitions, and more. An e-newsletter is available through this site, along with several community guides, including:
  - Creating Local Coalitions to Address Long Term Care Workforce Issues
  - Improving Public Awareness of Work in Long Term Care
  - Recognizing Direct Care Workers
  - Home Care Cooperatives: Worker Ownership In Focus

- The **Wisconsin Association of Homes and Services for the Aging**'s web site at http://www.wahsa.org/ provides access to several downloadable publications with many ideas for improving workplaces and retention rates. Of particular relevance are:
  - The Gratitude Attitude
  - Enhancing Employment in Long Term Care: A Guide to Retention
  - Models for Practice During the First 90 Days of Employment

- The **Wisconsin Assisted Living Association** (WALA) occasionally offers seminars, open to the public, on workplace philosophy. For a flavor of what this training includes, see the web site at http://www.leadershipthatworks.com/Consulting/FISH!%20Philosophy.htm. Watch WALA's web site at http://www.ewala.org/index.htm for future offerings.

- The **University of Wisconsin Extension** provides an on-line, interactive calculator for determining the direct **costs of staff turnover** to a particular organization. It may be found at http://www.uwex.edu/ces/cced/publicat/turn.html.

- For more information about the **self-sufficiency standard** for various household configurations in each county and tribe of Wisconsin, along with other community-specific information, see another UW Extension web site at http://www.uwex.edu/ces/cced/Indicators_Links.htm#sufficiency.

- Information about the Caregiver Retention Project being conducted by the **Milwaukee Aging Consortium**, including reports of its studies, is available at http://www.milwagingconsortium.org/.

Wisconsin PAS Workforce Library

The following is a list of PAS Workforce resources related to Wisconsin. The list is provided and maintained by the National Clearinghouse on the Direct Care Workforce. Each citation contains an abstract and information about how to obtain the entire version.

Reinhard, Susan, and Robyn Stone. (January 2001). *Promoting quality i The Wellspring model.* The Commonwealth Fund.

Abstract:
This paper primarily highlights the various components of the Wel model, a quality-care improvement program for nursing homes. T model has six core elements: 1) an alliance of nursing homes that committed to making quality care a top priority; 2) shared service geriatric nurse practitioner (GNP) who trains the care teams in ea home; 3) the formation of care teams (multidisciplinary) who lear practices from the GNP and subsequently educate the rest of the staff; 4) networking between facilities to discuss best practices; 5 empowerment of all nursing home staff to make decisions regardi work environment; and 6) continuous monitoring and reviews by regarding performance data on resident outcomes and physical er Although not the main focus of the paper, Reinhard and Stone ma between quality care and CNA empowerment and a link between style and CNA turnover.

Obtain the Full Version:
Available on the web:
www.cmwf.org/usr_doc/reinhard_wellspring_432.pdf

Workforce Development Workgroup. (May 1999). *Workforce developme report.* Department of Health and Family Services.

Abstract:
The Workforce Development Work Group was an official state task brought together to analyze the problem of the direct-care worker and to make recommendations to address the problem of recruitm retention of competent workers. The report is a compilation of suc

Legal Information

Wisconsin Olmstead Plans and Lawsuits

Wisconsin PAS Projects

Research/Demo Projects to Improve PAS Workforce

Wisconsin Resources

Contact Info and Descriptions for all Wisconsin Medicaid Waivers

Wisconsin Agencies Related to PAS

Wisconsin resources for employment of persons with disabilities

Wisconsin Library

PAS Reports and Publications related to Wisconsin

Wisconsin PAS Workforce Library

Wisconsin Links

PAS Web Links Related to Wisconsin

based on discussions with service providers, analysis of research f
focus groups responses. The workgroup made eight general recon
in the areas of recruitment, retention, training, wages and benefit
organizational culture. These recommendations were to assist the
of Health and Family Services in their efforts to begin a dialogue t
State of Wisconsin and provider agencies.

Obtain the Full Version:
To get a hard copy of this report, send you request to:Hollister Ch
Health & Family Services chasehl@dhfs.state.wi.us or call her at 6
8877.

Ondrejka, Jennifer, and Howard Mandeville. (24 January 2002). *A comn*
of the direct service workforce crisis. Wisconsin Council on Developmen

Abstract:
This position statement formulates an approach to the direct servi
crisis guided by the Wisconsin Council on Developmental Disabiliti
values of self-determination, opportunity, independence and inter
and inclusion for people with developmental disabilities. The pape
three goals: to transform direct service work into jobs that are fai
adequately compensated, achievable, and meaningful.

Obtain the Full Version:
Available on the web:
www.wcdd.org/Publications/common_understanding.PDF

Sarbacker, Chris, and Howard Mandeville. (June 2002). *Direct service w*
Survival Coalition of Wisconsin Disability Organizations.

Abstract:
This workgroup paper identifies specific policy changes to improve
and retention of frontline workers providing service for individuals
disabilities by increasing wages and benefits. Recommendations ir
increasing Medicaid waiver rates, including base re-estimate adjus
budgets to account for rising costs, reforming health insurance re
investing in training initiatives to improve organizational support f
service work.

Obtain the Full Version:
Available on the web:
www.dawninfo.org/co/sc/workgroup/issue2_workforce.pdf

Eleson, Charity. (March 2002). *The workforce riddle for counties.* The D
Disability Network, Wisconsin Council on Developmental Disabilities.

Abstract:

This article argues that a real commitment to the Wisconsin Counc
Developmental Disabilities' core values of self-determination, oppo
independence and interdependence, and inclusion can only be rea
substantial funding increases sufficient to fund living wages and h
for direct service workers. Eleson argues that a service system's v
only as effective as the infrastructure, tools, and budget that enac
values.

Obtain the Full Version:
Available on the web:
www.dawninfo.org/advocacy/issues/workforce/workforce_riddle_count

Wenger, Gaye. (March 2002). *The workforce riddle in a rural county*. Th
Disability Network. Wisconsin Council on Developmental Disabilities.

Abstract:
In this autobiographical narrative, Wenger describes the direct se
workforce crisis in the Community Integration Program (CIP) for p
developmental disabilities in Marinette County, Wisconsin, which h
unable to fund wage increases for frontline workers since 1994. W
encourages stakeholders to work together to achieve a living wag
workers, arguing that the workforce crisis is so grave that CIP is u
accommodate any new consumers.

