

**TAKING CARE OF MOM AND DAD:
WHY WE NEED A QUALITY WORKFORCE TO
SERVE OUR OLDER AMERICANS**

FIELD HEARING
BEFORE THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
ONE HUNDRED ELEVENTH CONGRESS
SECOND SESSION

WILKES-BARRE, PA

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MONDAY, AUGUST 2, 2010

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Wilkes-Barre, PA.

The Committee met, pursuant to notice, at 10 a.m., at Wilkes University (Hon. Robert P. Casey Jr.) presiding.
Present: Senator Casey [presiding].

**STATEMENT OF BERNARD GRAHAM, PH.D., DEAN, NESBITT
COLLEGE OF PHARMACY AND NURSING, WILKES UNIVERSITY**

Dr. GRAHAM. Good morning. My name is Bernie Graham, and I am the Dean of the Nesbitt College of Pharmacy and Nursing here at Wilkes University.

The college is the home to the School of Pharmacy, which has graduated approximately 700 Doctors of Pharmacy since the first graduating class in the year 2000. These graduates have mainly settled in northeastern Pennsylvania and are having a positive impact on the healthcare of our population, especially in the area of immunization and medication therapy management, areas in which pharmacists have gained the knowledge and experience and now have the privileges in the Commonwealth.

We are also the home of the School of Nursing. Nursing education, in one form or another, has been a hallmark of Wilkes University since 1952. Since inception, Wilkes University has awarded over 1,500 degrees in nursing. Wilkes currently awards a B.S. in nursing, has an accelerated entry-level Master's degree for career-change adult learners with a Bachelor's degree in other fields, has a traditional Nursing Master's of Science programs and, most recently, the Doctor of Nursing Practice.

At the master's level and now the doctoral level, Wilkes has concentration areas to prepare clinical nurses, nurse specialists in geriatrics, which is the care of the aged population, and psychiatric mental health. We also prepare graduates for the areas of nursing management and nursing education.

We in education also see this train of aging citizens fast approaching. The need for a larger workforce of well-trained healthcare individuals is obvious, but also perplexing. We have responded to the well-publicized need, but something, probably the economy or lack of money, has led to an interesting problem. Some—not many, but an increasing number—of our graduates are

having a hard time finding employment. This is both in nursing and pharmacy.

We see the workload of the existing workforce increasing almost beyond capacity, but yet employment market is very slow. This has also led to a very interesting problem with the training of the bachelor-level nurses in Wilkes-Barre. This problem is with all B.S. programs here in the region.

The local hospitals are so overworked that they cannot precept any senior-level nursing students. These students, in their last year, need individual mentoring and leadership experiences, which can only be accomplished at bedside. This is a problem that we, as educators, are trying to address.

As you can see that this hearing today will be informative and extremely timely, and we thank the Senator for his concern. Senator Bob Casey, who will soon be the senior Senator from Pennsylvania, will chair this U.S. Senate Special Committee on Aging field hearing, entitled "Taking Care of Mom and Dad: Why We Need A Quality Workforce to Serve Our Older Americans." The hearing will focus on legislative action in the Senate and taking measures to ensure that Pennsylvanians have access to a quality workforce to care for an aging population, with a focus on medical education in the frontline healthcare workforce.

Senator Casey.

OPENING STATEMENT OF SENATOR ROBERT CASEY

Senator CASEY. [Off-mike.] I call this hearing of the Senate Special Committee on Aging to order.

I do want to, first of all, thank Wilkes University and President Gilmour and Dr. Bernie Graham for having us here, for welcoming us and giving us this opportunity—

OK. We want to thank Dean Graham and President Gilmore and others for welcoming us here to Wilkes University today to focus on a series of challenges that the people of northeastern Pennsylvania, the people of our Commonwealth, and, indeed, our country face as it relates to caring for older citizens throughout our Commonwealth and our country.

There are many, many challenges, but there are also, as we will find out today, a lot of solutions to those difficult challenges. We have in Pennsylvania one of the fastest-growing populations in the country over the age of not only 65, but also the age of 85. We know that, for example, when you compare that to the United States of America, we know that the baby boom generation will start turning 65 next year.

By the year 2030, all 78 million—that is hard to believe—but 78 million will have reached that age, the age of 65 by the year 2030. Between 2005 and 2030, the number of adults age 65 and older will almost double—almost double, just imagine that—from 37 million to over 70 million, accounting for an increase of 12 percent of the population to 20 percent.

So what that means is that the country will look like Lackawanna County or Luzerne County because, as you know, now about 12.5 percent roughly of our U.S. population is over 65. Pennsylvania is above 15 percent, just about 15.5 percent. But here in Luzerne County and next door in Lackawanna County, consistently

over the last 20 or 30 years, but it is certainly in the last 10 to 20 years, both counties have been right about 19 or 20 percent over 65.

So that increase nationally will mean that the country will have a percent over 65 that we have had here for many, many years.

What we have to do, though, is not just recite those numbers and list the many challenges we have. We have to recommit ourselves to make sure that those who are, as Hubert Humphrey said a long time ago, in the twilight of life, that those who are in that age bracket get all the help that they need.

Who are we talking about here? We are talking about people who fought our wars, worked in our factories, taught our children, and gave us life and love. All of those Pennsylvanians and all of those Americans, we have an obligation to make sure that they are taken care of in the best way possible.

We have the blessing in this country of the best education systems in the world, the best schools in the world. When it is working as it should and when we are focused on the best parts of it, our healthcare is the best in the world. We have to bring all of that learning, all of that knowledge, all of that expertise and ability to strategies to care for, to take care of those in the twilight of their lives.

In Pennsylvania, we have a particularly significant challenge over the age of 65. We are fourth in that category for the country. This puts us in a unique position to be able to be, in a sense, a laboratory for all kinds of great strategies, all kinds of new ideas, all kinds of new pathways of learning to make sure that we are taking care of people who have contributed so much to Pennsylvania and to our country.

I remember reading a story, a series of stories in the Philadelphia Inquirer about a decade ago, about I want to say it was 1998, or 1999. I will get the date, but it was in that time period. The writer of the story was Michael Vitez, and he was talking about long-term care in Pennsylvania and across the country. I will never forget something he wrote in that story, that series.

I think I am quoting him accurately. He said, "Advocates for the frail elderly say that life can have quality and meaning even until the very last breath." Life can have quality and meaning even to the very last breath. Sometimes we forget that. Sometimes we think of long-term care, nursing home care, care for older citizens as somehow—oh, I don't know, I guess somehow just kind of managing old age and figuring out a way to make it as comfortable as possible.

Well, we don't really believe that if we think about it for a little while. We don't believe that. We believe that life does have quality and meaning, even to the very last breath. That means that people can have full lives, lives of great contribution and lives of great promise even when someone is very old. That there is not just a dignity and a worth, but also a lot of opportunity and a lot of promise in the life of someone much older. They can contribute so much if we have the strategies in place to take care of them.

So, first of all, it is a necessity that we get this right. The people of our country who are in that age bracket know that we have not

just an obligation to them, but this is critically important that we get this right for our workforce and for our quality of life.

In Pennsylvania, we know that the trend, just like it is across the country, those who are over the age of 85 are going to increase even faster than the population over 65. Pennsylvania is expected to grow by 50.6 percent between the years—we are 10 years into this now—2000 and 2030. So in that 30-year time period, the population over 85 is supposed to grow by more than 50 percent.

We also believe that when we are focused on these sets of challenges, this is an opportunity for our State of Pennsylvania. We were talking just earlier this morning about our healthcare infrastructure. We have a lot of it in Pennsylvania. A big workforce, you can make an argument, pretty good argument, that healthcare is our biggest employer if you set aside the jobs that are in agriculture or the economic impact of agriculture or tourism, Government employment.

But you can make a very good argument that healthcare is either the biggest employer or a very close second. The bill that we passed in Congress and the President signed into law this year, the healthcare reform bill, presents an opportunity to create new models of care for people across this country.

We know that in Scranton, for example, we have a medical school. A lot of people didn't think that would happen. But because of the leadership of a number of people, including Dean D'Alessandri, who is here with us today, will provide testimony, this school allows us to test some of those new models of care in primary care, comparative effectiveness research, all kinds of new discoveries and new ways of approaching the care for older Americans, to benefit them.

We know that collaboration will be critically important with other healthcare providers and other experts in the field to make northeastern Pennsylvania a leader, literally a leader in this field in the world. Not just in the State or the country, but indeed across the world.

So this isn't just some problem we have got to manage. This is an opportunity. It is an opportunity for Pennsylvania, and it is an opportunity especially for northeastern Pennsylvania. For that reason, we should embrace it, not just hope we can deal with it. We should embrace it as an opportunity.

Third, I think we are also at the same time, as much as we think of this as both a necessity in terms of demographics and opportunity because of our values, it is also something that calls us to be summoned by our conscience and our commitment to get it right. We will not be the kind of community that we have been in northeastern Pennsylvania and across the State unless we get this right.

The good news is we know exactly how to get it right, and we can do this. Our parents and our grandparents who raised us and cared for us and built this region, built this Commonwealth, and really built the country, when you think of the generations two or three that just preceded ours, how they got us through World War II. We weren't prepared for World War II. But they fought that battle, and they built our economy. They built the middle class.

They made us the envy of the world—our economy, our way of life, our ability to defend freedom. All of that came from one or two generations of Americans. So we have a great opportunity not only to improve and grow strategies to care for older citizens, but also to build a very strong economy.

We are told that the American Association of Medical Colleges predicts that the United States is expected to face a shortage by the year 2025 of between 124,000 and 159,000 physicians across the country. The American Association of Colleges of Nursing reports that the number of registered nurses needed will grow, will grow by 260,000 nurses by that same year, 2025.

So we are going to need more doctors. We are going to need more nurses, and we are also going to need more direct care workers in roughly that same time period. Direct care workers are often not given the respect they deserve for the work that they do. It is the direct care workforce that provides most of the care to our loved ones. They help every day of the week a quarter of a million Pennsylvanians and their families, every single day.

It is one of the fastest-growing populations. According to the Bureau of Labor Statistics, employment of home health aides and personal and home healthcare aides is expected to grow between 46 and 50 percent between the years of 2008 and 2018. Just imagine, in one decade in one part of our healthcare workforce, direct care workers is going to grow by roughly 50 percent in Pennsylvania.

So it is our responsibility to make sure these jobs are both personally rewarding, but also that they provide an opportunity for advancement and economic stability. So, for that reason, tomorrow I will introduce in the U.S. Senate the Direct Care Workforce Empowerment Act. This legislation will do three things.

First of all, ensure that home care workers receive the Federal minimum wage and overtime protections of the Fair Labor Standards Act. That is a good idea. I can't believe we haven't done it already. It doesn't make any sense that we haven't done it. No. 2, improve Federal and State data collection and oversight with respect to the direct care workforce. Three, establish a grant program to help States improve direct care worker recruitment, retention, and training—three or four words that we hear over and over again when it comes this part of our healthcare workforce.

So we are here to talk about how we care for Pennsylvanians and Americans in the twilight of their lives, just as we hear a lot of talk about folks that we worry about in the dawn of their lives, our children. Both ends of our age spectrum, young children and older citizens, both need our help, both need our attention, and both need much more of our focus.

So we will have three panels today. Our first panel will be one person, but someone who I think will be able to give us a great overview of some of the opportunities we have, especially in relationship to the new healthcare bill. Dr. Janet Heinrich, the Associate Administrator of the Bureau of Health Professionals of the Health Resources Services Administration.

Dr. Heinrich is a former executive director of the American Academy of Nursing. She is here today to discuss many of the important changes that the Affordable Care Act, the health reform bill I re-

ferred to earlier, has made to improve and support the healthcare workforce.

As I will tell her and I will remind our other witnesses, if we can keep your testimony to about 5 minutes, you should know, each of the witnesses should know that your entire testimony will be made part of the record. So if there is a part of it that you want to make sure is part of the record, don't worry, it will be part of the record.

If you can keep it to around 5 minutes, Doctor, we would appreciate it. So, Doctor, why don't you start us off? Thank you very much for being here.

[The prepared statement of Senator Senator Casey follows:]

STATEMENT OF JANET HEINRICH, DRPH, ASSOCIATE ADMINISTRATOR, BUREAU OF HEALTH PROFESSIONALS, HEALTH RESOURCES AND SERVICES ADMINISTRATION, ROCKVILLE, MD

Dr. HEINRICH. Senator Casey, Mr. Chairman, thank you for the opportunity to testify today on behalf of the Secretary of Health and Human Services and the Administrator of Health Resources and Services Administration, which I will refer to as HRSA.

The Affordable Care Act provides us many opportunities, especially as we think about expanding the essential healthcare workforce and the importance of the direct care worker, as you so eloquently described.

HRSA is the primary Federal agency for improving access to healthcare services for people who are uninsured, isolated, medically vulnerable, including the elderly. Our programs help Americans receive quality care without regard to ability to pay. HRSA programs also help train the future nurses, doctors, and other clinicians so essential to providing our healthcare services.

My testimony today will focus on new activities related to the Prevention and Public Health Fund, our programs to improve access, the new programs we have for the frontline direct care workers, and specific programs for training people to care for older people. I want to give examples of organizations in this area especially that are taking advantage of these new opportunities that are made possible through the Affordable Care Act.

Let us start with the Prevention and Public Health Fund. We know that communities across the country have suffered from a shortage of primary care workers. Without action, experts continue to say that we will have a shortfall in our needs to care for the aging population, with a decline in the number of students selecting primary care.

To address this, Secretary Sebelius announced a series of new investments worth \$250 million, made possible by the Affordable Care Act, to increase the number of providers in primary care. Specifically, we will be funding additional primary care residency slots to train new primary care physicians. We will be supporting physician assistants training for primary care, as well as nurse practitioner training programs—nurses who will be going into primary care, and one of those specialties, of course, is geriatrics.

