

Statement of

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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.