Obtain the Full Version:
Available on the web:
www.dawninfo.org/advocacy/issues/workforce/workforce_riddle.PDF

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qualitative and quantitative methods, and conducted by a team of
from the Institute of the Future of Aging Services (IFAS) sought to
outcomes associated with the model's adoption. Wellspsring is a q
improvement effort of 11 freestanding nursing homes in Eastern V

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Abstract:
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This chart describes existing or enacted direct-care workforce initi state as of March 2004. The information was collected as part of a survey of state initiatives on the long-term care direct-care workf Additional details about this state may be found in the full report.

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January 1999 through December 2002. The workforce projects we
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which strengthen or expand the workforce in their respective com
Awards were granted to projects which were designed to recruit h
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cooperative is organized into three parts. The first gives a backgr
Waushara County, its workforce issues, a description of how the c
was built, and a discussion on the future of cooperative care. Part
summarizes the results of surveys given to cooperative members
their consumers. Part three includes the survey instruments and r

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Wisconsin Strategy.

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training, and lack of opportunity for career advancement and the
rates among frontline caregivers. These high turnover rates are c
damaging to productivity and quality of care.

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Wisconsin: A passion for their work fuels longevity and commitment am

core of workers.

Abstract:
This project looked at worker satisfaction and found that, for a gr
direct support workers, the relationship with their people with dev
disabilities was their primary motivator. This helped mitigate factc
low pay and status with which they were dissatisfied

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Abstract:
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people with developmental disabilities confirm that low wages and
health insurance benefits contribute to high staff turnover rates, p
the continuity of support relied upon by people with developmenta

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on the web at www.wcdd.org
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report investigates what strategies service users and their families
get COP financial support, and how they find and manage persona
workers on their own. The study also looks at working conditions
care workers, and how they get hired.

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Abstract:
This newspaper article from 2002 highlights Cooperative Care's in one of 99 semi-finalists in the 2002 Innovations in American Gove Awards, a program of the Institute for Government Innovations at University's John F. Kennedy School of Government. The article al brief summary of Cooperative Care, and its success in achieving b more benefits for home care workers.

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Abstract:
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this study was commissioned as a follow-up to the Phase I and Ph
nursing home staffing studies conducted for the Centers for Medic
Medicaid Services by Abt Associates. The researchers surveyed all
mandating minimum staffing ratios and conducted case studies of
(Arkansas, California, Delaware, Minnesota, Missouri, Ohio, Vermc
Wisconsin) that either instituted, modified or eliminated nursing sl
recent years. The report concludes that minimum staffing ratios c
impose a standard on facilities that have inadequate staffing, but
are not the only factor affecting the quality of care residents recei

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Abstract:
This study examines the factors that make caregivers stay in their
study includes a literature review, focus groups with caregivers, e
forums, educator and trainer forums, and a caregiver survey. The
the need to foster new models of community collaboration througl
stakeholder coalitions. These coalitions are essential to achieve th
identified in the study: the need for support services, supervisor t
career ladder development/improved wages and benefits. For a cc
Caregiver Survey click here

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Available on the web:
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Wisconsin Long Term Care Workforce Alliance. (January 2004). *Creating address long term care workforce issues.*

Abstract:
This guide describes how community members with common inter
form local alliances to create locally-tailored solutions to direct-ca
problems. It identifies potential coalition members and recommen
get started and maintain interest. It also describes five local coalit
currently active in Wisconsin.

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http://www.directcareclearinghouse.org/download/Alliance Newsletter-

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This guide describes Kenosha County's experience as one example local stakeholder coalition can do to improve public awareness of t role that direct care workers perform in the lives of older persons with disabilities. It describes the strategies, campaign goals, targe methods and theme of the county's 'Make More Than A Living: Ma Difference' campaign.

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http://www.directcareclearinghouse.org/download/Alliance Newsletter-

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Abstract:
In 2001 the Centers for Medicare and Medicaid Services (CMS) aw Choice Systems Change (RCSC) Grants to states and other entitie improve state long-term care systems. Twenty grantees began on initiatives to improve the recruitment and retention of direct servi This report focuses on the workforce initiatives of these 20 grante in-depth look at 7. The report strongly recomends that policymake providers, and consumers address workforce problems.

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This report identifies a range of workforce improvement initiatives level to reduce high vacancy and turnover rates among direct-car improve the quality of their jobs. The report summarizes the expe five states (California, Massachusetts, North Carolina, Pennsylvani Wisconsin) that have pursued several strategies to address the se shortage of direct-care workers.

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Abstract:
This paper explores the use of worker-owned home care cooperati strategy to create a more stable long-term care workforce. The au highlight three different models of worker-owned home care coop job-training model, the cooperative conversion model, and the mu stakeholder model. The authors argue that home care cooperative workers a number of benefits including: living wage jobs, a demo organizational culture, and the opportunity to take part in quality

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Abstract:
A new report released by the Wisconsin Hospital Association (WH immediate action to address growing shortages in the health care including those in long-term care. The report found that hospitals able to fill vacant positions due to a shrinking applicant pool as ex knowledgeable employees retire. WHA suggests that finding a vial lasting solution to ensure an adequate health care workforce will collaboration among health care providers, educators, and state g officials. Some of the action steps they suggest to improve recruit include: support new entrants in the health care workforce, encou educational strategies, and continue efforts to create interest in h careers.

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Available on the web:
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Wisconsin. The one-page fact sheet also comments on pay, turno
steady rise in employer expenses.

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Available on the web:
www.wiworkforcealliance.com/advocacy/factsheet.pdf

Direct Care Workforce Issues Committee. (June 2005). *Strengthening W care workforce.* Wisconsin Council on Long Term Care Reform.

Abstract:
This paper discusses Wisconsin's direct-care worker staffing short highlights the effect of shortages on agencies, family caregivers, a quality of care for consumers. The authors suggest that without se intervention, staffing shortages in Wisconsin will worsen. To chang author recommends that employers improve compensation, offer create career ladders for workers.

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Kathleen McGwin. (May 2005). *The possibilities of relationships.* Cooper

Abstract:
This article, written by Kathy McGwin of Cooperative Care, a work home care cooperative, discusses the importance of relationships care. McGwin looks at how maintaining positive relationships withi environment is key to retention and quality care. She suggests th should set personal goals about their motivations in life and apply everyday relationships with people and at work.

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Abstract:
In an effort to better understand the makeup of the home and cor based long-term support workers, Wisconsin conducted an on-line July 2004. Each county's lead agency administering the state's Co Options Home and Community Based Waiver was asked to fill out This report provides an overview of the ways in which counties pu

care and support services for elderly people and people with disab
the Community Option and Home and Community Based Waiver F

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dhfs.wisconsin.gov/aging/directcare.pdf

Center for Health Workforce Distribution Studies, University of Washing
(November 2004). *Effects of the Workforce Investment Act of 1998 on l*
development in the states. Health Resources and Services Administratio
Health Professions, Health Resources and Services Administration.