There will be \$5 million to help States to plan and implement innovative strategies to expand their primary care workforce. This is a terribly important program, again made available under the

Affordable Care Act, to encourage our States to address barriers to expanding the healthcare workforce, especially for primary care. So that, in fact, States can address issues of scope of practice which limit what providers other than physicians can provide, especially to older populations. Certainly, we know that Pennsylvania is a leader in this area of addressing scope of practice issues.

Let us focus now on the programs we have to increase access to care. HRSA's mission to improve health and achieve health equity through access to health services includes the administration of the Community Health Center Program, and the National Health Service Corps.

With the community health centers, their mission is to provide primary care to vulnerable populations, including older citizens, no matter their ability to pay. Across the country, we have a network of over 1,100 healthcare centers. In fact, there are more than 20 HRSA-funded community health center service sites within 50 miles of where we are today.

Community health centers are a vital source of healthcare for aging populations. In 2009, health centers served over 1 million patients age 65 years and older.

The Affordable Care Act provides \$11 billion in funding over the next 5 years to increase support for community health centers. About \$9.5 billion of that will increase services at existing sites, provide funds for new community health center sites, and fund plans to create more community health centers in underserved areas.

With the National Health Service Corps, HRSA seeks to strengthen primary care by placing healthcare providers in communities where they are needed most. For example, the National Health Service Corps, through scholarship and loan repayment programs, help address specific shortage areas for medicine, dentistry, and mental health providers.

In fact, there are currently 12 National Health Service Corps providers serving across northeastern Pennsylvania. Moreover, in recognition of the aging of the U.S. population, geriatricians were included recently as a physician category in the National Health Service Corps to help provide more of these essential services in underserved areas.

The Affordable Care Act increases and extends funding for this corps. Through the loan repayment program, we now offer \$145,000 over 5 years to repay student loans that treat uninsured and underinsured citizens. This is a substantial increase from what was available to students before.

With the scholarship program, there is payment for tuition, fees, a living stipend to students enrolled in accredited programs for dentistry, nurse practitioners, nurse midwives, and physician assistants, as well as physicians.

Let us now talk about the frontline worker and the needs that you just spoke about. Across the United States, there is growing concern about current and projected shortages of frontline workers, direct care workers such as nursing and home health assistants who provide the services for the elderly, chronically ill, and disabled. The number of older and disabled patients with very com-

plex healthcare needs is outpacing the supply of workers trained to meet these needs.

As a result, the need to train personal and home health aides is ever increasing. The Affordable Care Act addresses some of these challenges in training for frontline workers. Let me describe three new programs that we are administering.

We have now, as a result of the Affordable Care Act, the Personal and Home Healthcare Aide State Training Program. This program is designed to address the challenges that you have just described. The Personal and Home Care Aide State Training Program aims to ensure the supply of competent personal and home health aides with acquired skills that would be transportable to any job market in the Nation, thus strengthening the direct care workforce.

This program will support the development, evaluation, and demonstration of competency-based uniform curriculums to train qualified personal and home health aides. That program is now in the review process, and we will be making awards by the end of September.

Another new program is the Nursing Assistant and Home Health Aide Program. This program establishes a new initiative to train nursing home aides and home health aides. It will support the development, demonstration, and evaluation of, again, competency-based uniform curriculum to train qualified assistants, strengthen the direct care workforce, making sure that they have the necessary skills that can be transportable and building blocks for moving up to other higher paying professions in healthcare.

Awards and grants will be made to colleges and community-based training programs for development, testing, and training of these programs and emphasize telehealth and new communication methodologies for training.

Another program is the Patient Navigator Outreach and Chronic Disease Prevention Program. This program is reauthorized under the Affordable Care Act and expanded. This program supports individuals serving within communities to assist patients in overcoming barriers to receiving healthcare services.

Patient navigators help patients coordinate healthcare services, determine whether clinical trials are right for them, conduct outreach to populations to make sure that they have access to the care they need.

We have several geriatric programs, and I will be brief here in consideration of time available. In addition to supporting the frontline workers, the Affordable Care Act reauthorizes HRSA programs specifically focused on training the healthcare workers we need with the special skills in geriatrics.

Moreover, it is important that we appreciate the fact that these training programs, as a result of the Affordable Care Act, are more focused than ever before on interdisciplinary training. We need to be able to work in teams. No one profession can do it alone. We are not only relying on physicians or nurses, but an array of health professionals that we will be needing.

So one of our programs, the Comprehensive Geriatric Education Program, really targets nurses and nurses who will receive degrees in geriatric nursing, long-term care, geropsychiatric nursing, and

other nursing areas that specialize in elderly populations. In 2009 in Pennsylvania, HRSA awarded these grants to the Community College of Allegheny County and the University of Pennsylvania.

We also have a Geriatric Education Center Program. These programs provide interdisciplinary training for health professionals in assessment, chronic disease syndromes, care planning, emergency preparedness for elderly, and cultural competencies unique to caring for older Americans.

The Affordable Care Act authorizes supplemental grants to these programs in geriatrics, chronic care management, long-term care for faculty in a broad array of health professions schools, as well as training for frontline, direct care workers and family caregivers. The Affordable Care Act authorizes these short-term intensive courses to assist in these areas.

Currently, in 2010, we have awarded grants to the University of Pennsylvania, University of Pittsburgh, and Thomas Jefferson University. Interestingly enough, Thomas Jefferson University provides these geriatric education programs through a consortium that includes Marywood University and The Commonwealth Medical College in Scranton, and The Commonwealth Medical College then expands these through three regional campuses in Scranton, here in Wilkes-Barre, and Williamsport. So a broad reach that I think is very innovative.

We also have the geriatric training program for physicians, dentists, and behavioral and mental health professionals. This program supports geriatric training to train these professionals who will go into the geriatric specialties in their professions. We also have a Geriatric Career Award that provides career development for faculty who will be training in these programs.

Another program that you have in this area is the Area Health Education Center Program. We fund the Area Health Education Center programs to really encourage the establishment and maintenance of community-based primary care training in off-campus rural and underserved areas. One goal is to educate and train students to become culturally competent primary care providers.

The Pennsylvania Area Health Education Center has seven AHEC centers, including northeastern Pennsylvania center, which is located on the campus of Keystone College and serves a nine-county regional area that includes Wilkes-Barre and Scranton. The northeast Pennsylvania center also offers programs to spark interest in science and preparing for health careers among students in the high school and lower grades and encourages students to enter the health professions careers.

In this area, there are consortium that include East Stroudsburg University, Wilkes University, and the University of Scranton to provide these experiences for students still in their high school years. I can't stress enough that we really do need to encourage the pipeline to go into the health professions careers.

Whether we like it or not, in medicine and nursing for sure, we have a huge cadre that are just at the cusp of retirement. So, as fast as we are bringing in the health professions on the front end, we are losing them to retirement on the other end.

So, in conclusion, we are extremely proud of our programs, look forward to continuing to work with you, Mr. Chairman, to ensure

the provision of quality care to all Americans and by ensuring the availability of highly competent, adequately prepared healthcare workers, especially workers who can care for our older citizens.

Thank you very much. I am happy to answer any questions.
[The prepared statement of Dr. Heinrich follows:]



Statement of

Janet Heinrich, DrPH, RN, FAAN

**Associate Administrator
Health Resources and Services Administration
U.S. Department of Health and Human Services
Bureau of Health Professions**

**Before the
Special Committee on Aging
U.S. Senate**

**Wilkes Barre, PA
August 2, 2010**

Mr. Chairman, thank you for the opportunity to testify today on behalf of the Secretary for Health and Human Services and the Administrator of the Health Resources and Services Administration (HRSA), to discuss the very important provisions in the Affordable Care Act (ACA) that will help to build a quality health professions workforce to care for our older citizens. We appreciate your interest and welcome the opportunity to work with you, Mr. Chairman, and the Committee, to strengthen HHS and HRSA programs that train the physicians, nurses, and direct care workers who will care for our aging population.

Introduction

HRSA is the primary Federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable, including the elderly. Our programs help Americans receive quality health care without regard to their ability to pay. HRSA programs also help to train future nurses, doctors, and other clinicians, placing them in areas of the country where health resources are scarce.

My testimony will briefly describe the activities funded by the Prevention and Public Health Fund, HRSA's role in increasing access to care and the number of frontline direct-care workers, and other ways that HRSA is working to train the health care workforce to provide high quality care to older Americans. In addition, I will outline how the Affordable Care Act supports all of these activities, particularly in northeastern Pennsylvania.

The Prevention and Public Health Fund

Communities across the country have long suffered from a shortage of primary care providers. Without action, experts project a continued primary care shortfall due to the needs of an aging population and a decline in the number of medical students choosing primary care. The Association of American Medical Colleges estimated that the Nation would have a shortage of approximately 21,000 primary care physicians in 2015. To address this, Secretary Sebelius announced a series of new investments worth \$250 million—made possible by the Affordable Care Act—to increase the number of health care providers and strengthen the primary care workforce. The new investments will support the training and development of more than 16,000 new primary care providers over the next five years. Specific activities include:

- \$168 million in funding to create additional primary care residency slots to train more than 500 new primary care physicians by 2015;
- \$32 million in funding to support physician assistant training in primary care with the goal of developing more than 600 new physician assistants, who can practice medicine as members of a team with their supervising physician. Physician Assistants are trained in a shorter period of time compared to physicians;
- \$30 million to train an additional 600 nurse practitioners, including providing incentives for part-time students to become full-time and complete their education sooner;
- \$5 million in funding to encourage States to plan and implement innovative strategies to expand their primary care workforce by 10 to 25 percent over ten years to meet increased demand for primary care services; and
- \$15 million in funding for the operation of 10 nurse-managed health clinics that both provide comprehensive primary health care services to populations living in medically underserved communities, and assist in the training of nurse practitioners and other health care providers.

Additionally, HRSA's Bureau of Health Professions administers several specific geriatric health professions training and education programs, including several new geriatric programs established in the Affordable Care Act. I will expand on these activities later in my testimony.

Increasing Access to Care

HRSA's mission is to improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs. To increase access to quality services for underserved populations, HRSA administers both the Community Health Center Program, and the National Health Service Corps.

Community Health Centers

HRSA-funded Community Health Centers provide primary health care to vulnerable Americans—including our older citizens—regardless of their ability to pay. A network of 1,100 health center grantees across the nation provide primary health care at more than 7,900 sites, ranging from large medical facilities to clinics and mobile vans. In fact, there are more than 20 HRSA-funded Community Health Center service delivery sites within 50 miles of where we sit today in Wilkes-Barre. Across the Nation, these health centers serve nearly 19 million patients, about 40 percent of whom have no health insurance. Charges for services are set according to income, and only nominal fees are collected from the poorest patients. Community Health Centers are also a vital source of health care for our aging population. In 2009, health centers served 1,291,248 patients age 65 years and older. This was 3.3 percent of the US population 65 years and older (39,570,590) and 6.9 percent of total health center patients (18,753,858) served in 2009.

The Affordable Care Act provides \$11 billion in funding over the next 5 years to support the Community Health Center Program. Of the \$11 billion provided, \$1.5 billion will be used to support major construction and renovation of community health centers nationwide. The remaining \$9.5 billion will increase services at existing sites, provide funds to operate new community health center sites, and fund plans to create more community health centers in under-served areas.

National Health Service Corps

In addition to providing direct patient care, HRSA seeks to strengthen primary care by placing health care providers in communities where they are needed most. For example, the National Health Service Corps (NHSC), through scholarship and loan repayment programs, helps Health Professional Shortage Areas (HPSAs) in the U.S. obtain medical, dental, and mental health providers in order to meet the area's need for health care. Since its inception in 1970, more than 30,000 primary care physicians, nurse practitioners, certified nurse midwives, physician assistants, dentists, dental hygienists, and mental health professionals have served in the NHSC, expanding access to health services and improving the health of people who live in urban and rural areas where health care is scarce. In fact, there are currently 12 NHSC providers serving across northeastern Pennsylvania in Lycoming, Susquehanna, Union, Wayne, and Wyoming Counties. Moreover, in recognition of the aging of the US population, geriatricians were included recently as a physician category in NHSC to help provide more of them to underserved rural and urban areas.

The Affordable Care Act increases and extends funding for the NHSC. The NHSC Loan Repayment Program now offers up to \$145,000 over 5 years to repay student loans in exchange for service in community health centers, rural health clinics or other health care facilities that treat uninsured and underserved citizens. Initially, clinicians commit to serving 2 years and receive up to \$50,000 to repay student loans. Prior to the Affordable Care Act, the maximum amount that students could receive for a 2 year commitment was \$35,000. With increasing costs for health professions education, the Affordable Care Act provided an important increase in loan repayment. The NHSC scholarship program pays tuition, fees and provides a living stipend to students enrolled in accredited medical (MD or DO), dental, nurse practitioner, certified nurse midwife and physician

assistant training. Upon graduation, scholarship recipients serve as primary care providers for two to four years in a community-based site in a high-need area.

In addition to directly assisting in the placement of primary care providers, HRSA also supports the health profession programs, medical and nursing schools for example, that provide the infrastructure for their education and training.

Increasing the Number of Frontline Direct-Care Workers

Across the United States, there is growing concern about current and projected shortages of frontline direct-care workers such as nursing and home health aides who provide care and services to the elderly, chronically ill, and disabled. The number of older and disabled patients with very complex health care needs outpaces the supply of health care providers equipped with the knowledge and skills to adequately care for them. At the same time, the elderly will increasingly rely on home care. This trend reflects several developments, including efforts to contain costs by moving patients out of hospitals and nursing care facilities as quickly as possible, the realization that treatment can be more effective in familiar rather than clinical surroundings, and the development and improvement of medical technologies for in-home treatment.

