Statement of

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Good afternoon Chairman Chernof, Vice-Chairman Warshawsky, and distinguished members of the Commission. Thank you for the opportunity to testify before you on the critical challenges facing the workforce for long term services and supports.

My name is Tracy Lustig. I am senior program officer with the Institute of Medicine of The National Academies, and the director of the Forum on Aging, Disability, and Independence which is co-convened by the Institute of Medicine and the National Research Council.

Today, I come before the Commission in my capacity as the staff lead for the Institute of Medicine's Committee on the Future Health Care Workforce for Older Americans, which included Commissioner Carol Raphael among its members. In 2008, the Committee released the report *Retooling for an Aging America: Building the Health Care Workforce*. This report considers the workforce broadly: namely, to include **professionals** (e.g., nurses, physicians, social workers); **direct-care workers** (e.g., nurse aides, home health aides, personal- and home-care aides); **family caregivers** (e.g., friends, family, and others who provide services and supports); and even **individuals** themselves.

The 2001 Institute of Medicine report *Improving the Quality of Long-Term Care* broadly defined long-term care as an array of health care, personal care, and social services generally provided over a sustained period of time to persons with

chronic conditions and functional limitations. The 2008 report I am representing, and therefore my remarks today, primarily focused on the *health care* aspects of long-term services and supports for *older adults*. However, as the report itself states, health care services for older adults are often intertwined with personal care and, in particular, many health care services are provided by the same workers who provide personal-care services. Therefore, many of our conclusions and recommendations are applicable to the long-term services and supports workforce for younger individuals as well.

To begin, we know that there will soon be more older Americans than ever before due both to increases in longevity and the aging of the baby boom generation. We also know that older adults use considerably more health care services than younger persons, that older adults have complex health care needs, and are best cared for with interdisciplinary, team-based approaches to care.

So, the question arises: how adequate is our workforce supply to meet these impending needs?

The answer is quite simple: we are woefully unprepared. There is a considerable shortfall in the quality and organization of the workforce to care for tomorrow's older Americans. I would like to review some of our findings about the different segments of the workforce, and then summarize our key recommendations.

I. HEALTH CARE PROFESSIONALS

The need for health care professionals trained in geriatric principles is escalating, but even though opportunities for geriatric specialization exist, few providers choose this career path. The education and training of professionals in the area of geriatrics is hampered by a scarcity of faculty, inadequate and variable academic curricula and clinical experiences, and a lack of opportunities for advanced training. Furthermore, the recruitment of geriatric professionals is hampered by several factors including persistent stereotypes of older populations and significant financial disincentives.

- In 2008, there were only a little more than 7,000 certified geriatricians, a 22 percent decrease from the year 2000.
- Additionally, there is only about 1 geriatric psychiatrist for every 11,000 older adults; at current rates, in 2030 there will only be one for every 20,000 older persons.
- Less than one percent of nurses, pharmacists, and physician assistants are specialists in geriatrics; less than 4 percent of social workers specialize in aging.

While the professional health care workforce is important, for long-term services and supports, the direct-care workers and family caregivers are really where we need to focus our attention.

II. DIRECT-CARE WORKERS

While often overlooked, the direct-care workforce is in many respects the linchpin of the formal health care delivery system for older adults as they are the primary providers of paid hands-on care. They provide clinical services plus assistance with other services and supports such as bathing, dressing, housekeeping, and food preparation. Direct-care workers primarily work in home-care settings, nursing homes, and assisted living facilities.

Direct-care workers have rewarding but difficult jobs. They have high physical and emotional demands placed on them, and significant potential for on-the-job injury. For example, in 2006, the Bureau of Labor Statistics reported that the rate of non-fatal occupational injury and illness involving days away from work among nursing aides, orderlies, and attendants was four times the average rate of all occupations and higher than that of construction workers and truck drivers. Eighty-six percent of the injuries and illnesses were due to overexertion.

Direct-care workers often receive inadequate training for their duties. Federal training requirements exist for some types of direct-care workers, but these requirements have not changed in 25 years. Some states require more hours than the federal minimum, but both the quality and quantity of this training has been questioned. Also, little is known about the training for many direct-care workers who work in community-based settings, and no federal minimum training standards exist for personal care aides.

Other factors that contribute to job dissatisfaction include low pay, poor relationships with supervisors, a lack of respect from other health care professionals, lack of involvement in care planning, and few opportunities for advancement. As a result of all these issues, turnover rates among direct-care workers are high in all settings of care (which may lead to poor clinical outcomes).

Overall, the number of direct-care workers is insufficient to meet demand, which will be exacerbated as care continues to shift from institutional settings to the home and community. Even back in 2001, the Institute of Medicine report *Improving the Quality of Long-Term Care* stated that "one of the most important reported barriers to the expansion of [personal care services] and [home- and community-based services] waiver services was the shortage of direct-care workers, particularly those working in the home."