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employment, retention, and earnings of participants in Departmer
(DOL) employment and training programs. This report explores hc
resources have been used to support the healthcare workforce ac
states, including, but not limited to, the direct-care workforce.

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Available on the web:
bhpr.hrsa.gov/healthworkforce/reports/wia/wia.htm

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assistants. AARP Public Policy Institute.

Abstract:
This report examines certified nurse aide (CNA) training programs
Information was gathered by interviewing key informants, includir
experts in CNA training and testing. Recommendations include inc
federal requirement for initial training to at least 100-120 hours, e
CNAs are reimbursed for the cost of training, and screening trainir
applicants to identify needs such as remedial English or ESL classe

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Available on the web:
www.aarp.org/research/longtermcare/nursinghomes/2006_08_cna.htm

Whitaker, Julie. (2002). *Preventing a "revolving door" workforce: Lesso*
literature. Bureau of Aging and Long Term Care Resources, Wisconsin D
Health and Family Services.

Abstract:
This article analyzes the causes of high turnover among direct-car
through a review of literature and research. According to the auth
promising strategies for reducing turnover are rooted in improving
pay and benefits, building opportunities for broader worker partici

providing meaningful training. The article also provides examples
cooperatives, which have been successful in reducing turnover rat

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Bridges, Tameshia and Carol Regan. (February 2007). *Subsidizing healt coverage for the home care workforce in two Wisconsin counties: An an* Health Care for Health Care Workers.

Abstract:
This report describes a provider employer organization (PEO) in W makes affordable health insurance available to home care workers union-sponsored PEO, will offer insurance to home care and child providers and aims to lower the cost of coverage through a purch and subsidization. The paper provides background information on workforce and TRIADA, analyzes potential sources of funding for s and recommends options in making health insurance affordable.

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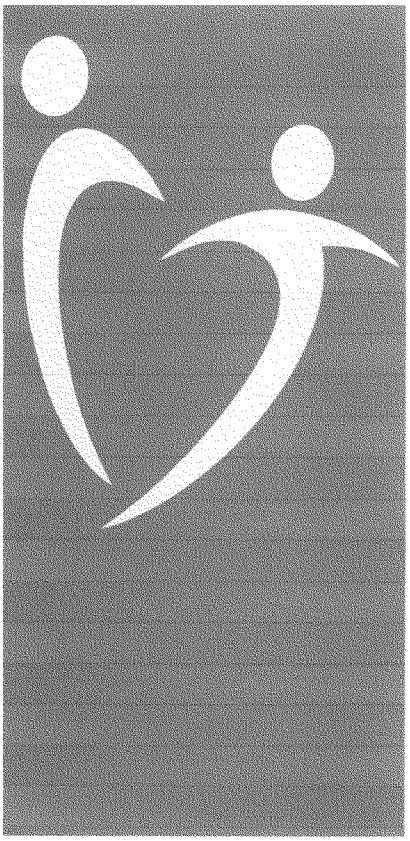

Subsidizing Health Insurance Coverage for the Home Care Workforce in Two Wisconsin Counties:

An Analysis of Options

Prepared for:
The Wisconsin Regional Training Partnership

By the:
Paraprofessional Healthcare Institute
Health Care for Health Care Workers Initiative

October 2006

HEALTH CARE *for* Health Care Workers
An Initiative of the Paraprofessional Healthcare Institute

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Subsidizing Health Insurance Coverage for the Home Care Workforce in Two Wisconsin Counties:

An Analysis of Options

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Health Care for Health Care Workers, a campaign to expand access to affordable health insurance coverage for the direct-care workforce, is an initiative of the **Paraprofessional Healthcare Institute** (PHI). The nonprofit PHI works to strengthen the direct-care workforce within our nation's long-term care system. PHI's program activities include developing innovative approaches to recruitment, training, and supervision; client-centered caregiving practices; and effective public policy. Our premise is that creating quality jobs for direct-care workers is essential to providing high-quality, cost-effective services to long-term care consumers.

Wisconsin Regional Training Partnership (WRTP) is a non-profit membership organization that is dedicated to family-sustaining jobs in Wisconsin. It develops programs that help employers and union members expand employment and advancement opportunities. Through WRTP employers are able to upgrade the skills of current employees and recruit and retain qualified job candidates. WRTP's programs prepare low-income, unemployed, and young workers for careers in a wide range of targeted industries. WRTP created TRIADA, a nonprofit professional employer organization or PEO. It contracts with employers, for a set fee, to help improve recruitment, training, and retention of a quality direct-care workforce. TRIADA, as a co-employer of employees, can take responsibility for many personnel matters such as health benefits (see www.wrtp.org).

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Introduction

The high cost of health insurance is a serious issue in Wisconsin. Two groups that have particular difficulties in obtaining affordable coverage are home care providers (e.g., small businesses) and their employees (e.g., low-wage service workers). As small businesses, home care agencies find it particularly difficult to purchase employer-sponsored insurance (ESI) for their employees, and when offered, many employees are unable to participate given the high cost of premiums, significant out-of-pocket costs, and eligibility status. Yet providing health insurance for direct-care workers may play a stronger role in reducing turnover and increasing retention than increasing wages alone. As Wisconsin works towards identifying strategies to meet the increasing demand for direct-care workers,[1] supporting access to affordable health insurance will prove beneficial to employers, workers, and consumers alike.

The purpose of this paper is to identify possible options for subsidizing health insurance for the home care workforce in Milwaukee and Dane counties under an innovative purchasing arrangement—a union-sponsored Professional Employer Organization (PEO)—created by the Wisconsin Regional Training Partnership (WRTP), the nonprofit training organization affiliated with the Wisconsin AFL-CIO. One of the objectives in creating the PEO was to offer affordable health coverage to home care workers beginning July 2006. The WRTP PEO, TRIADA, is unique from other PEOs because it will work in partnership with the Service Employees International Union (SEIU) to provide health insurance through SEIU's national Health Care Access Trust.

To provide a context for understanding the various options for subsidizing worker and employer health care premiums, this paper is divided into four parts:

- Background on the home care workforce and the availability of health insurance coverage for these workers;
- Description of the TRIADA PEO;
- Analysis of potential sources of funding to subsidize employee and employer premium costs; and
- Recommended options for the WRTP to consider in making health insurance affordable for this market.