Yet today, many are fortunate to find any direct-care staff at all. Rates of vacancies and staff turnover are now so high that, in some parts of the country, state associations representing nursing homes and home care agencies report that their member agencies are increasingly unable to provide care to clients due to an absence of nursing and direct-care staff. As a result, the training of personal and home care aides is an increasingly important element in the provision of quality care to older populations. The Affordable Care Act addresses some of the challenges in training front line health workers through several different programs.

Personal and Home Care Aide State Training Program

The Affordable Care Act created a very important program designed to address the challenges I've just described. The Personal and Home Care Aide State Training Program (PHCAST) aims to ensure the supply of competent personal and home care aides with acquired skills that would be transportable to any job market in the Nation, thus strengthening the direct care worker workforce. PHCAST will support the development, evaluation, and demonstration of a competency based-uniform curriculum to train qualified personal and home care aides by awarding grants to States to conduct demonstration projects for the development of core training competencies and certification programs for personal and home care aides.

PHCAST grantees will develop written materials and protocols for core training competencies, including the development of certification tests for personal or home care aides who completed such training competencies. This new demonstration program will provide funding for Federal fiscal years 2010 through 2012, with approximately \$5 million expected to be available each year to fund 6 awardees.

Nursing Assistant and Home Health Aide Program

The Affordable Care Act also created the Nursing Assistant and Home Health Aide (NAHHA) Program to establish a new initiative to train nursing home aides and home health aides. The NAHHA Program supports the development, demonstration, and evaluation of a competency based uniform-curriculum to train qualified nursing assistants and home health aides, strengthening the direct care workforce by providing nursing assistants and home health care aides with the necessary skills that can be transportable to any job market in the Nation.

NAHHA Program grants will be made to colleges or community-based training programs for the development, testing, and demonstration of training programs on-campus, at alternative sites, and through telehealth methodologies. This new program will provide funding for Federal fiscal years 2010 through 2012, with approximately \$2.5 million expected to be available each year to fund 10 awards.

Patient Navigator Outreach and Chronic Disease Prevention Program

The Affordable Care Act also reauthorized the Patient Navigator Outreach and Chronic Disease Prevention Program, and \$5 million in regular FY 2010 appropriations was provided. This valuable program supports patient navigator services within communities to assist patients in overcoming barriers to receiving health services. Patient navigators help patients coordinate health services, provide patients with information on clinical trials, conduct outreach to populations suffering health disparities, and assist community organizations in helping individuals access care.

Geriatrics Programs

In addition to supporting programs to train front line health workers, the Affordable Care Act reauthorized the HRSA programs specifically focused on training our health workforce to provide high-quality geriatric care. The goal of each of these programs is to improve access to—and quality of—health care for America's elderly. Many elderly, especially the frail elderly, have multiple complex health problems that are most effectively addressed using an interprofessional team care delivery model. However, the vast majority of the physicians and health care practitioners who care for elderly patients have not been trained in interprofessional geriatric care teams to meet the special needs of the elderly. HRSA administers several programs to provide education and training opportunities to health professions students, faculty, and practitioners at the generalist and specialist levels in the interdisciplinary care of geriatric patients.

Comprehensive Geriatric Education Program

HRSA supports the Comprehensive Geriatric Education Program (CGEP). This program supports the development of individuals in geriatric education by providing training to individuals who will provide geriatric care for the elderly, developing and disseminating curricula related to the treatment of the health problems of elderly individuals, training faculty members in geriatrics, or providing continuing education to individuals who provide geriatric care. In FY 2009, HRSA awarded CGEP grants to the Community College of Allegheny County and the University of Pennsylvania.

Under CGEP, the Affordable Care Act establishes traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing, long-term care, gero-psychiatric nursing or other nursing areas that specialize in the care of the elderly population.

Geriatric Education Center Program

The Geriatric Education Center (GEC) Program provides interdisciplinary training for health care professionals in assessment, chronic disease syndromes, care planning, emergency preparedness, and cultural competence unique to older Americans. GEC grantees use their funding to improve the training of health professionals in geriatrics, including geriatric residencies, traineeships, or fellowships; develop and disseminate curricula relating to the treatment of the health problems of elderly individuals; support the training and retraining of

faculty to provide instruction in geriatrics; support continuing education of health professionals who provide geriatric care; and provide students with clinical training in geriatrics in nursing homes, chronic and acute disease hospitals, ambulatory care centers, and senior centers.

The Affordable Care Act authorizes supplemental grant funding to support training in geriatrics, chronic care management, and long-term care for faculty in a broad array of health professions schools, as well as training for the front line, direct care workers and family caregivers. Specifically, the Affordable Care Act authorized GECs to offer short-term intensive courses that will focus on geriatrics, chronic care management, and long-term care. These courses will provide supplemental training for faculty members in medical schools and other health professions schools who do not have formal training in geriatrics, upgrade their knowledge and clinical skills in the care of older adults and adults with functional limitations, and enhance their interdisciplinary teaching skills. In FY 2010, HRSA awarded GEC grants to the University of Pennsylvania, the University of Pittsburgh, and Thomas Jefferson University. Thomas Jefferson University provides its geriatric education services through a consortium that includes Marywood University and The Commonwealth Medical College (TCMC) in Scranton. TCMC offers its education through three regional campuses in Scranton, Wilkes-Barre, and Williamsport, and also provides online courses.

The Affordable Care Act also requires GECs that receive funding to provide the short-term intensive courses to conduct family caregiver and direct care provider training, or address best practices in mental health. The GECs that address family caregiver and direct care provider training must work with appropriate community partners to develop training program content and to publicize the availability of training courses in their service areas. The training programs will include instruction on the management of psychological and behavioral aspects of dementia, communication techniques for working with individuals who have dementia, and the appropriate, safe, and effective use of medications for older adults.

Geriatric Training for Physicians, Dentists, and Behavioral and Mental Health Professionals Program

The Geriatric Training for Physicians and Dentists (GTPD) Program provides support for geriatric training projects to train physicians, dentists and behavioral and mental health professionals who plan to teach geriatric medicine, geriatric dentistry, or geriatric behavioral or mental health. The program provides both intensive one-year retraining for faculty and two-year fellowship training in geriatrics that give training exposure to older adult patients in various levels of wellness and functioning and from a range of socioeconomic and racial/ethnic backgrounds. In FY 2010 HRSA awarded the University of Pennsylvania more than \$4.6 million in GTPD funding over 5 years to provide geriatric training to 16 physicians.

The Affordable Care Act expanded the definition of behavioral and mental health professionals and thereby the disciplines eligible for support under the program. The new definition now includes individuals with a graduate or postgraduate degree in psychiatry, psychology, psychiatric nursing, social work, substance abuse disorder prevention and treatment, marriage and family counseling, or professional counseling.

Geriatric Academic Career Award Program

The Geriatric Academic Career Award (GACA) Program promotes the career development of academic geriatricians. Award recipients are required to provide training in clinical geriatrics, including the training of interdisciplinary teams of health care professionals. The provision of such training must constitute at least 75 percent of the obligations of the individual receiving the award. In FY 2009, two physicians at the University of Pennsylvania received Geriatric Academic Career Awards under the program.

The Affordable Care Act greatly expanded the disciplines eligible to receive the awards to include individuals in allopathic medicine, osteopathic medicine, nursing, social work, psychology, dentistry, pharmacy, and allied health.

Area Health Education Center Program

HRSA also funds the Area Health Education Centers (AHEC) Program, which was reauthorized by the Affordable Care Act. The AHEC Program encourages the establishment and maintenance of community-based, primary care training programs in off-campus rural and underserved areas. One goal of this program is to educate and train students to become culturally competent primary care health professionals who will provide healthcare to underserved populations. A related goal is to increase the number and variety of primary care health professionals who provide care to underserved populations in Health Professional Shortage Areas (HPSAs) and other medically underserved areas.

The Pennsylvania Area Health Education Center has 7 AHEC Centers, including the Northeast Pennsylvania AHEC Center, which is located on the campus of Keystone College and serves a nine county region including Wilkes-Barre and Scranton. The Northeast Pennsylvania AHEC has served as a community partner in the founding and accreditation of The Commonwealth Medical College (TCMC) and is committed to using resources and additional community partnerships to offer TCMC support and help the institution grow. In addition, over the last six months, the Northeast Pennsylvania AHEC placed 8 primary care residents and 110 medical and nursing students in underserved practice sites.

The Northeast Pennsylvania AHEC also offers programs to spark interest in science preparedness and health careers among students from kindergarten through high school, encouraging those students who do become health professionals to return to northeastern Pennsylvania to serve as community health care providers. Additionally, the Northeast PA AHEC partners with the Upward Bound programs at East Stroudsburg University, Wilkes University, and University of Success (University of Scranton), to provide experiences that expose high school students from underserved backgrounds to health careers, and assist them in preparing to enter health professions education.

Conclusion

At HRSA, we are extremely proud of our programs and look forward to continuing to work with you, Mr. Chairman, to ensure the provision of quality health care to all older Americans by ensuring the availability of a highly competent and adequately supplied health care workforce. The Department of Health and Human Services has invested a great deal of time and resources in promoting access to health care services and the development of the health care workforce. While there is more work to be done, HRSA is pleased with the additional opportunities and funding the Affordable Care Act provides to further this work that is so essential to providing care to our aging population. I truly appreciate the opportunity to testify today, and I would be pleased to answer any questions at this time.

Senator CASEY. Doctor, thank you very much.

I wanted to ask you a few questions that relate to northeastern Pennsylvania in particular. We have, fortunately, passed the Affordable Care Act. It took a lot of work to get that bill passed. I spent a substantial amount of time working on a lot of different parts of the bill.

We are happy it passed. In fact, we are very happy it passed. But we know that if this were a five-chapter book, as hard as passage and enactment was, there are probably four chapters after that that are all going to be difficult. A lot of those chapters, a lot of the challenges are on implementation.

We have an opportunity I think in northeastern Pennsylvania and throughout the Commonwealth to take advantage of parts of the bill that, frankly, not enough people have heard a great deal about, which is true of a lot of parts of the bill. I think there is a chance, as we begin to implement different parts of the Affordable Care Act, that people will have a better sense of what those provisions are all about.

As it relates to the whole series of programs that you outlined, we have a lot of program names, a lot of acronyms, and fortunately, a lot of funding to be able to help move those programs forward, either new programs, new strategies, or existing programs that will be expanded or reauthorized.

I guess one question a lot of people might have is if someone bumped into you walking out of here today and said I heard you passed this big healthcare bill, and I know here in northeastern Pennsylvania, we have got a number of healthcare challenges. One of them is this challenge of taking care of and providing quality care for older citizens. How would you rank or prioritize the programs within the legislation that would be most helpful in the near term?

In addition to the programs, what Health and Human Services resources do you think could be made available for the people of northeastern Pennsylvania?

Dr. HEINRICH. It almost sounds like you are asking me to choose among my children. [Laughter.]

The fact is that there are themes, I think, in the Affordable Care Act that are very important to this area, as well as the rest of the country. But it seems as though you may have a head start on some of these areas.

So I think there is definitely the theme of expanding the primary care workforce. With the primary care workforce, we have to emphasize the fact that it is physicians, yes, but it is also nurses. It is also pharmacists. It is also physician assistants. They all play a critical role in providing primary care access, especially for older and a growing older population.

Senator CASEY. Can I just stop you there?

Dr. HEINRICH. Yes.

Senator CASEY. Just so we kind of go program by program. You stated in your testimony with the Prevention and Public Health Fund, and you spoke there about primary care workforce. The bullet points you have, it is \$168 million for residency slots, \$32 million for physician assistants training, money for nurse practitioners, innovative strategies, nurse-managed health clinics.

What is the best way for individuals—well, let me say what is the best way for institutions in northeastern Pennsylvania to take advantage of the Prevention and Public Health Fund? Let me just start with that.

Dr. HEINRICH. OK. The Prevention and Public Health Fund was, in fact, a one-time—the \$250 million was a one-time initiative that may be, in fact, repeated in the future, but we are not sure. It depends on the availability of funding. But I think that the message for the institutions in this area is that you have a new and developing medical school. You have nursing programs. I haven't heard about physician assistant programs.

But there are, in fact, opportunities for different levels of training for healthcare providers. It sounds like the School of Nursing here at Wilkes is already taking advantage of a lot of the increasing, expanding programs in nursing. I would hope that they would continue to do so in the future. I learned, as I came in this morning, that, in fact, the new expanding medical school is also taking advantage of some of the ongoing programs.

So the message is that primary care is interdisciplinary and that there are monies that are available for expanding the numbers, and we would hope to continue that in the future.

Senator CASEY. So for all those areas that I just talked about, this fund is a 5-year program, right?

Dr. HEINRICH. Right.

Senator CASEY. It will support 16,000 new primary care providers. So there are obviously opportunities.

What is the best way to access these programs? In other words, how do you apply? What is the process?

Dr. HEINRICH. There is a Web site called www.grants.gov, and on that Web site, you will see all of the initiatives, all the competition for all of our grants. You can also go to HRSA, hrsa.gov, and look for grant opportunities, and they will be listed there as well.

Senator CASEY. Obviously, you mentioned before the impact that the community health centers will have. I don't think many people understand that we have had a very successful community health center program, strategy—I don't know how you want to define that. But it has been in place for years. In your testimony, you pointed to some of that history and the network of sites all around the country.

But this community health center part of the healthcare bill is \$11 billion more that will be provided over 5 years to support that. It is almost impossible to calculate, in my judgment, the positive healthcare benefits that will provide to the country. That community health center part of the healthcare bill could be its own bill, and it would be considered a substantial piece of healthcare legislation.