III. **INDIVIDUALS AND FAMILY CAREGIVERS**

Consumers play a sizable role in their own care, not just as recipients of services but as prominent actors in the delivery process, such as through disease self-management and care coordination. In spite of this, little is done to recognize their role on their own care team. Moreover, public policy has traditionally viewed family caregivers' service as a personal, moral obligation, and not as an extension of the workforce. However, family caregivers are the predominant providers of long-term services and supports and in general are thought to

provide task assistance that is of low cost, high quality, and consistent with individual preferences. While family caregivers are taking on increasingly complex responsibilities (e.g., wound care, medication administration, care coordination), little is done to prepare them for their roles on the care team.

IV. RECOMMENDATIONS

In its report, the Institute of Medicine committee recommended that steps 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 providers with expertise in caring for older adults. Finally, we need to change the way that care is organized and delivered, including the way we use the workforce.

A. **Enhancing Geriatric Competence**

While efforts to educate and train the formal workforce have improved, they remain inadequate overall in scope and consistency. One notable way in which professional 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.

The committee also recommended that states and the federal government increase the existing minimum training standards for direct-care workers and all certifications should require demonstration of competence in the care of older adults. In addition, all states should also establish minimum training requirements for personal care aides.

Finally, individuals and the family and friends who help care for them need to be better integrated into the health care team. By learning self-management skills, individuals can improve their health and reduce their needs for formal care. As family caregivers play a large role in the delivery of increasingly complex health care services at home, training opportunities need to be made available for them.

B. **Increasing Recruitment and Retention**

Besides being inadequately prepared in geriatrics in general, the workforce is not large enough to meet current needs, and these shortages will be even worse in the future. The recruitment and retention of all types of workers is challenging, most often due to the serious financial disincentives associated with caring for older adults. The effort, time, and costs associated with extra years of geriatric training do not translate into additional income. For example, a geriatrician earns less than a general internist despite the extra training required to become a certified geriatrician. The committee recommended policies and programs that provide loan forgiveness, scholarships, and direct financial incentives for professionals who become geriatric specialists.

The need for direct-care workers is particularly dire. To help improve the quality of these jobs, more needs to be done to improve job desirability, including greater opportunities for career growth. Additionally, direct-care workers are typically very poorly paid. They are more likely to live in poverty, to lack health insurance, and to rely on food stamps than other workers. The committee recommended increased pay and access to fringe benefits. The 2001 Institute of Medicine report *Improving the Quality of Long-Term Care* made similar recommendations for direct-care workers related to improved education and training, competitive wages, and career development opportunities.

C. **Improving Models of Care**

Simply expanding the capacity of the current system to meet the rising needs of older adults would not address the serious shortcomings. A number of new models of care show great promise to improve the quality of care and reduce costs. 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 value of interdisciplinary teams for the care of older adults with complex care needs has been increasingly acknowledged. This implies an interaction and an interdependence among workforce members with different areas of expertise who are working together to treat an individual. Still, health care professionals are typically trained separately by discipline. As a result, professionals may gain

little understanding of or appreciation for the expertise and contributions of other providers (including direct-care workers and family caregivers) or the skills needed to effectively participate in an interdisciplinary team. For example, the landmark 2001 Institute of Medicine report *Crossing the Quality Chasm* noted that as part of person-centered care, providers should "focus on accommodating family and friends on who patients rely, involving them as appropriate in decision making, supporting them as caregivers, making them welcome and comfortable in the care-delivery setting, and recognizing their needs and contributions." This type of interdisciplinary team-based care may be especially important for providing seamless care during transitions between settings.

Another workforce adaptation that needs development is the expansion of the roles of many members of the workforce. Shifting various care responsibilities (such as through job delegation) will improve efficiency but will also require increased training to impart the skills needed to deliver more technical services as well as the skills needed to be effective delegators. More research is needed on how we can best maximize the use of all of the members of the workforce.

As part of this ideal of maximizing the efficient use of workers, the committee also recommended that federal agencies provide support for the development of technological advancements that could enhance individuals' capacity to provide care. 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 and the efficient use of all caregivers.

V. CONCLUSION

I'd like to acknowledge the immense task this Commission has to consider a wide range of issues that affect the delivery of long-term services and supports. While there are many important factors, I'd argue that the *workforce* that delivers the services and supports you are considering is essential. Because the bottom line is even if all of the other challenges are met, it won't matter if there isn't anyone there to provide the care.

Again, I want to thank the Commission for allowing me to testify and I look forward to responding to any questions or comments you may have.