The Home Care Workforce and Health Insurance Status

Home Care Workers in Wisconsin

Home care work is one of the fastest-growing jobs in America. The most recent data from the U.S. Bureau of Labor Statistics (BLS) indicate that there are 12,990 home health aides and 19,150 personal and home care aides in Wisconsin.[2] However, because this data only includes home care workers employed by agencies and does not count those who are independent providers employed directly by consumers, the total workforce is estimated to be much larger.[3]

Home care work is primarily low wage and part-time. The average wage of personal and home care aides in Wisconsin is $9.17, with a mean annual income of $19,080. Home care workers average fewer weeks of employment and fewer hours per week compared to direct-care workers in hospitals or nursing facilities. Nationally only one-third of home care workers are employed full-time, year round.

An in-depth, statewide picture of the home care workforce in Wisconsin is not available. However, a study of direct-care workers from 11 agencies across long-term care sectors (including residential care) in Milwaukee found the following:[4]

- Over one-third of direct-care workers surveyed (37.5 percent) received coverage from their employer; more than one-quarter were uninsured (27.5 percent); and 12.3 percent were covered by Medicaid.
- Of those surveyed, 26 percent reported annual incomes under $15,000, and 35 percent reported annual incomes between $15,000 and $25,000.
- Half of those surveyed had a child under the age of 18; nearly half said they were single (45 percent); and 29 percent identified themselves as married.
- The average age of home care workers who answered the survey was 52 years.
- Home care workers reported working on average less than 31 hours/week.

Health Insurance Availability

Wisconsin has one of the lowest rates of uninsured residents (11 percent) in the country, in part because of the high rate of employer-sponsored health coverage.[5] A study by state of Wisconsin found that 40 percent of the uninsured population in the state is childless adults, most with incomes less than 200 percent of the federal poverty level (FPL).[6] Many of these workers are employed by small businesses, which have difficulty accessing affordable health plans. As childless adults, they also do not qualify for Medicaid coverage (see page 7).

As the Milwaukee study cited above suggests, direct-care workers in Wisconsin are uninsured at a rate that is more than twice that of the overall uninsured population (27.5 percent vs. 11 percent)—and the rate for home care workers is likely even higher. Despite their low incomes, only 12 percent of direct-care workers in the Milwaukee study were covered by Medicaid, possibly because many do not have children under age 19 and therefore are ineligible. Certainly, a major reason for this high rate of uninsurance among direct-care workers is that they are employed by small businesses that, like other small businesses, increasingly cannot afford to offer coverage to their employees.

Small businesses face particular challenges in obtaining affordable health insurance coverage. Barriers for small employers include the size and characteristics of the company's workforce and the administrative and claim costs associated with providing health insurance. For small businesses, premium costs generally end up being slightly higher than for large employers.[7] Wisconsin does not regulate insurance for the small group market—for example, through community rating, guaranteed issue, and/or guaranteed renewability—though this kind of government regulation has been shown to improve access to affordable coverage. As a result, less than half (46 percent) of small employers provide health insurance, as compared to 98 percent of large employers.

Home care workers are at a disadvantage for another reason as well. For workers employed by firms with a majority of employees earning less than $10/hour, premium costs for employeees are much higher than average, as shown in Table 1. However, even with employees picking up a larger share of the premium, small home care employers whose revenue primarily comes from Medicaid reimbursement simply cannot afford their share of rapidly rising health care premiums.

Table 1

Average Premium Costs for Workers in Low-Wage Establishments: Wisconsin 2004[8]

	All private-sector establishments		Private-sector establishments at which a majority of workers earn less than $10 per hour	
	Total Premium	Worker's Share	Total Premium	Worker's Share
Single Coverage	$3,927	$795	$3,779	$1,037
Worker plus One	$7,491	$1,712	$6,537	$2,085
Family Coverage	$10,146	$2,193	$10,712	$3,140

To address the need for affordable coverage for home care employers and their workers, the Wisconsin Regional Training Partnership (WRTP) created TRIADA, a professional employer organization (PEO) that will offer insurance to both home care and child care providers. TRIADA will be able to lower the cost of health insurance options for this segment of the market through group purchasing. A purchasing pool alone, however, is not necessarily capable of sufficiently lowering costs to make health coverage affordable to these small businesses and their employees. By pairing the pool with a subsidy that lowers the cost of insurance to home care agencies and low-income workers, TRIADA may be able to further stimulate demand, increase market share, and lower administrative costs.[9, 10]

TRIADA: WRTP's Professional Employer Organization (PEO)

The WRTP is a nonprofit membership organization of employers, unions, and associations that develops programs to help union members expand employment and advancement opportunities and upgrade their skills, and helps employers recruit and retain qualified job candidates. The WRTP has three main goals: to preserve quality jobs in the community; to improve access to jobs in targeted sectors of the regional economy; and to operate a PEO to provide health benefits and other human resource services to human services agencies.

A PEO is a business model that many small private sector businesses use to reduce administrative costs. It is a co-employment strategy that allows multiple employers to purchase human resource services from a single entity, reducing the costs for individual agencies. The PEO is more than a human resources provider, however. Direct-care workers employed by participating home care agencies have two employers: the PEO for purposes of payroll, benefits, and other HR services, and the agency for purposes of hiring and daily supervision. Provider agencies still manage all aspects of the day-to-day operations of their agencies; the PEO provides economies of scale in administration.

WRTP's PEO differs from other PEOs in several key ways. First, its mission is to improve human resource services, so costs to providers are kept to a minimum and the PEO's finances are transparent to participating agencies. Second, it will focus on services that improve the jobs of direct-care workers: health insurance and other benefits that are crucial for worker retention. Third, in partnership with employers who already receive public funds to provide services, it is in a position to seek private and public funding to support implementation and services.

In 2004, with health insurance premiums in Milwaukee 55 percent higher than those in other large Midwestern metropolitan areas and premiums for small and midsize employers expected to rise 23 percent,[11] WRTP set up a PEO to explore alternatives to insurance available in the small-group market, particularly for human service providers.

The PEO will have a collective bargaining agreement with SEIU, thus allowing employees, as union members, access to the SEIU Health Care Access Trust (HCAT), SEIU's new health plan with United Health Care. The Fund will offer multiple plans with different benefit packages including medical, dental, vision, and prescription drug coverage. Price of the plans will range from $20 per member per month (pmpm) for family coverage in the discount Lilac plan to $260 pmpm for medical, dental, vision, and prescription drug coverage for a single adult under the full coverage Violet Plan. United Health Care will handle claims and enrollees will have access to UHC's extensive provider network. Further description of the plan options is available in the **Appendix A** and premium costs for the Violet plans are detailed in **Table 2** (see p. 9).