So it is a part of the bill that I don't think people know much about yet, but it will be of tremendous help. As you said, you said there are more than 20 HRSA-funded community health center service delivery sites within 50 miles of Wilkes-Barre, as we sit here today. That is substantial.

I wanted to also go to the part of your testimony on page 4 and 5. You talked there about increasing the number of frontline direct care workers as a major priority.

Dr. HEINRICH. Right.

Senator CASEY. You talked about in particular I highlighted “older and disabled patients with very complex healthcare needs.” Sometimes I think we forget that it is not just demographics, but the complexity of the healthcare needs is significant.

Obviously, the rates of vacancy and staff turnover. We talk about that over and over again. I have always found that in a long-term care facility, when you walk in the door—and I know I am simplifying this a bit, but it tells you a lot. You walk in the door, one of the first questions you should ask is what is your turnover rate?

Interestingly, in my experience, and I am not a professional, but in my experience you can have a very successful long-term care facility even though the turnover rates are pretty high—40, 50 percent. A lot of them have 90 percent, right?

Dr. HEINRICH. I was going to say that would be good.

Senator CASEY. Much higher. I mean 40, 50 percent would be—it is hard to believe that that would be actually a good number compared to a lot of other sites.

But in this category, I wanted to clarify something on page 4. You have two sections here, two programs. Personal and Home Healthcare Aide State Training Program. That is No. 1 on that page. It is a \$5 million program. No. 2, you have the Nursing Assistant and Home Health Aide Program. That is \$2.5 million.

What I wanted to know was, and get a better description of, the difference between home care aide, that part of the first program, and home health aide? I think people can get confused by the overlap in the terminology. What is the difference between those two?

Dr. HEINRICH. In fact, you have a number of terms that are used for people who are direct frontline workers, and it is one of the issues that we hope to address in our programs, as a matter of fact. So you have your personal assistant. You have home health aides. You have nursing assistants who work in nursing homes. Then you also have assistants who work in hospitals.

Each of those areas have been looked at separately, and it seems to me very few people, very few organizations have looked across all of these siloed areas and said what are the basic competencies? Can you build those competencies as you move from, say, personal assistant, personal care assistant on through to maybe the more complex activities you would be expected to perform in a nursing home or even a hospital?

What we would hope is that through our model curriculums, we could actually look at competency-based skills where an individual could build their skill base and progress forward, even to thinking about entry into new types of jobs, new jobs in the healthcare provider disciplines.

Senator CASEY. Both these programs are 2 years, 2010 to 2012?

Dr. HEINRICH. Yes. Well, one is 3, I think.

Senator CASEY. OK. I also—I wanted to ask you as well. We have obviously the great opportunity, which is to say that it might be one of the few, if the only place in the country to be able to say this is accurate, and that is because we have a new medical school that is just getting off the ground.

The medical school has their second class coming in. Is that right, Doctor? I don't mean to jump ahead to panel No. 2. I want to make sure we are right.

As that school develops—and it is a tremendous opportunity, and that is an understatement—it just happens to be developing and growing as we are beginning to implement the healthcare bill. So it is a tremendous opportunity for lots of reasons.

But what role can medical schools play in developing this workforce that we have spoken about this morning already? Especially when we have both a significant challenge, but also a tremendous opportunity here at the medical school but even nationwide the new strategies, the new programs that the healthcare bill provides?

Dr. HEINRICH. Right. Well, again, with the new focus on primary care and the new focus on interdisciplinary education, it seems to me that there are many opportunities, as a new school is developing curriculum and thinking about how they are going to meet the needs of the population in different ways, and it sounds like you are very fortunate that the leadership of the medical school is really moving in that direction.

So for many of our medical schools, it is very difficult to fight tradition. So, here you are with the opportunity to think about how you train together medicine, pharmacy, nursing, and the area of mental health. I was just so excited to hear about the program in pharmacy and nursing that you have here where you already have training programs, basic science programs where people are leveraging your existing resources so that you are much more efficient in the training programs.

Sad to say, though, that you still have issues with the preceptorship and the placement because you have to have the clinical training, and it sounds like that is still a challenge for many of these programs. So we have to find ways of addressing the barriers that we have there with our expanding student populations but still needing the excellent preceptors and the clinical sites for the training.

Even when we expand physician clinical training beyond the hospital walls, which is wonderful to hear is happening in this community, into home care, into skilled nursing care, you still need to have hospital clinical sites to have an excellent program. It sounds like that is the direction that people are going.

Senator CASEY. Well, we are fortunate to have these opportunities.

Doctor, I know we are over time by a little bit, and I have a lot more questions. But what we will do is I and, I think, others will submit questions for the record. If you could answer those in writing, we are grateful. I wish we had more time to spend, but we have got two more panels.

Dr. HEINRICH. Thank you very much. Appreciate it.

Senator CASEY. Doctor, thank you for your testimony. We are grateful for your service. Especially at this time in our Nation's history, we are confronting a lot of difficult healthcare challenges. So thanks for your service.

Dr. HEINRICH. But it is fun doing all that implementation. Thank you very much.

Senator CASEY. Thank you.

We will move to our second panel. What I will do by way of introduction, as our witnesses are moving to the witness table, I would, first of all, like to welcome, as I mentioned him before, Dr. Bob D'Alessandri, the Executive Officer and Chief Academic Officer of The Commonwealth Medical College, who is responsible for setting priorities, institutional direction, and management, and functioning of The Commonwealth Medical College, as well as the curriculum development and execution, the student experience, faculty recruitment, and the execution of the research agenda at the medical college.

Dr. D'Alessandri is an educator with over 18 years of experience in senior leadership positions at West Virginia University, including almost 15 years as dean of the West Virginia University School of Medicine.

Our other witness today on our second panel, Dr. Vera Salter, Professional Development Director of the Direct Care Alliance. Dr. Salter was the founding director of the National Clearinghouse on the Direct Care Workforce at PHI, where she worked from 2001 to 2007. Before that, she co-owned a national planning and marketing firm with clients across the continuum of health and long-term care services.

She has served as vice president of a multi-institutional healthcare system and has held a number of health planning and research positions. Dr. Salter, thank you.

Dr. D'Alessandri, thank you. I think we will start with Dr. D'Alessandri.

STATEMENT OF ROBERT D'ALESSANDRI, M.D., EXECUTIVE OFFICER AND CHIEF ACADEMIC OFFICER, THE COMMONWEALTH MEDICAL COLLEGE, SCRANTON, PA

Dr. D'ALESSANDRI. Thank you very much.

Good morning, Senator Casey, Dr. Heinrich, staff, and honored guests. I am delighted to be here this morning to speak to you about our aging population and the need for more medical personnel to care for them.

While we have all seen the statistics—the percentage of the population aging, the increased demand because of chronic diseases, the aging of the provider population—those challenges are different in rural and small-town America. We, as a Nation, need to come up with solutions that are not one-size-fits-all because our needs and challenges are unique.

I would like to take just a minute and introduce myself and my school to you because why we were created is specifically relevant to these interests. Wilkes-Barre, Scranton, Pennsylvania, northeast Pennsylvania has many small communities. Like many small communities in the United States, we suffer from a number of concerns.

We have an aging population with many chronic diseases. In fact, Pennsylvania has the third-oldest population in America. Our physician population is also aging. In fact, almost half of the current physicians in this region will retire in the next decade. It is estimated that by 2025 this region will lack almost 1,500 needed physicians to care for our population.

We have a very fragile healthcare system. Hospitals incapable of investing capital in infrastructure improvement.

We have had a poor track record of recruiting physicians, both primary care and specialists, to the region. Almost half of Pennsylvania physicians practice either around Philadelphia or Pittsburgh despite the fact that only one-quarter of the population resides there. Not surprisingly, that is where Pennsylvania's medical schools have traditionally been located. Northeastern Pennsylvania suffers from a shortage of almost every type of physician and has fewer physicians per capita than national averages.

We have over \$1 billion in care. Yes, that is \$1 billion leaving the region because people cannot get appointments with physicians or cannot get access to physicians for the type of care they need. This involves increased expense, hardship, and inconvenience for families and patients.

We also have a region that has experienced tough economic times. The heyday of coal has been and gone. The economy here is not made up of major corporations. It is small companies, businesses trying to hang on. We don't have a lot of wealthy people to support healthcare, the arts, and community civic programs.

As I said at the beginning, we have a scenario that is typical of most of America's small cities and towns—nothing remarkable, significant, or special, just people who work hard, who are trying to carve out good lives for their families and get their loved ones good, high-quality healthcare. What is unique about this community is how it decided to address the problem of physician aging, lack of access to care, and their relative lack of success in recruiting replacements for these aging physicians.

This community came to the conclusion it needed to grow its own physicians and thus start its own medical school. The community had several goals for the school that included improving healthcare in northeast Pennsylvania by increasing the number of area specialists and primary care physicians; improving the quality of care in the region; improving access to care, especially in underserved and rural areas; generating economic impact by creating high-paying, sustainable jobs and attracting fresh dollars into the economy; increasing the education of the area residents; and providing the region with "intellectual capital."

I was hired in 2007 from West Virginia University to take these ideas and help create the school. In 3 years, we have obtained degree-granting authority from the State, received provisional accreditation from the LCME, the Liaison Committee on Medical Education, and the Middle States Higher Education Commission. We offer two degrees, a Master's in Biomedical Sciences and a Doctor of Medicine Degree.

We have hired 160 full-time faculty and staff. We have over 700 community-based physicians participating on a volunteer basis to train our M.D. students and have graduated our first class of Master's students. Next week, our second class of M.D. students—65 of them like the first class—begins.

Our 40 Master's students began in July. Our second-year medical students begin in late August. It has been a very busy 3 years.

Now we are not a model that is easily replicable in America. Starting a freestanding medical school is not a model that is really

economically feasible. We exist because Blue Cross of Northeastern Pennsylvania invested \$25 million in funding our startup and another \$45 million in our new building. Our State invested \$35 million in our building, funded our feasibility study, and gives us an important, but modest grant every year.

Thanks to Senators Casey and Specter and our congressional representatives, the Federal Government has supported TCMC, helping us with grants to fund our Clinical Skills and Simulation Center and other small projects. Ongoing funding is a challenge not only for us, but for the other dozen or so new startup schools across the country. But solving the problems of communities such as ours, the small towns and cities in America, and having enough doctors and other health providers to take care of our aging population is a complex issue.

The solution starts, like many problems, with changing our educational process because we don't just need more doctors, we need doctors with different skills. We need to address the problem of fragmentation in the healthcare system by training physicians, nurses, pharmacists, physical therapists, and others to work as a team.

As Dr. Heinrich mentioned, this is the interdisciplinary model. We need each of these individuals to understand not only their role, but others as well. We need to train physicians not just to lead, but how to work effectively as a team member.

At TCMC, we have created the first Consortium of Health Professions Education Program with all the regional schools that have health education programs to develop opportunities for our students to learn to work as a member of an interdisciplinary team.

We need physicians who can communicate effectively. Effective communication is essential for safe and effective care. This is one of the major complaints we hear from seniors. "My doctor doesn't listen to me." We need to develop these skills as rigorously as we teach molecular biology.

We need physicians who know how to find information on state-of-the-art care and then incorporate it into their practice. One of our faculty told our students recently that he is not doing one procedure the same way he learned in medical school or his residency. What we teach today has a very short shelf life. We need to develop their interest in being lifelong learners and their skills at finding the information on care that they need, when they need it.

We need physicians who understand the process of care improvement, how systems of care work and how to improve quality and safety as members of the healthcare team. Concepts like 6 Sigma and other quality improvement strategies and processes need to be learned by students, and they need to see they play a role in care and process improvement so care is both effective and cost efficient. Students need to understand critical thinking and systems thinking.

We need physicians who understand when care should be standardized and when patients need proven therapies modified for their particular issues. Standardization of care flies in the face of how many schools select and train physicians. They are selected because they are independent thinkers, not because they can follow a formula. But data shows that, in many cases, standardization im-

proves care and improves costs. We need physicians to know when each is important.

Physicians need to be trained in cultures that are collaborative, transparent, outcomes focused, accountable, team based, patient focused, and service oriented. They need to see this culture modeled not only at their medical school, but in their community sites where they train.

To do that will take a culture change in many of our healthcare organizations. They need to see models of care that work, first and foremost, for the patient, but also for the care team. They need to see innovative, cost-effective models, and we need a system that supports the development of these models, another place the Federal Government could provide support perhaps.

Physicians must understand the critical issues facing our seniors—polypharmacy, end-of-life issues, depression, dementia, and the need to feel that you can still contribute in some way. Each of our students is assigned to a multi-generational family. The student follows this family for 4 years, makes house visits, hears from family members about how they have to make choices between medicine and food.

I have to tell you that I have learned a great deal from my mother, who is 92. She keeps teaching me all the time. In recent years, she continues to get her Medicaid bills when she sees a physician, and frequently, she hands me the bill and tells me, “Pay this.” I look at it and say, “Mom, this is not a bill. I don’t have to pay this.”

She said, “No, no, pay it.” I say, “No. I’m not paying. It’s not a bill.” A month later, she receives another bill, and she says, “Pay it.” I say, “It says, Mom, this is not a bill.”

The next month, of course, she gets a letter from the collection agency saying that she is late. So I pay the bill. Then 6 months later, she gets a check from the provider saying you have overpaid. She says to me, “Don’t you know what you are doing?” I said, “No, I really don’t.”

This is a complicated system, and seniors face this all the time. We would like our students to hear that from the families that they follow. We would like them to actually see what healthcare is all about in the home, not just in the clinic.

So the very first part of this program is that the student visits the family in the home, and one of the first things we ask them to do is look in the medicine cabinet because that is where you will find an entire history of healthcare. It is a very important part of the educational experience, and to my knowledge, this may be unique in the education of medical students.

