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

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 five 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 on Aging to ensure continued progress in this area.