Potential Sources of Public Funding to Subsidize Insurance Costs

Basically, there are three ways to subsidize health insurance costs:

1. Assist workers in paying the employee share of the health insurance premium;
2. Assist home care agencies through an increase in the Medicaid reimbursement rate targeted specifically to pay for health insurance costs;
3. Provide reinsurance to help lower premium costs by "insuring the insurers."

The first two options rely on Medicaid funding, the federal–state program that pays health care providers to deliver health and long-term care services to frail elderly, people with disabilities, low-income families with dependent children, and certain other children and pregnant women. Notably, Medicaid is the program that insures low-income families (and many home care workers fit this category) and supplies the primary revenue stream for home care agencies that provide long-term care services. As a state/federal partnership, the state pays 42 percent of Medicaid costs and the federal government pays 58 percent.[12]

Premium Assistance for Workers

Wisconsin's Medicaid Program for Low-Income Families

Wisconsin's Medicaid program includes Medical Assistance (standard fee-for-service Medicaid) and BadgerCare, a managed-care program that provides wider eligibility but requires families to pay a monthly premium. As of December 2005, 647,000 low-income Wisconsin residents were enrolled in Medicaid. Another 91,000 low-income, working families were enrolled in BadgerCare.[13]

The Medicaid benefit package, which is the same for Medical Assistance or BadgerCare, is comprehensive, covering a wide range of services including physician and hospital care, diagnostic tests, vision, dental, and prescription drugs[14] (see **Appendix B**). Eligibility requirements for Medicaid are as follows:

- Low-income adults with a disability, as determined by receipt of Supplemental Security Income (SSI) or other factors, are eligible for Medical Assistance.
- Children (up to age 19) and their families with incomes below the federal poverty level (in 2006, the FPL is $9,800 for an individual and $3,400 is added for each additional person) are eligible for Medical Assistance.
- Children (up to age 19) and families with incomes below 185 percent of FPL ($30,710 for a family of three; $37,000 for a family of four) are eligible for BadgerCare.
- Childless adults without disabilities are not eligible for Medicaid.

Home care workers who meet the categorical and income requirements are eligible for Medicaid coverage. As noted above, in Milwaukee, 12 percent of direct-care workers across all sectors currently obtain insurance through the state's Medicaid programs.

States have the option of providing premium assistance to all Medicaid eligibles under a Health Insurance Premium Payment program under Section 1906 of the Social Security Act. Premium assistance programs use public funds to subsidize the employee's contribution for private or employer-sponsored insurance. Wisconsin has opted to roll their HIPP program into BadgerCare and offer it to families with incomes below 185 percent of FPL.

BadgerCare and HIPP. The BadgerCare program began in July 1999 as an 1115 waiver to expand Medicaid eligibility to families with children under age 19 with incomes up to 185 percent of the FPL. Once enrolled in BadgerCare, families can maintain their eligibility until their income reaches 200 percent of FPL. As an 1115 waiver, BadgerCare qualifies for higher federal match than the traditional Medicaid program, with 71 percent of costs paid by the federal government.

Families enrolled in BadgerCare pay a monthly premium. The Wisconsin Department of Health and Family Services works in cooperation with employers to collect the premium through wage withholding or through electronic funds transfer from the member's checking or savings account.

Coordination with employer-sponsored insurance (ESI) is an integral part of the BadgerCare program. ESI is defined by BadgerCare as "family coverage under a group health insurance plan offered by an employer for which the employer pays at least 80% of the cost, excluding any deductibles or co-payments."[15] If the employer pays more than 80 percent of the ESI premium, employees are not eligible to participate in BadgerCare. There are no specifications as to level of coverage provided under ESI.

For workers whose employers pay between 60 percent and 80 percent of the premium of ESI, premium assistance is available under BadgerCare through the HIPP program. Eligibility for HIPP is based on the following criteria:

- Families with children under 19 with incomes up to 185 percent of FPL *(childless adults are not eligible for HIPP)*;
- Access to an ESI that is subsidized by the employer at 60 to 80 percent of the premium cost;
- Uninsured for six months prior to application.

If the state Medicaid agency determines that it is more cost-effective than providing coverage directly through BadgerCare, HIPP will pay the full employee cost for ESI, including the premium, co-insurance, and deductible. In addition, if the employer-sponsored plan does not cover the same benefits as the BadgerCare program, the state will provide wraparound coverage for non-covered services. As of March 2006, 1,388 individuals, representing 381 families, were enrolled in the HIPP.[16]

Subsidizing Employee Premiums through Medicaid

The BadgerCare HIPP program is a potential source for subsidizing the premium for eligible workers who are covered under health insurance plan offered through the PEO. There is no cap on enrollment into HIPP. When discussing the HIPP program with Wisconsin Department of Health and Family Services (DHFS) staff, they expressed interest in finding ways to increase enrollment in the program.

The ability for BadgerCare HIPP to support workers enrolled in coverage through the WRTP PEO will depend on two factors. First, BadgerCare is only available to families with children under age 19 with incomes up to 185 percent of FPL. While many home care workers will meet the income eligibility requirements, many will not qualify because they do not have minor children. HIPP could potentially support approximately half of the employees and their families. Arranging subsidies for low-wage childless workers would then need to be addressed.

Second, the state would need to determine if the PEO meets the state's ESI criteria that the employer must pay 60 to 80 percent of the premium. As currently structured, the PEO offers two types of plans (see **Appendix A**). The lower cost Lilac plan would not meet the definition of ESI as

it is not a health insurance product but rather provides access to certain services at a discount. Violet plans that provide insurance coverage for employees and their families would be eligible for HIPP assistance. **Table 2** shows the estimated premium amounts for the coverage categories for the Violet plans, and how much the employer would have to pay in order for it to meet the 60 to 80 percent requirement.

Table 2

Premium Costs of the Five Violet Plans Estimates of Employer Share at 60 and 80%

Type of Coverage	Violet A	Violet B	Violet C	Violet D	Violet E
Employee and Children					
Full Cost	$121.88	$146.25	$213.28	$273.00	$383.91
60%	$73.12	$87.75	$127.96	$163.80	$230.34
80%	$97.50	$117.00	$170.64	$218.40	$307.12
Family					
Full Cost	$219.83	$263.70	$384.69	$492.41	$692.45
60%	$131.89	$158.22	$230.84	$295.44	$415.47
80%	$175.86	$210.96	$307.92	$393.92	$553.96

The BadgerCare HIPP program could further benefit eligible workers by providing wrap-around coverage for services not provided by their insurance plan and paying the deductible and co-payments for covered services. **Appendix B** compares the benefit package of the Violet plans and the BadgerCare benefit. As can be seen in this table, BadgerCare provides a number of additional benefits, including family planning services, physical therapy, and vision care.