We also want our students to follow healthcare providers, not just physicians, but many of the direct providers that we are talking about. Experiences in nursing homes and in other facilities where care is provided, that is part of our new curriculum.

Our country needs a cadre of physicians specialized in the problems of our seniors. To that end, we are also planning a special training program in geriatrics. These specialists become resources for primary care physicians as well as seniors. Part of that program is not merely learning about the diseases and the illnesses that relate to seniors, but it is also learning about the social problems and also the health policy issues.

We want these geriatricians of the future to relate not only to the diseases and illnesses that affect our seniors, but also the economic and social problems as well. We want them to become leaders in policy changes as well. This is an important new aspect of geriatric training.

We need to view medical education as a continuum of competency. We need an educational program that is cost effective and allows students to move through it not in lockstep, but as they develop competencies that build through the educational process. We are in some danger of pricing the cost of medical education out of the marketplace.

Finally, we need to connect the education of physicians to their community and to service. We need to select bright students who want to serve, who want to make healthcare better, stronger, more effective—who want to care not only for the individual but improve the care in their community. We need to prepare physicians in their educational program to do that.

I would recommend to the Committee three excellent resources—the new Carnegie Foundation Report, entitled “Educating Physicians: A Call for Reform of Medical School and Residency,” the Josiah Macy Foundation’s reports on medical education and the new medical schools, and a wonderful book by Boston physician Atul Gawande, entitled “The Checklist Manifesto,” that addresses how healthcare can be safer and the importance of team communication. All these resources discuss what physicians need to know to care more effectively for patients.

At TCMC, we are addressing many of these issues and recommendations. Our curriculum was easy to adjust to current needs since we could start from a clean slate and attracted faculty who want to teach state-of-the-art curriculum.

Our model also has a community benefit. Since most of our faculty are community practitioners, they learn state-of-the-art care and thinking in their faculty development courses. Changing the way they deliver care will change over time the quality of care in our communities. Our educational model is deeply rooted in our goals and our reason for being. Our students are assigned a multi-generational family that they follow for 4 years. I mentioned that.

They are exposed to an integrated curriculum from the very beginning where science and patient care are constantly tied together to create relevance. They are deeply embedded in our region’s communities. In the first 2 years, they have a clinical mentor, they do community research projects, and they learn about quality and safety processes all in a community-based setting.

In their third and fourth years, they actually live in those communities and learn directly from over 700 volunteer clinical faculty who have been specially trained to teach students community-based medicine. Our students learn how to work in teams in our Clinical Skills and Simulation Center and develop their professionalism and community service skills as part of the educational process.

It is good public policy for the Federal Government to support new schools—to support new models of education, innovative models that seek to educate the students differently. The answer to our problems is not just to have more resources to train more doctors.

We need to provide new models of medical education that lead and support new, effective models of care.

We need to support educational innovation and the programs that are trying to do that and educational programs that are trying to change community-based care. We need to give our students the tools that they are going to use to take care of us and our children and grandchildren.

Then we need to invest in our hospitals and clinics who are barely hanging on. We need to make it possible for them to innovate and support quality improvement. If we are going to keep these newly trained physicians in this community, the places they practice must support the way they have been taught to practice.

Our hospitals and clinics need infrastructure, information technology, training in systems thinking, quality improvement, improved communication. They must be examples of innovation, not just places that are themselves on life support.

Then our small cities and towns will be able to care for our aging population. Our students who train in these communities will want to stay and raise their families in these communities. The answer is not just more money. It is money we spend differently to creatively meet the needs of an aging America in an effective and sensitive manner.

The medical schools in this country committed to innovation and reengineering the educational and care delivery models deserve your consideration and support. The new medical schools can be a community-based catalyst for change, creating a national model that will enhance the efficiency and effectiveness of healthcare that is available to all Americans of every age.

Our aging population must have access to the latest, most effective treatments, to providers who are sensitive and knowledgeable about their special needs, and we will be able to provide the kind of healthcare that works for everyone.

Thank you very much.

[The prepared statement of Dr. D'Alessandri follows:]



*Testimony to the United States Senate Special Committee on Aging
By Robert M. D'Alessandri, MD
President, The Commonwealth Medical College
Scranton, Pennsylvania
August 2, 2010*

Good Morning Senators, staff and honored guests. I am delighted to be here this morning to speak to you about our aging population and the need for more medical personnel to take care of them. While we have all seen the statistics—the percentage of the population aging, the increased demand because of chronic diseases, the aging of the provider population -- those challenges are different in rural and small town America. And we as a nation need to come up with solutions that are not “one size fits all” because our needs and challenges are unique.

I'd like to take just a minute and introduce myself—and my school to you because why we were created is specifically relevant to your interests.

Scranton, Pennsylvania, like many small communities in America, suffers from a number of concerns:

1. We have an aging population with many chronic diseases—in fact Pennsylvania has the third oldest population in America.
2. Our physician population is also aging—in fact almost one-half of the current physicians in the region will retire in the next decade. It is estimated that by 2025 this region will lack almost 1,500 needed physicians to care for the population.
3. We have a very fragile health care system—hospitals incapable of investing capital in infrastructure improvements.
4. We have had a poor track record of recruiting physicians—both primary care and specialists—to the region. Almost one-half of Pennsylvania physicians practice either around Philadelphia or Pittsburgh despite the fact

that only one quarter of the population resides there—not surprisingly that is where Pennsylvania’s medical schools have traditionally been located. Northeastern Pennsylvania suffers from a shortage of almost every type of physician and has fewer physicians per capita than national averages.

5. We have over one billion dollars in care, yes that is billion, leaving the region because they cannot get appointments with physicians or cannot get access to physicians for the type of care they need. This involves increased expense, hardship and inconvenience for families and patients.
6. We also have a region that has experienced tough economic times. The heyday of coal has come and gone. The economy here is not made up of major corporations-- it is small companies and businesses trying to hang on. We don’t have a lot of wealthy people to support health care, the arts, and community civic programs.

As I said at the beginning, we have a scenario that is typical of most of America’s small cities and towns—nothing remarkable, significant or special—just people who work hard, who are trying to carve out good lives for their families and get their loved ones good, high quality, health care.

What is unique about this community is how it decided to address the problem of physician aging, lack of access to care and their relative lack of success in recruiting replacements for these aging physicians. This community came to the conclusion it needed to grow its own physicians and thus start its own medical school.

The community had several goals for the school that included:

1. Improving healthcare in Northeast Pennsylvania by:
 - Increasing the number of area specialists and primary care physicians
 - Improving the quality of care in the region
 - Improving access to care especially in underserved and rural areas.
2. Generating economic impact by creating high paying, sustainable jobs and attracting fresh dollars into the economy; and
3. Increasing the education of the area residents and providing the region with “intellectual capital.”

I was hired in 2007 from West Virginia University to take these ideas and create the school. In three years we have obtained degree granting authority from the state, received provisional accreditation from the Liaison Committee on Medical Education and the Middle States Higher Education Commission. We now offer two degrees—a Master's in Biomedical Sciences and a Doctor of Medicine Degree. We have hired 160 full-time faculty and staff, we have over 700 community-based physicians participating on a volunteer basis to train our MD students and have graduated our first class of Master's students. Next week our second class of MD students—65 of them like the first class—begins. Our 40 Master's students began in July. And our second year medical students begin in late August. It has been a very busy three years!

We are not a model that is easily replicable in America. Starting a freestanding medical school is not a model that is really economically feasible. We exist because Blue Cross of NEPA invested \$25 million in funding our start up and another \$45 million in our new building. The Commonwealth of Pennsylvania invested \$35 million in our building, funded our feasibility study and gives us an important but modest grant every year. Thanks to Senators Casey and Specter and our Congressional Representatives the federal government has supported TCMC helping us with grants to fund our Clinical Skills and Simulation Center and other essential projects.

Ongoing funding is a challenge—not only for us but for the other dozen or so new start up schools across the country. But solving the problems of communities such as ours—the small towns and cities in America—and having enough doctors and other health providers to take care of our aging population is a complex issue.

The solutions start, like many problems, with changing our educational process-- because we don't just need more doctors, we need doctors with different skills.

- We need to address the problem of fragmentation in the health care system by training doctors, nurses, pharmacists, physical therapists, and others to work as a team. We need each of these individuals to understand not only their role in health care but others roles as well. We need to train physicians not just to lead but how to work effectively as a team member. At The Commonwealth Medical College we have created the first Consortium of Health Professions Education Programs with all the regional schools that have health education programs to develop opportunities for our students to learn to work as members of a team.

- We need physicians who can communicate effectively. Effective communication is essential for safe and effective care. This is one of the major complaints we hear from seniors – “my doctor doesn’t listen to me.” We need to develop these skills as rigorously as we teach molecular biology.
- We need physicians who know how to find information on state-of-the-art care and then incorporate it into their practice. One of our faculty told our students recently that he is not doing one procedure the same way he learned in medical school or during his residency. What we teach them today has a short shelf life—we need to develop their interest in being lifelong learners and their skills at finding the information on care that they need, when they need it.
- We need physicians who understand the process of care improvement, how systems of care work and how to improve quality and safety as members of the health care team. Concepts like six sigma and other quality improvement strategies and processes need to be learned by students and they need to see that they play a role in care and process improvement so care is both effective and cost efficient. Students need to understand critical thinking and systems thinking.
- We need physicians who understand when care should be standardized and when patients need proven therapies modified for their particular issues. Standardization of care flies in the face of how many schools select and train physicians—they are selected because they are independent thinkers not because they can follow a formula. But data shows that in many cases standardization improves care and improves costs. We need physicians to know when each is important.
- Physicians need to be trained in cultures that are collaborative, transparent, outcomes focused, accountable, team based, patient focused and service oriented. They need to see this culture modeled not only at their medical school but in their community sites where they train. To do that will take a culture change in many of our health care organizations. They need to see models of care that work—first and foremost for the patient but also for the care team. They need to see innovative and cost effective models and we need a system that supports the development of these models.
- Physicians must understand the critical issues facing our seniors: polypharmacy, end of life issues, depression, dementia, and the need to feel that you can still contribute in some way. Each of our students is assigned to a multi-

generational family. The student follows this family for four years, makes house visits and learns how family interactions affect health care. We want our students to hear from family members about how they have to make choices between medicine and food.

- Our country needs a cadre of physicians specialized in the problems of our seniors. To that end, The Commonwealth Medical College is planning a special training program in Geriatrics. These specialists become resources for primary care physicians and seniors as well.
- We need to view medical education as a continuum about competency. We need an educational program that is cost effective and allows students to move through it not in lockstep but as they develop competencies that build through the educational process. We are in some danger of pricing the cost of medical education out of the marketplace.
- Finally, we need to connect the education of physicians to their community and to service. We need to select bright students who want to serve, who want to make health care better, stronger, more effective -- who want to care not only for the individual patient but improve the care in their community. And we need to prepare physicians in their educational program to do that.

I would recommend to the Committee three excellent resources—the new Carnegie Foundation Report entitled *Educating Physicians: A Call for Reform of Medical School and Residency*, the Josiah Macy Foundation's reports on medical education and the new medical schools, and a wonderful book by Boston physician Atul Gawande entitled *The Checklist Manifesto* that addresses how our healthcare can be safer and the importance of team communication. All these resources discuss what physicians need to know to care more effectively for patients.

At TCMC we are addressing many of these issues and recommendations. Our curriculum was easy to adjust to current needs since we could start from a clean slate and attract faculty who want to teach state-of-the-art curriculum. Our model also has a community benefit—since most of our faculty are community practitioners they learn state-of-the-art care and thinking in their faculty development courses. Changing the way they deliver care will change over time the quality of care in the community.

Our educational model is deeply rooted in our goals and our reason for being. Our students are assigned a multi-generational family that they follow for the entire four

years of their education. They are exposed to an integrated curriculum from the very beginning where science and patient care are constantly tied together to create relevance. They are deeply embedded in our region's communities—in the first two years they have a clinical mentor, they do community research projects and they learn about quality and safety processes all in a community-based setting. In their third and fourth years they actually live in those communities and learn directly from over 700 volunteer clinical faculty who have been specially trained to teach students community-based medicine. Our students learn how to work in teams in our Clinical Skills and Simulation Center and develop their professionalism and community service skills as part of the educational process.

It is good public policy for the federal government to support new schools--to support new models of education, innovative models that seek to educate the students differently. The answer to our problems is not to just have more resources to train more doctors—we need to provide new models of medical education that lead and support new, effective models of care. We need to support educational innovation and the programs that are trying to do that and educational programs that are trying to change community-based care. We need to give our students the tools that they are going to use to take care of us and our children and grandchildren.

Then we need to invest in our hospitals and clinics who are barely hanging on—we need to make it possible for them to innovate and support quality improvement. If we are going to keep these newly-trained physicians in the community the places they practice need to support the way they have been taught to practice. These hospitals and clinics need infrastructure, information technology, training in systems thinking, quality improvement and improved communications. They need to be examples of innovation; not just be places that are themselves on life support.

Then our small cities and towns will be able to care for our aging population. Our students who train in these communities will want to stay and raise their families in these communities.

The answer is not just more money -- its money we spend differently to creatively meet the needs of an aging America in an effective and sensitive manner. The medical schools in this country committed to innovation and reengineering the educational and care delivery models deserve your consideration and support. The new medical schools can be a community-based catalyst for change, creating a national model that

will enhance the efficiency and cost-effectiveness of health care that is available to all Americans of every age. Our aging population will have access to the latest, most effective treatments, to providers who are sensitive and knowledgeable about their special needs, and we will be able to provide the kind of healthcare that works for everyone.

Thank you, Senator Casey and the members of the Committee, for invitng me to share my personal and professional perspective.

Senator CASEY. Thank you, Dean. Thank you, Dean, for that testimony.

Dr. Salter, thank you.

STATEMENT OF VERA SALTER, PH.D., PROFESSIONAL DEVELOPMENT DIRECTOR, THE DIRECT CARE ALLIANCE, NEW YORK, NY

Dr. SALTER. Thank you, Senator Casey.

I want to start by thanking you for your announcement that you are going to introduce the Direct Care Worker Empowerment Act tomorrow. That is very exciting news for us, and I think the very title is critical because what is so important is to recognize that there will soon be 4 million direct care workers working daily, one on one, with elders and people with disabilities.

It is only if direct care workers have the resources and are empowered to take the actions that are needed to improve the quality of life for those they are working with, that is the way we are going to get quality care. I work with Direct Care Alliance, and I am proud to work for an organization that is the advocacy voice for direct care workers throughout the country.

I won't go through the statistics again of the greatly increasing aging population, but I think one theme I have heard from many of the panelists is that as the population ages, the cohorts of people that are available to do the work to care for them is shrinking.

Senator CASEY. You might want to move that mike a little closer.

Dr. SALTER. Saying that there is a gap between the care needs and the number of people who will be available to do that work, whether they are family caregivers or paid caregivers because you were talking of the physicians aging out of the profession and this is aging out of the profession. So the crisis becomes amplified by that care gap.

I want to add that in 2008, there were 3.2 million nursing assistants, home health aides, and personal assistants in the United States. That number is projected to increase to 4.3 million by as early as 2018. I would like to also comment on the question you asked about the difference between home care aides and personal assistants and home health aides.

In some ways, if you think of an elder or a person with disabilities that needs care in their home for a long period of time, the complexity of the work that a personal assistant has to provide may be greater than a home health aide, who is defined as someone who is working for a home care agency under the Medicare program.

So, in some ways, the definitions of workers are created by the funding stream and not by the competencies that are required to do the work. That is why I think it is so important that the training and the compensation be based on competencies, as many of you have already said.

So who are direct care workers? There are 165,000 direct care workers employed in Pennsylvania, and these are among the largest and fastest-growing occupations in the Commonwealth, projected to increase by 50 percent in the next 10 years. Most direct care workers receive low wages—on average, \$10 an hour—little or no benefits, and insufficient training and professional development.

As a result, as we have said already, this profession is plagued by high turnover rates that compromise the quality of care of the people they serve. If we are to retain direct care workers in this profession and make it an occupation that people want to enter, we will need to provide basic labor protections as are provided in the bill that you are introducing, livable wages and benefits, training and opportunities for advancement.

I was asked to address the issues of what is needed in terms of training, certification, and advancement to make direct care a desirable profession. First, I want to stress that all direct care workers should be required to receive adequate training.

Currently, Federal regulations require only 75 hours of training for nursing assistants and home health aides, and there are no Federal requirements for personal care assistants who provide services under the Medicaid program or to private individuals. We recommend, in line with a recent Institute of Medicine report, that all direct care workers receive at least 120 hours of training, either before they start work or while they are working on the job.

We also think it is very important that direct care workers have competency-based credentialing and recognition of their professional competency. The Direct Care Alliance has just established a National Professional Credential for personal assistance workers, the group that is not currently federally regulated. We also recommend that specialty credentials in such areas as dementia, peer mentoring, wound care, diabetes management, and many other areas be available to direct care workers.

I would love to see more recognition of the role of direct care workers in the care team because while they are the people who are spending all day with an elder in their home, they are often not included as part of the medical team.

One of the things that struck me as we look at the competencies of this workforce, this is difficult work. The same issues of communication, knowledge of a variety of medical background are critical for people to do their work well. Yet, as you know, under the Fair Labor Standards Act, they have been—home care workers have been categorized as “companions” and not as professionals that are a necessary part of the team.

One of the most critical things is respect and opportunities for advancement. There have been numerous evaluative studies of what it takes to retain direct care workers, and it is really in some ways blazingly obvious. But I just want to tell you about some of those studies.

There was a program funded through the Robert Wood Johnson Foundation called the Better Jobs, Better Care program, and there was a special edition of the *Geriatric Journal* that gave the results of some of those studies, and the message gets repeated. For example, a study in Massachusetts found that nursing assistants were more committed to their jobs when they perceive their jobs as having more autonomy, use of knowledge, and teamwork.

In another study at Cornell, a retention specialist program demonstrated that assigning a manager with expertise in all of the techniques of retaining people improved retention when compared to facilities without such a program. The WIN A STEP UP program

in North Carolina provides continuing education and compensation for education modules, also had great success.

There are numerous career ladder programs throughout the country, and at Genesis Healthcare, headquartered in Kennett Square, PA, they have had a geriatric nursing assistant specialist program for 21 years that trains and compensates nursing assistants for their advanced knowledge.

There have been many studies of what direct care workers are looking for, and in one study conducted by Dr. Peter Kemper, a professor at Penn State, he summarized what is important to direct care workers. What they want is more pay, better work relationships, being appreciated, listened to, and treated with respect, which is basically what we all want in our work.

Unfortunately, recognition of these issues and efforts to create the right work environment is limited and sporadic. What is needed is a broad public policy that changes the way direct care work is managed and compensated so this becomes a respected profession that people want to enter.

[The prepared statement of Dr. Salter follows:]

SENATE SPECIAL COMMITTEE ON AGING HEARING
*Taking care of Mom and Dad: Why We Need a Quality Workforce to Serve
Our Older Americans*

Wilkes University Wilkes-Barre, Pennsylvania

August 2, 2010

TESTIMONY OF VERA SALTER Ph.D. PROFESSIONAL
DEVELOPMENT DIRECTOR, DIRECT CARE ALLIANCE.

My name is Vera Salter and I am the Professional Development Director for the Direct Care Alliance, a non-profit organization that serves as the national advocacy voice for the nearly 4 million direct care workers in the United States. Previously I founded the National Clearinghouse on the Direct Care Workforce at PHI, and worked with the US Department of Labor to establish an apprenticeship program for home health aides.

As you know the number of Americans needing long-term care is expected to double in the coming decades from 13 million in 2000 to 27 million in 2050. In Pennsylvaniaⁱ 1,867,500 people were aged over 65 in 2008 comprising 15 percent of the population and nearly one million people were aged over 75. In the Scranton Wilkes-Barre MSA 17.8 percent of the population is aged over 65.ⁱⁱ Those who need paid long-term services and supports in the future will find that direct care workers will provide the vast majority (over 70) percent of that care.

In 2008 there were 3.2 million nursing assistants, home health aides and personal assistants in the United States and that number is projected to increase to 4.3 million as early as 2018.ⁱⁱⁱ There are 165,000 direct care workers employed in Pennsylvania and these are among the largest and fastest growing occupations in the Commonwealth projected to increase by 50 percent over the next ten years.^{iv}

Most direct care workers receive low wages (on average \$10 an hour) little or no benefits and insufficient training and professional development. As a result this profession is plagued by high turnover rates that compromise the quality of care of the people they serve. If we are to retain direct care

workers in this profession we will need to provide basic labor protections, livable wages and benefits, training and opportunities for advancement.

I have been asked to address the issue of what is needed in terms of training, certification and advancement opportunities to make direct care a desirable profession.

Training: First I want to stress that all direct care workers should be required to receive adequate training. Currently Federal regulations require only 75 hours of training for Nursing Assistants and Home Health Aides, and there are no Federal requirements for personal care assistants who provide services under the Medicaid program or to private individuals. We recommend that all direct care workers receive at least 120 hours of training and continuing education on the job as indicated in the 2008 Institute of Medicine Report “ *Retooling for an Aging America: Building the Health Care Workforce*.”

Recognition and Certification: Second we recommend that all direct care workers have competency-based professional credentialing programs available to them so they can receive recognition for their knowledge and skills. The Direct Care Alliance has established a National Professional Credential for personal assistance workers, a group that is not currently federally regulated. We also recommend that specialty credentials in such areas as dementia, peer mentoring, wound care, diabetes management and many other areas be available to direct care workers.

Respect and Opportunities for Advancement: We believe that it is imperative for direct care workers to have improved working conditions and opportunities for advancement within their field if they are to remain in this work and provide the quality care that our elders deserve. There are many ways that senior aides can serve as peer-mentors for new recruits and receive training and compensation for their expertise beyond their entry-level skills. Genesis HealthCare headquartered in Kennett Square Pennsylvania has maintained a Geriatric Nursing Assistant Specialist program for 21 years that trains and compensates nursing assistants for their advanced knowledge.

There have been numerous qualitative and quantitative studies that have documented the measures are effective in retaining workers.^v

These include:

- An analysis of interviews with participants in a large career ladder demonstration in Massachusetts that examined whether nursing assistants were more committed to their jobs when they perceive their jobs as having more autonomy, use of knowledge and teamwork.
- A retention specialist program that demonstrates that assigning a manager with expertise in retention programs to a facility can improve retention when compared to facilities without such a program.
- The WIN A STEP UP program in North Carolina that provides continuing education and compensation for education modules.

Dr. Peter Kemper, a Professor at Penn State University interviewed direct care workers in all settings in his role as evaluator of the Better Jobs Better Care project. He summarized what they say is most important to them: “More pay, better work relationships, being appreciated, listened to and treated with respect.”

In other words, what we all want in our work. Unfortunately these efforts are limited and sporadic. What is needed is a broad public policy that changes the way direct care work is managed and compensated.

ⁱ Kaiser State Health Facts

ⁱⁱ U.S. Census 2003 ACS Survey

ⁱⁱⁱ PHI Facts 3 February 2010 Update.

^{iv} PHI State Facts: Pennsylvania’s Direct-Care Workforce October 2009

^v A number of these studies are included in a special edition of *The Gerontologist* July 2008 48 (suppl. 1)

Senator CASEY. Well, Doctor, thank you very much.

I want to thank both of our witnesses for your testimony. I just had a couple of questions, and in light of our time, probably just maybe about 5 minutes of questions.

First of all, Dr. D'Alessandri, I wanted to ask a basic question about—kind of a “where we are” question. I know the medical school is up and running. You have got your second class coming in. But can you give us a little update on the construction, kind of where that is.

Dr. D'ALESSANDRI. Construction is proceeding very nicely. We will be occupying the building by April 11, 2011, in plenty of time to accept our third class. At that time, the class will increase in size to 100 and eventually 120 students per year. So we are right on target for that and feel very, very good about that.

Senator CASEY. This incoming class is?

Dr. D'ALESSANDRI. Sixty-five.

Senator CASEY. Last year's was 65?

Dr. D'ALESSANDRI. That is correct. We are currently at Lackawanna College, utilizing their temporary space there, and that is really the limit that we could manage at the present time.

Senator CASEY. You mentioned the students working with a multi-generational family. We don't hear enough about those kinds of approaches, and I wanted to have you expand on that and why you think that is so critically important to expose a young medical student to that kind of experience?

Dr. D'ALESSANDRI. Right. It really is a very important concept. Our students are relatively young. Not relatively, they are young. Most of them, if not all of them, have very little experience with the healthcare system. Their parents are young.

By the time they become familiar with the healthcare system from a patient perspective, they are physicians and treated differently. Physicians don't really understand healthcare from the patient perspective, and we see the patient in the clinic, in the office, and patients just won't tell you things.

So the young mom who takes her two children, waits in the waiting room for 2 hours, then sees the doctor in a skimpy gown, waits there for 20 minutes, and her doctor walks in and looks at her and wonders why her kids are running around and she can't take care of them. That young lady will never say a word to the doctor about all of that.

But she will go home, complain about that. Our students, we hope, will hear that and will learn about the problems about the healthcare system from the patient's perspective. It isn't learning about medical knowledge. It is really learning about the social-economic impact that this has on a family and on their health, and that is really why we think this is so critical.

It will also bond those students to those families, and we hope those families will also play a role in recruiting those students and keeping them in our community.

Senator CASEY. I also want to note for the record that in Dr. D'Alessandri's testimony, starting on page 3 and going through most of page 5, when he walked through those various points about working effectively as a team member, helping physicians to communicate better, finding information on state-of-the-art care, how

a system of care works, standardization of care, collaborative and transparent outcomes-focused, accountable team-based focused strategies, critical issues facing seniors—when he went through that whole list, he starts with the word on page 3, “solutions,” which we want to hear about.

We know that sometimes, especially in Washington, we can be very good at diagnosing problems and challenges and not often enough outlining solutions and then pushing forth ways to implement those solutions. So we are grateful for that kind of roadmap or list of solutions that we can all work on together.

Dr. Salter, I wanted to ask you about—and a lot of your testimony is very consistent with my own unprofessional observations, but I think significant experience as a public official. I am not sure there is any public official in the State over the last decade or so who has spent as much time on some of these issues as they relate to direct care workers and older citizens as I have. I still don’t consider myself an expert, but I learned a lot along the way.

Your testimony was very consistent with experiences I have had, as both a public official and as a member of the family. As Dr. D’Alessandri and others have noted, we learn a lot more about healthcare and the work and the policy as members of the family than we do sometimes in our professional lives.

But one observation, one insight that you and others have had is that the direct care worker wants to be seen as a professional, wants to be valued more, and sometimes one of the ways to get there is to develop what people in the industry have said not a career ladder necessarily—it could be that, I guess—but a career kind of lattice. In other words, they can move almost laterally or—can you explain that, what your sense of that is?

Dr. SALTER. Well, we have found that when somebody enters an occupation, at the beginning they are learning the basics of doing it. But when you have spent 10, 20 years in the occupation, you have learned a lot of skill. There can be lots of ways to recognize people’s advanced knowledge so that people can have specialty training in geriatrics, in dementia, in diabetes management, and be compensated for it so that people are moving up a ladder, as it were, within the direct care profession.