Given the wrap-around nature of the HIPP program, home care employers would get the maximum state assistance by offering their employees the Violet A plan. For employees, services not covered under Violent A plan would be provided by BadgerCare. At the same time, employers would be able to keep their costs relatively low per employee.

"Premium Assistance"—or Subsidies—for Employers

Medicaid pays for the majority of Wisconsin's home care services. The reimbursement formula—i.e., the amount agencies receive for providing services—does not include the cost of health insurance for direct-care workers. To look at how Medicaid rates might be increased to help employers cover the cost of health insurance for employees, first it is important to understand how the state structures its Medicaid-funded home care services. Appendix C provides an overview of Wisconsin's community-based long-term care programs that provide home care services.

Medicaid-Funded Home Care Services

State Medicaid-funded home care services include both fee-for-service and managed-care programs. The Community Options Program (COP) and HCBS waiver programs, administered by county agencies, provide care on a fee-for-service basis. The state Department of Health and Family Services (DHFS) annually allocates funding to counties for these services based on the

previous year's utilization and projections for the current year. Counties then negotiate rates with provider agencies for the services provided. Counties are allowed to contribute their own funds to provide services as well. Counties must assure that funds are spent on services in accordance with the State's Allowable Cost Policy, a formula for determining rates. This policy sets the methodology for how counties determine the rate for services but not what counties pay; therefore, rates vary by county.

Family Care is a combination 1915(b)/(c) Medicaid waiver that provides home- and community-based services as a managed-care program. The state pays a capitated rate for services to the Care Management Organization (CMO), and then the CMO negotiates rates with providers. These capitated rates must be actuarially sound, as determined by an independent actuary, and be approved by CMS. At this time, the CMO in Milwaukee County is the Milwaukee County Care Management Organization under the Milwaukee County Department on Aging. Dane County is not yet in the program, but Family Care is expected to become a statewide program in the near future. As a statewide program, Family Care will be administered regionally as opposed to the current county-based structure. To facilitate this regional approach, DHFS recently awarded planning grants to 10 regions across the state to begin to develop strategies to expand Family Care and other long-term care reform measures. Milwaukee and Dane counties both received expansion grants.[17]

Premium Assistance through Increased Rate Payment to Home Care Employers

To assist employers in covering the cost of the PEO health insurance plan, WRTP could explore an increase in payments received by providers from the state's long-term care financing programs.

Wage pass-through for fee-for-service programs. One method of providing an increase in provider payments is through a wage pass-through designated for health insurance coverage for home care workers who provide services to individuals in the fee-for-service community-based long-term care programs. A pass-through is a designated funding allocation provided through Medicaid reimbursement for the specific purpose of increasing wages and/or benefits to direct-care workers. States can use two approaches in implementing a pass-through:

1. Designate a certain amount of the Medicaid reimbursement towards worker wages and/or benefits; or
2. Require that providers spend a percentage of an increase in the Medicaid reimbursement towards benefits. To determine the appropriate funding level, further work would need to be done with PEO-participating employers to calculate current reimbursement rates and the additional cents/hour or fee per enrollee that would be necessary to cover health care premiums.

California and Washington State both offer health insurance coverage to home care workers funded through the Medicaid reimbursement rate. In Washington for SFY 2007, the Department of Social and Health Services is paying home care agencies a maximum of $413.14/month per employee to cover health insurance for home care workers employed for at least 20 hours/week.[18] Health insurance benefits for independent providers† (IP) in the In-Home Supportive Services

† The term "independent providers" refers to direct-care workers who are hired directly by the consumer to provide services.

(IHSS) program in California are funded by both state and federal funds. California includes the cost of wages and benefits for IP providers in calculating the total cost of the services to IHSS consumers, thus picking up federal Medicaid funds to match state and county expenditures.[19]

In discussing the feasibility of a pass-through for health insurance coverage with representatives from the DHFS, several challenges were identified. First, the state's Medicaid waivers apply statewide; therefore, to increase the rate for two counties participating in the PEO, while not doing so for the rest of the state, may require approval from CMS. Second, DHFS believes that an enhanced rate for health insurance coverage would not meet the State's Allowable Cost Policy designating that counties must spend funds directly on services to clients.

DHFS also noted that any wage pass-through would be dependent on the legislature, not the department, designating specific funds. Moreover, a previous 5 percent wage pass-through for certified nursing assistants employed by nursing homes included in the state's 1999-2001 budget appears not to have been entirely successful. That wage pass-through allowed DHFS to increase the Medicaid allocation to counties specifically to increase wages for workers. While no formal evaluation is available, discussions with advocates suggest that a majority of the increases did not go to workers but simply enhanced the rate paid to providers. This is a common challenge for states implementing wage pass-throughs and indicates why such legislation should have a built in mechanism for monitoring and ensuring the goal of the pass-through is achieved.[20]

Rate enhancement through family care. Another option to explore is a rate enhancement for health insurance coverage for workers providing services in the Family Care program. This would have to be tied to the capitation rate the state pays to the CMO; the 2006 CMO capitation rate for Milwaukee County is $2,055.01/pmpm.[21]

Under the Family Care Program, a rate enhancement would require overcoming several obstacles. First, under the current Family Care contract—the document that details the program services and how the rate is set for services—CMOs cannot pay providers more than the Medicaid fee-for-service rate for services unless DHFS approves a higher rate. A higher rate may be granted if it will increase quality or if can be shown that the availability of providers is not sufficient at the current rate.

Second, a rate enhancement would require additional negotiations between the state and CMS, which must approve any amendment to the existing waiver contract. CMS has very specific requirements for capitation rate enhancements under managed care.[22] Rate enhancements to contractors under managed care are called incentive payments. These payments cannot be more than 105 percent of the approved rate. In addition, incentive payments must:

1. Be for a set period of time;
2. Not be automatically renewable;
3. Be made available to public and private contractors;
4. Not be conditioned on intergovernmental transfer agreements; and,
5. Be necessary for specific activities or targets.

Local or county funding. In addition to exploring an increase in state-level support, it may be beneficial to look to local funding sources for support of TRIADA's health insurance plans. Counties have some discretion in how they allocate funds for long-term care services. Since TRIADA is initially starting in Dane and Milwaukee counties, it would be beneficial to begin developing relationships with the aging divisions in these counties to gain support and gauge their interest in supporting health insurance coverage for home care workers in their counties. With success at the local level, the insurance program may garner increased support from DHFS or in the legislature.