There are also some people that do want to take that learning and move on to LPN or RN programs, but we have found that that is a minority. Many people who do this work do it because they love the work but find it impossible to stay in the occupation because it is so poorly compensated and regarded. So I think there are a lot of different pathways for different people, which is why the word “lattice” has been introduced.

There has also been a lot of success with peer mentoring programs because one of the biggest turnover times is in the first 6 months of the work. People enter the work in the nursing home, for example, and leave within 6 months. Whereas if there is a senior aide who has already done this work who is assigned to support them, they are much more likely to stay. Again, that peer mentoring role can be trained and supported with compensation.

So I think there are opportunities for people to move ahead in the profession and also to work in more supervisory ways because there is a shortage of RNs and a shortage of people to take on some

of the management functions because a lot of self-scheduling where people are allowed to schedule their own work that can be organized. So, there are many ways that people can be empowered more and compensated for their knowledge and their advanced work.

Senator CASEY. Well, I can't tell you how many times over the last it is now 15 years since I have been a public official that people have told me that are experts in long-term care that run nursing homes about a whole myriad of problems. It would be complicated enough if this were just a worker, direct worker, direct care worker problem, but this is a big employer problem.

Dr. SALTER. Right.

Senator CASEY. We haven't gotten our public policy right to the extent that you have a nursing home might train over the course of a year or more, or maybe more than a year, they might train 10 people and retain 1.

Dr. SALTER. Yes.

Senator CASEY. So they spend all that time, all those dollars training someone who leaves within months. So it is obviously bad for the worker, bad for the employer in a significant way, and bad for the person in that bed who is dealing with Mary or John for a couple of months, maybe longer, and then they have a turnover and then another turnover, another turnover.

So the family is confused. The person who is the recipient of that care is not getting the quality of care they should get. The employer is out money, and the worker is bouncing around to different jobs. So we need to get it right, and there is a lot more to do to get it right.

I did want to ask Dr. D'Alessandri one more question. Just about the—you did mention the training program in geriatrics. Can you talk about that for a moment just a little more?

Dr. D'ALESSANDRI. Sure. Also, I wanted to mention just a couple of things that relate to that, if I might?

Senator CASEY. Yes.

Dr. D'ALESSANDRI. One is that we think pipeline programs are really critical, and I know that Dr. Heinrich mentioned that. We are actually involved in and have applied for an HCOP program and have been working with Wilkes and LCCC, Luzerne County Community College, in developing those pipeline programs.

So we think that has a real important aspect in terms of training workforce in healthcare for this region and really focusing on rural, first-generation, underserved minorities. So that is a really strong program for us.

The second is that in residency programs—and I really applaud the effort that HRSA is making in increasing residency slots primary care. But very often, primary care residency slots go unfilled. Where the dollars would be better spent or at least equally well spent, let me put it that way, would be really encouraging medical schools to increase primary care training among their students and giving incentives for medical schools to really educate primary care physicians.

The geriatric program is a very important one. Ninety-five percent of the care, primary care for seniors is really going to be with primary care providers, not with geriatricians. We see geriatricians

as being a resource for the primary care provider, as well as the patient and for other agencies that work with seniors. We see the geriatrician as the advocate in terms of public policy for the senior from the healthcare perspective.

So, with that in mind, the training program involves not only the usual aspects of medical education, disease, and that sort of thing for the geriatrician, but it also involves an intense knowledge of the social agencies and other agencies that relate to seniors—

Senator CASEY. To be an advocate.

Dr. D'ALESSANDRI. To be an advocate. An understanding from the senior's perspective of how they may utilize and work with those. I was intrigued by the navigator concept that Dr. Heinrich talked about. In some ways, the geriatrician is also a navigator, helping the senior through the system, and maybe even helping the primary care provider through the system.

So we think that the traditional model teaching knowledge-based content, skills, all of that is very important, but also the other aspect of this, health policy and also understanding dynamics within the community, are really important.

For example, transportation is a huge problem in our area for not only seniors, but for everyone. Getting to an appointment, relying on family, those kind of things. Helping work through those problems with seniors, we see the geriatrician as being a very important part of that.

Senator CASEY. Well, Doctor, thank you so much. Dr. D'Alessandri, Dr. Salter, I know we have more questions, but not enough time. But we will send questions for the record that will be additional to amplify your testimony. We are grateful for your time here today. Thank you very much.

Dr. D'ALESSANDRI. Thank you, Senator. Thank you.

Senator CASEY. We will move to our third panel. As our panelists are getting to their seats and we are transitioning to our third and final panel, we will be pleased to welcome Melissa Lear and Connie Kreider.

Melissa is President of Beck N'Call Home Health and President of Allen Lear Home Health. In these positions, she has focused on providing in-home assistance to older citizens in the indigent, serving people whose activities of daily living are not covered under Medicare, Medicaid, or other insurance programs.

Ms. Kreider is a Certified Nurse's Assistant and since 1998 has worked at Luthercare, an assisted living facility in our Commonwealth. She is also the co-chair of the Pennsylvania Direct Care Workers Association.

So, Ms. Lear, we will start with you.

**STATEMENT OF MELISSA LEAR, PRESIDENT, BECK N'CALL
AND PRESIDENT, ALLEN LEAR HOME CARE ASSOCIATES,
EAST STROUDSBURG, PA**

Mr. LEAR. OK. Good morning and—I guess almost afternoon now. I can't thank you enough for letting me come here and do this.

Senator CASEY. Let me interrupt for one second. I know your printed testimony is longer than 5 minutes.

Mr. LEAR. I am going to make this amazing for you.

Senator CASEY. Summarize as best you can.

Mr. LEAR. The fact of the matter is that I am one of the faces of home care. I am not only the CEO, I am a registered nurse. As the CEO of two companies, I still see patients on a regular basis.

I could talk about home care from now until years after I am dead and gone. I think that the reason that it is important for me to be here today is to let you know that recruitment has always been a problem in home health for both aide—direct care workers, home health aides and nurses. But my agencies have been successful over the years by making the rewards and benefits of working in home care a primary focus.

I don't believe that the financial rewards of doing this kind of work are ever going to match the personal satisfaction that the people who do it get. So a few of the real important factors of working in home care is our one-to-one patient relationships. I graduated with a bunch of nurses who work in hospitals. They see 10, 12, 14 patients a shift. I see one at a time. They have my undivided attention for the amount of time that I am there, and I am there however long I need to stay to get done what I am there to do.

If you would imagine for a moment sitting in the kitchen with Miss Vivian in her late 90's, and she cries and speaks softly to you about how cruel it is for her to continue living. She has lost most of her sight. She has outlived all of her friends, and her family lives too far away to help. She knows and you know that without home care she would be placed in a nursing facility, being forced to leave her home.

Imagine working with Miss Margaret, performing wound care on a dressing and listening as she tells the story of how her husband built the home she still lives in with her son. She reminds you that your agency took care of her husband also, and it has been a few years since he passed away.

She lets you know that what she wants most for her 100th birthday, which is right around the corner, is a record number of birthday cards. So you head back to the office. You spread the word. All the employees that can get a card in the mail to her do so. Miss Margaret got an unbelievable number of cards, a spot on the local news, huge bouquets of flowers, and one more birthday before she passed away at 101 years of age.

In total, your agency provided almost 9 years of care to Mr. and Mrs., but they rarely required more than 3 or 4 hours per day because their son, in his 80's, bridged the gap between our services.

The only difference between you and I is that I don't have to imagine these stories. These are not the stories of my employees or employees of other agencies. For me, they are real events, and they belong to me.

Benefits to working in home care include flexible schedules that work for patients as well as staff. It is a process of care that I have kind of coined the phrase “wholistic,” meaning W-H-O-L-E, because we solve care management problems that stem across the entire family dynamics. We find many problems in home care that we can fix that we have talked about earlier today that physicians don’t know about, hospital discharge planners don’t know about, clinics don’t know about because families are either too embarrassed to share it or don’t believe that anyone has the solution.

I can offer to you that the first single-biggest impact you can make in the future recruitment of individuals is to encourage and support a growing influx of available nurses, home health aides, and caregivers, and that would be to show firsthand potential pool of individuals the impact that they can make on another person’s life.

What makes a young man or woman at the age of 18 enlist in the military is not a paycheck. It is a deep-seated love for their country and the freedom that being part of this country brings them. It is the need to be part of something bigger than is just themselves. It is a lifestyle that is presented to them when they are very young.

This is what we need to do for the home care agency. I was not a nurse since a long, long time ago when I was 18. I quit college three times before I finally finished. I didn’t finish in nursing. I have a Bachelor’s degree in computer information systems. I have a Master’s in business. I didn’t graduate from nursing school until I was in my late 30’s, when I went back and decided this is what I wanted to do.

I spent 2½ years working full time while I attended classes and did clinical rotations. During my 2 years of clinical care work, I spent weeks in nursing homes learning to apply what I had learned. I moved to a hospital clinical rotation. I spent three semesters, did clinical rotations in four or five different hospital settings. I spent one day in home care and hospice. That was not enough to change my life.

I already knew home care. I already loved home care. That is what keeps me in home care today. Most people that I meet still have no idea what a home care nurse is, what a home care aide is. They don’t understand what we do or the impact that we make. My very small agencies employ 75 people, and we see approximately 200 patients a day. We make a huge difference in the community that we serve.

Picking through to see what I really want to add. I think that home care also has a very serious place in chronic care management, and I would hope that as different issues of the healthcare reform come through that home care is not left off the table. We are a very important resource to kind of spread that physician avenue for patients out geographically.

I know that there are a lot of initiatives under the healthcare reform legislation that focus on chronic care management, and I would like to let everybody know that home care would certainly love to partner in many of these endeavors in reaching out to people from telehealth right on up through any other demonstration

projects that are going on. We certainly would be appreciative to be present at the table when those are put forth.

The only other thing I can share is that we serve a large number of populations who are squeezed between Medicaid and Medicare. When you cross over, just over the Medicaid border of financial eligibility is a population of individuals who are making hardcore choices between taking their meds every other day, between doing their lab work as regularly as they should because they can't afford to have someone come into their home and do it. Medicare doesn't cover it in many, many cases for them, and they don't have the ability to get out to a physician or a lab to do this kind of testing.

The example would be like a Coumadin patient, someone who takes blood thinners, requires frequent blood monitoring. Right now, you can have a Medicaid patient who gets that service covered for them. They could be monitored every 2 weeks like a physician would order.

Somebody who just misses those financial eligibility guidelines is negotiating with their physicians, trying to stretch that time period out because they don't have the resources available or the means to get that kind of medical care as regularly as they should.

The one final note I will toss in is if there is an opportunity at some point in the near future to allow Pennsylvania physician assistants and nurse practitioners to order and write home care services, that would be a huge help for us. We work with a lot of nurse practitioners who right now are not permitted to sign our home care orders, and it slows down a patient's availability of services.

[The prepared statement of Ms. Lear follows:]

Senate Special Committee on Aging Hearing
Monday, August 2, 2010

Taking Care of Mom and Dad:
Why We Need a Quality Workforce to Serve Our Older Americans

Wilkes University
Wilkes-Barre, PA

Testimony from:
Melissa Lear, RN
President of Beck 'N Call
President of Allen Lear Home Care Associates
Proud Member of the Pennsylvania Homecare Association

Good morning and thank you for your continuing interest in caring and supporting older Pennsylvanians. My name is Melissa Lear, I am president of Beck N' Call and Allen Lear Home Care Associates, long time members of the Pennsylvania Homecare Association. These agencies are located in East Stroudsburg and together provide both non-medical and medical homecare services to predominantly geriatric patients.

I am also a registered nurse and have been in the business of bringing care and services into seniors' homes for more than fifteen years. In that time many changes have occurred – and as I read about health care reform – I imagine there are many more changes on the horizon. However, too often, when policymakers talk about health care reform, the issue of long term care or seniors' care is rarely mentioned and “workforce” never even gets placed on the agenda!

So, needless to say, I'm thrilled with today's hearing topic and I am honored to have been asked to come and share my thoughts! I especially like the title, “Taking Care of Mom and Dad” – because this is not just a senior issue– it is a family issue and a fundamental public policy issue for both federal and state government.

I would like to focus my remarks on three areas: 1) Barriers to providing care and support to senior citizens; 2) Improving and preparing our workforce to accommodate our growing senior population; and 3) Retooling our health care system to address the needs of our growing senior population.

1. Meeting the Increased Need for Senior Care and Support

For small agencies like mine, that care for about 200 patients a day and employ 75 health care workers, our biggest challenge is recruiting and maintaining a qualified workforce. This is especially true of nurses and homecare aides. It's impossible to compete with the salaries, bonuses, and benefits being offered to nurses by large health systems, but I am sure that you've heard that over and over again. So over the years, my agencies have taken a different approach. We have been successful recruiting nurses and home health aides by making the benefits and rewards of working in homecare a primary focus, because the financial rewards of doing this kind of work will never match the personal satisfaction...Ever. Benefits to working in homecare include:

- One to one patient relationships. (Try finding that in a hospital setting. The beauty of working in homecare is that I can only be asked to see one patient at a time. They get my undivided attention for the duration of my visit.)

Imagine sitting at the kitchen with Ms. Vivian, in her late 90's, as she cries and softly speaks to you about how cruel it is for her to continue living. She has lost most of her sight, outlived all of her friends, and her family lives too far away to help. She knows, and you know, that without homecare she would be placed in a nursing facility, being forced to leave her home.