One way to consider building local support is through the local planning efforts to expand the Family Care program. As the state embarks on significant long-term care reform and the expansion of the Family Care program, WRTP may want to consider getting involved in some of the regional planning grant work to promote living wage standards for direct-care workers in the program. Although it may not result in immediate funding for the WRTP PEO, such involvement would highlight the need for workers' wages and benefits to be considered in the rate setting and contract parameters of future Family Care sites.

Public Reinsurance Reform Proposal

The PEO may also be able to lower costs by taking advantage of the state's newly proposed reinsurance program.

Recognizing the continuing need to address the challenges that small businesses face in finding affordable health insurance, Governor Jim Doyle signed an Executive Order in July 2006 establishing the "Healthy Wisconsin Council," which is tasked with establishing the structure and funding of the Healthy Wisconsin Program. Healthy Wisconsin will be a reinsurance program that will cover the costs of catastrophic care. The council is to complete its work by December 2006, in order for the program to receive legislative funding in the 2007-2009 biennial budgets. In addition, federal funding for this program will be explored through an 1115 waiver, which could generate new federal matching funds for existing health care expenditures.

Reinsurance is essentially insurance for insurance companies. It allows an insurance company to contract with a separate company or entity to transfer all or part of their risk or liability for high-cost, catastrophic health care claims. The reinsurer would then be responsible for payment of the high-cost claims.

The goal of reinsurance programs is to stabilize or reduce health insurance premiums by keeping health care costs at a manageable and predictable level for insurance companies and businesses. Reinsurance plans are becoming of greater interest to states as they attempt to address the challenges that small businesses and low-wage workers face in obtaining affordable health insurance coverage. When the details of the Wisconsin reinsurance plan become available in early 2007, the potential cost impact on premiums for the PEO should be analyzed.

Additional Sources of PEO Funding

Additional support for the PEO's health insurance plans may be available through local, federal, or private sources.

- The successful lobbying of the Wisconsin Federation of Cooperatives (WFC) that resulted in the creation of Co-Op Care provides a model for potentially gaining federal and state support for the WRTP PEO. Co-Op Care is a pilot project of five health insurance purchasing cooperatives aimed at dairy farmers in Wisconsin. WFC was successful in highlighting the need for affordable health care among farmers in Wisconsin and gaining the attention of U.S. Senator Herb Kohl for funding and Governor Doyle to initiate the pilot. Funding for Co-Op Care is primarily from federal appropriations ($4.5 million) and other state grants related to agriculture.[23] At this time, health insurance available through Co-op Care is targeted to dairy farmers and the organization does not anticipate making it available to other cooperatives, such as home care cooperatives currently operating in Wisconsin.[24] Given the anticipated growth of Family Care and other rebalancing efforts for community-based care, the WRTP PEO could pursue similar support. By highlighting the need and shortage of direct-care workers, the WRTP may be able to gain attention of legislators and other government officials to sponsor the PEO's health insurance product.
- In New York, a three-year, state-funded demonstration program allocated $200 million to address home care worker recruitment and retention. Employers of personal care aides in cities and counties with populations of one million or more received funds to provide continuous health benefits to home care workers and to evaluate the impact. The demonstration successfully showed greater job satisfaction largely due to seamless access to health benefits[25] and increased tenure among personal care aides. Pilot projects such as this could be pursued in Wisconsin to meet the state's twin goals of insuring the working uninsured and ensuring a stable, quality long-term care workforce.

Conclusion: Recommended Options for Subsidizing PEO Premiums

A series of pilot programs financed by private and public funds have tested options to increase coverage of the uninsured by combining group purchasing and premium subsidies for small employers and individuals.[26] The key lessons learned from these programs, which can be applied in shaping the TRIADA program are:

* The larger the subsidy for low-wage workers, the higher the participation rate;
* Small employers will participate if (a) they feel the amount they must contribute is affordable and predictable, and will remain so over time; and (b) their administrative burden is minimized and simplified.

To make the PEO a success, WRTP needs to explore potential subsidies for home care workers and their employers to cover their health care premiums. As discussed above, WRTP should explore three possible alternatives:

1. Direct premium subsidies for home care workers, which could be provided through the Badger Care HIPP program. The challenge with this subsidy program is that it would likely cover only half the workforce, as adult workers without children are not eligible for premium assistance.
2. An increase in the Medicaid rate for home care providers, designated specifically for health insurance benefits. Challenges here include (a) building legislative support and then ensuring that a wage-pass through is in fact applied to health insurance premiums, and (b) negotiating rate increases, in the case of managed long-term care, with CMS.
3. Seeking additional private and public support by showing that health insurance is essential to attract and retain the home- and community-based workers Wisconsin needs to provide quality long-term care.

The PEO is a clear example of the kind of innovation that the state should support to improve recruitment and retention of direct-care workers, reduce administrative inefficiencies, and support quality care for Wisconsin's elderly and disabled population. In partnership with SEIU, it offers an innovative model for providing coverage with a range of health insurance products that are affordable to home care employers and their workers. This range of options will allow the PEO, and its participating employers, to offer plans that build on each other and can be improved over time. The key to the PEO's success is ensuring that premium levels are affordable to low-wage workers and to the publicly funded agencies providing human services in the community.

Endnotes

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3. National studies have indicated that the number of homecare workers can be four times higher than those identified by traditional studies. There are an estimated 4,200 independent home care workers in Wisconsin's Community Options Program and related HCBS waiver programs; approximately 1,000 are in Milwaukee County. The PEO discussed in this report will not provide coverage to independent providers.

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14. For a full description of the Wisconsin Medicaid program, see http://dhfs.wisconsin.gov/Medicaid/index.htm

15. Wisconsin State Statutes. Chapter 49, Public Assistance, Section 49.665(1) (c).

16. Personal email correspondence with Greg DiMiceli from the Wisconsin Department of Health and Family Services, April 10, 2006

17. The following regions/lead organizations received Long-Term Care Planning Grants: West Central Wisconsin Care Management Collaborative, Community Care of Central Wisconsin, Northwest Long-Term Care Options, Southwestern Care Management Coalition, Southeast Wisconsin Care Management Organization, Dane and Rock Counties, Family Partnership Care Management Organization, Milwaukee County, West Central Consortium for Long-Term Support and Health Care Reform, and the Northeast Wisconsin Long-Term Care Consortium. A map indicating all regions receiving planning grants is available at http://dhfs.wisconsin.gov/managedltc/grants/pdf/map.pdf

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Appendix A – Description of Plans Offered through the WRTP PEO*

Lilac Plan

Lilac provides information, support, and guidance to assist in gaining access to the health care system, and provides financial savings for health and well-being services. The plan focuses on the opportunities for the lowest income workers with the least or no employer support. Lilac focuses on health care access and direct services, not traditional insurance, because the existing health care delivery system, unless obtained through public sponsorship, is too expensive.

NurseLineSM*	24-hour telephone access to registered nurses. Help with caring for minor illnesses and injuries, understanding diagnosed conditions and chronic diseases; discovering and evaluating possible benefits and risks of various treatment options; learning about specific medications; preparing for doctor visits; improve and maintain health; choose the right care in the right place at the right time.
Health Risk Assessment (HRA)	A confidential self-assessment of an individual's current health status that can be used to promote a healthier lifestyle for the individual. Available for each member and their spouse. Based on the results of the HRA there is intervention to assist members with modifications to their lifestyle and health risk factors.
Health & Well-being Savings Network	Increased access to a broad range of services, including health care products and services. An ID card is used to access a network of providers and facilities that include: General Medicine, Complementary/Alternative Medicine, Wellness Services, Pharmacy, Dental, Vision, Behavioral Health, Long-Term Care Services, Hearing, Infertility. Members receive a lower cost and avoid the common problem of being turned down for services.
Dental Coverage	2 cleanings, 1 exam per participant per year. $10 co-pay per visit in network. Out of network has a 50 percent co-insurance. Access to the lower costs provided by the Health & Well-being Savings Network apply.
Vision	1 eye exam per participant per year. Access to the lower costs provided by the Health & Well-being Savings Network apply.
SEIU Member Assistance	Access to advocates that assist with referrals to the most helpful public programs, charitable programs and local services. Also, confidential help over the phone with the concerns of life, including: depression, managing stress, strengthening personal relationships, communicating effectively, workplace effectiveness, parenting and family concerns, coping with grief and loss, physical abuse, legal and financial assistance.

*Source: United Health Group and Service Employees International Union.

Appendix A – Description of Plans Offered through the WRTP PEO*

Violet Plans

This plan builds upon the access initiated through Lilac by combining Lilac with one of four insurance plans. The focus is workers with some employer support and/or higher incomes. Violet offers insurance coverage focusing on access to the right care at the right place at the right time, because access to preventive care, immunizations, lab work, diagnostics and accident coverage improve the health of members and lowers the overall cost of health care. Violet consists of Lilac plus additional insured coverage.

Lilac	Intrinsic to the design of Violet is the member's access to and participation in Lilac. The plan includes access to a wide range of health and well-being providers, with savings, as well dental and vision benefits and 24/7 telephone or online access to registered nurses. Please refer to the Plan Designs spreadsheet for details.
	PLUS
Office Visits	Plans A & B have a $15 co-pay with a $450 annual maximum benefit for plan A & B. Plans C & D have a $10 co-pay with a $500 annual max. Plan E has a $10 copay, with a $1,000 max.
Diagnostics, Lab & X ray	For all Plans, coverage is 80 percent in network with a $300 annual maximum benefit.
Outpatient Surgery Facility	Plans B, C, D & E provide coverage for a percentage of the charges with a plan annual maximum.
Inpatient Facility & Inpatient Physician Services	Plans D & E provide coverage for inpatient stays, with an annual maximum benefit.
Out-of-network	Plan pays some costs for services accessed out-of-network. Out-of-network the plan will base reimbursement on Medicare reimbursement rates. Members are responsible for their portion of the deductible and coinsurance in addition to the amount between the Medicare allowable rates and the providers' actual charge.
Lifetime Maximum	$2 million
Pharmacy	Plans C, D & E provide a retail pharmacy benefit with a $10/$25/$50 member co-pay structure. Plan E also includes mail order, and a higher annual benefit maximum.
Accident Benefit	80 percent coverage for Emergency Room, facility, supplies and equipment and all professional fees including physician services for treatment of a trauma related (accident) injury on an outpatient basis at an emergency room.

*Source: United Health Group and Service Employees International Union.

Appendix B – Comparison of Covered Services

Covered Services	BadgerCare	Violet A	Violet B	Violet C	Violet D	Violet E
Dental	Covered	Discount	Discount	Discount	Discount	Discount
Diagnostic, screening, preventative, and rehabilitative services	Covered					
EPSDT Services	Covered					
Family planning services	Covered					
Inpatient hospital services	Covered	Discount	Discount	Discount	Covered	Covered
Laboratory and x-ray services	Covered	Covered	Covered	Covered	Covered	Covered
Nurse midwife services	Covered					
Other specified and remedial care	Covered					
Outpatient hospital services—Surgical	Covered	Discount	Covered	Covered	Covered	Covered
Outpatient hospital services—Nonsurgical	Covered	Discount	Discount	Discount	Discount	Discount
Physical therapy and related services	Covered					
Physician services —Office visits	Covered	Covered	Covered	Covered	Covered	Covered
Physician Services —Inpatient	Covered	Discount	Discount	Discount	Covered	Covered
Physician Services —Outpatient	Covered	Discount	Discount	Discount	Discount	Discount
Prescription drugs	Covered	Discount	Covered	Covered	Covered	
Primary care case management services	Covered					
Prosthetic devices	Covered					
Eyeglasses	Covered					

Appendix C – Community-Based Long-Term Care Programs in Wisconsin*

Waiver Name	Waiver Type	Geographic Area	Target Population
Community Options Program Waiver (COP-W) and Community Integration Program II	1915(c)	Statewide (except Fond du Lac, La Crosse, Portage, and Richland)	Elderly and individuals with physical disabilities
Community Integration Programs 1A and 1B (CIP)	1915(c)	Statewide (except Fond du Lac, La Crosse, Portage, and Richland)	Individuals with developmental disabilities
Brain Injury Waiver	1915(c)	Statewide(except Fond du Lac, La Crosse, Portage, and Richland)	Adults with brain injury
Children's Waivers	1915(c)	Statewide	Children with disabilities and autism
Community Options Program	Not a federal waiver program. COP operates with state funds only.	Statewide (except Fond du Lac, La Crosse, Portage, and Richland)	Elderly, individuals with physical or developmental disabilities, and individuals with mental health or substance abuse issues
Family Care	1915(b)/(c)	Fond du Lac, La Crosse, Milwaukee, Portage, and Richland	Elderly and individuals with physical or developmental disabilities

*The Family Care program in Milwaukee County differs from the others because it is not the primary means of providing services to individuals with physical or developmental disabilities. Family Care in Milwaukee County is open to individuals over age 60, regardless of whether they have a disability. Individuals with a disability who are under 60 receive services under the CIP or COP programs.

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