Imagine working with Mrs. Margaret, performing her wound care dressing change, and listening as she tells you the story of how her husband built the home she still lives in with her son. She reminds you that your agency took care of her husband also, but it has been a few years since he passed away. And she lets you know that what she wants most for her 100th birthday (which is right around the corner) is a record number of birthday cards. So you head back to the office, and spread the word so that all the employees can get a card into the mail to her. She got an unbelievable number of cards, and a spot on the local news, huge bouquets of flowers, and one more birthday before she passed away at 101 years of age. In total, your agency provided almost 9 years of care to this Mr. & Mrs., but they rarely required more than 3 to 4 hours of care per day because their son (in his 80's) bridge the gaps between services.

The only difference between you and I, is that I don't have to imagine these scenarios. For me they are real events. These are not stories from my employees, or from other agencies. They belong to me.

- Benefits to homecare include flexible scheduling that works for patients as well as staff. The main source of home health aide recruitment that we do is focused on the part-time employee. This isn't because all we are seeking is a part-time employee, but rather because part-time work is all that many of the best caregivers can provide. (Remember that many of our paid caregivers are wives, mothers, daughters, and granddaughters, with endless responsibilities. I employ individuals that could never maintain a full time position at this time in their life because they work around school bus schedules and other multi-generational family issues.)
- Another benefit to homecare is what I call "Whole-istic (Note: not spelled wrong. I made it up to describe the whole kind of care that we provide) Care Management". This is how we describe our opportunity to work with, support, and educate patients and families. It is the focus of what we do every day. Solving problems that left unaddressed would end in disaster. Working with patients and families, who are doing the best they can with what they have available to them, and then teaching them how to do things better. Over the years we have been successful by emphasizing the flexibility and the one-to-one care home health offers that is so rewarding!

"Whole-istic" Care Management means that often times we are delivered into situations that hospitals, doctors, and discharge planners were simply not aware of because the patients come and go from these types of settings. Because we deliver care at home, we are the ones that frequently find out there is no heat in the winter, no food in the fridge, no money for laundry. We are the ones who find homes in remarkably poor condition, and nearly unlivable. We are the ones who often find seniors neglected, and sometimes children neglected, and get them connected to agencies that can offer support and resources.

We find other things too, things we can fix. We find that our patient, who has just lost her daughter to breast cancer, has a stair glide that doesn't work and because of that, she can't get the funeral of her child. My nurses worked together and enlisted

several volunteer firemen to come and get this patient out of the house, so she could be taken to the funeral. And my nurses delivered food to the home to feed the family and friends after the service.

I can offer to you that the single biggest impact you can make in the future recruitment of individuals to encourage and support a growing influx of available nurses, home health aides, and caregivers is to share first hand with a potential pool of individuals the impact they could make on the life of another.

What makes a young man or woman, at the age of 18 enlist in the military? It isn't the paycheck. It is a deep seeded love for their Country and the freedom that being part of this Country brings them. It is the need to be part of something that is bigger than just them selves. It is a lifestyle that is presented to them when they are young, via TV commercials, billboards, movies, educational programs, the list goes on and on. THIS is what we need to do for the homecare industry.

Nursing school was such an education for me. I spent 2.5 years working full time, attending classes, and doing clinical rotations. During my two years of clinical care work, I spent weeks in various nursing home settings learning to apply what I had learned in the textbook and classroom. Then I moved onto hospital clinical rotations. I spent three semesters, and did clinical rotations in 4 or 5 different area hospital settings. I spent one day in the homecare/hospice setting. If I didn't already know, and love homecare, that experience was not enough to make that my chosen field of work. I was already exposed to homecare. I already had the deep seeded love for it. I already knew that I would probably never work in any other setting. THIS is what we need to do for the homecare industry.

Homecare budgets are stretched so tightly, and compared to individual institutional settings our agencies are so small that we cannot make that kind of impact alone. Good employers will retain good staff. Good employers don't have to recruit, employees come to them. A career path can be well respected, totally rewarding, and easily attainable...but if no one knows about it, how will they choose that path? The homecare industry simply needs help putting the word out that the most rewarding healthcare work is done in the home setting.

- o On Thursday, June 17, 2010 in the early evening, a local low income senior housing complex in my county caught fire and had to be evacuated. A nurse who heard the news sent a text to our Nursing Director, who sent a text to me to let me know. At the same time, one of my home health aides, whose husband was a firefighter, called her Supervisor to let her know what was happening and where the residents were being moved to for the night. The next morning, I arrived at the office extra early and made a call to the local Aging Office to offer whatever support my agencies could provide to them. They asked for nursing staff to help do basic health and needs assessments for all the residents so that emergency services could be started. My nurses volunteered and headed over. They spent the day with the residents in the hotel that was now their

temporary home. At the end of the day, one nurse came back and said, “Thank you for letting me have the opportunity to do this today. The residents were mostly all medically stable, but they talked to me, and they cried, and they were afraid. I didn’t really do anything though.” And, tears were falling from her eyes. I reminded her that, in fact, she did so much. That is another story of a nurse who came to homecare and will never leave.

○
2. Preparing A Workforce to Support Growing Elderly Population

As Pennsylvania’s senior population continues to grow with the baby boomer generation starting to turn 65 next year, we must be prepared to meet their health care needs. In the latest U.S. Department of Labor report, homecare aides are one of this country’s largest and fastest growing professions totaling more than 3 million. In Pennsylvania alone, we have 158,000 direct care workers. In fact, home health aides and personal care aides are, and will continue to be the third and fourth fastest-growing occupation in the country from now until 2018. Of course, this is all market driven by our fast growing senior population and the trend to remain at home as we age.

How do we prepare? We need to elevate caregiving as a profession and recognize its importance in providing care and support for our seniors. While nursing and therapists are critically important when delivering medical care; most seniors also need assistance with daily routine activities in order to remain in their homes. These types of services, referred to as personal care are provided by personal care aides. And while better salaries and benefits are a must, other issues must also be addressed including adequate provider reimbursement under Medicare and Medicaid to support higher salaries and last but not least a culture change that promotes multi-disciplinary team approaches when caring and supporting a senior. Each person, whether it is a nurse, social worker or a home care aide must be respected and valued as a critical member of the team that is caring and supporting that senior.

Training is another component that must be addressed. While Pennsylvania has invested millions of dollars in direct care worker training, more effort must be given to adopt a universal curriculum for direct care workers that will guarantee families that a qualified individual is providing care to their loved one. Pennsylvania is currently working on this effort through the Dept. of Labor and Industry however coordination among state agencies such as the Dept. of Public Welfare and Aging is needed to implement this effort.

Today’s new “older population” is better educated, more ethnically and racially diverse, has at least one chronic condition, and their families are spread out, no longer remaining in the same home town. They rely on health care services far more than other segments of the population and therefore we must ensure that a trained workforce is prepared to meet their needs.

Our health care workers including physicians, nurses, and therapists receive very little geriatric training. Government must promote geriatric competence through enhancements in curriculum at medical schools. We should also offer financial incentives to increase the number of geriatric specialists in every health profession and provide employers with incentives to establish geriatric training of direct care workers.

Last but not least I would be remiss if I did not mention the role of family caregivers. Today, an estimated 1.3 million people in our state are caring for an older family member. Family caregivers are a critical extension of our formal health care system and provide 1.3 billion hours of care, at an economic value of nearly \$14.6 billion. They do this on top of other daily obligations such as holding down a job, caring for their own children and running a household. Without their efforts, their aging family member could be shifted to public programs, such as Medicaid. Government must do more to support family caregivers to help them continue to care for their loved ones at home; rather than a nursing home which eventually ends up as a Medicaid cost.

The Family Caregiver Support Program in Pennsylvania provides such support and should be expanded to include the federal definition so that more families can take advantage of this assistance, which provides modest financial stipends to offset costs for home modifications and support service such as adult day and in-home care.

3. Retool Our Health Care System – Including Long Term Care

Today in Pennsylvania, an estimated one million senior citizens each year are choosing to receive care and support in their homes. Most, about 300,000 are receiving medical care, such as nursing, therapy and aide services, under the Medicare benefit. Others are receiving personal care such as assistance with bathing, dressing, meal preparation, which is privately paid for or for low income seniors - they may be receiving services under the state's Medicaid Aging Waiver program or through the state lottery-funded program, known as OPTIONS.

My organizations provide both Medicare and Medicaid-funded home care services. Unfortunately, like other segments of our health care system, Medicare home health focuses on reactive care – care that must be in response to an acute episode. Essential changes must be made to create a system of preventive long term care services to complement and slow the need for more intensive and costly services such as those provided in a skilled nursing facility.

Every time a senior is cared for by a home health agency; the goal is to help that individual recover and remain as independent as possible. Strict Medicare rules do not permit us to manage seniors' chronic conditions, which account for a large number of frequent hospitalizations and ER visits. If chronic care management was permitted under the Medicare benefit, or some other comparable vehicle; home health agencies could monitor and assist patients in controlling their illnesses. Right now, statistics from CMS' website show that Pennsylvania home health agencies do a better job in keeping people out of the hospital than the national average. Less than 27% of our patients are readmitted when receiving home health. By reducing rehospitalizations, significant savings can be achieved; while keeping people well and where they want to be – at home.

Even as tightly stretched as the Medicaid funding can be, my organizations have had great success in managing patients with long term serious health issues, reducing those once frequently occurring hospitalizations, in both our elderly population and our HIV populations.

Chronic care management works, and it frequently requires only minimum visits to keep patients out of the hospitals. The development of chronic care management programs that are not overly burdensome with regulatory documentation would be the key to their success. The problem my agencies face is that these chronic care situations are one of those covered benefits for Medicaid recipients, and is not available to Medicare patients.

If you can imagine, I have two patients who require long term Coumadin therapy, which requires frequent blood monitoring. One patient is covered by Medicaid, and receives a nursing visit every two weeks to have the levels monitored and medication dosages adjusted. The other patient, doesn't meet the guidelines for Medicaid, but can't afford to pay out of pocket for the blood monitoring in the home, and like the first patient is not able to get out to a lab to do the blood monitoring. The second patient is now negotiating with the physician to "spread out" the time between blood tests because of the lack of coverage and the added expense, increasing their risks significantly for complications and a poor outcome.

Older Pennsylvanians deserve to be helped. They need to be helped during that window of time when we have a real opportunity to provide health benefits. People want their independence, and they long to be active and part of their family and community. Interventions that enable people to attain, regain or sustain their independence must be implemented as vital component of our long term care system.

The good news is that there are several initiatives under the health care reform legislation that focus on managing chronic conditions; however most efforts are aimed at physicians. Our hope is that home health agencies – already equipped with a team of professionals – nurses, therapists and aides – and who are accustomed to teaching and coaching people in their own homes – will be given the opportunity to work as partners with physicians to improve the way this country assists people in managing their chronic conditions. I am urging you to not let the opportunity to partner with homecare pass you by in this health care reform.

It has been my sincere pleasure to come here today. Homecare has had a place in the lives of individuals for many, many years. Homecare is a strong partner to all other healthcare delivery systems, and we welcome these organizations reaching out to us. Make sure homecare is at the table during every healthcare discussion so that we can share with you how homecare can help.

Senator CASEY. Thanks very much. You did a good job staying within the time, and I know, as I said before, your whole testimony will be part of the record.

Connie? Thank you very much.

**STATEMENT OF CONNIE KREIDER, DIRECT CARE WORKER,
COLUMBIA, PA**

Ms. KREIDER. Hi. Good morning. What an honor it is to be here today, and I would like to thank everybody for the opportunity.

I am a direct care worker. I have been in the field for roughly 13 years, and my background started in retail, which I intended to stay in. But with the overwhelming amount of stress and long hours and managing a family, a husband, and family's multiple schedules, it got to be harder and harder to stay in that field.

So I decided to look for a career change. Someone I had run into had said I should try to get into the nursing field because, of course, that is the cutting edge of the future, of a growing future. So I went down to the area nursing home, which I had never actually entered a nursing home before. So this was my first time ever.

This turned out to be a very rewarding and blessing area for me. I believe that people want to provide a positive way of life for the elderly. I believe that people want to actually give back. It is almost like a sense of giving to others.

I really am a firm believer of doing unto others as you would have them do unto you—the Golden Rule. Treat someone with love and respect, and they will treat you back with love and respect. If you work in this mindset, everything else really falls into place.

It is really sad that the Federal Government—Federal law only requires 75 hours of training in this field when, really, that is not near enough. You really need to have additional communication skills, compassion training, and good customer service, also with multitasking with several things going on at the same time.

On a daily basis, you may have anywhere between 8 to 12 to sometimes more residents. The high turnover for nurses aides in the first year is roughly 60 percent and in the second year is roughly 80 percent. They are not nearly prepared for the physical work, the emotional demands, and the stress that comes with this line of work.

So when there is this high turnover rate, who really suffers? Well, we all suffer. The residents are very upset that someone new has just come in to take care of them. The quality of care that is provided to the elderly and to people with disabilities is so important that change is very difficult on them and also difficult for the family members who have also formed a close relationship with the caregivers.

They form a close relationship with their caregivers and become emotionally attached with them. We become a part of their lives, and so many caregivers are often thought of as an extended member of the family. We are the eyes and the ears of the many different places we choose to work from. It takes a qualified, adequate, positive caregiver to stay focused on the issues. It requires a large amount of teamwork and communication and also a great sense of humor to pull this work off.

Direct care workers are roughly 90 percent female, and many work more than one job in order to support their families. Many do not have adequate healthcare, or if they do, it is so high in the cost of things that they really can't afford it. Many are great providers of others, but they lack the ability to provide for themselves. I can't stress that enough.

Stress takes a toll of your mind, body, and spirit. It can consume you and leave you feeling burned out. This is also seen across the board as "compassion fatigue." So who takes care of the caregiver? We need to be kind to each other, have a peaceful work environment, work as a team.

I am a member of the Pennsylvania Direct Care Workers Association, and we promote compassion and quality care for people living with disabilities and the elderly, the chronically ill, and the terminally ill. The association strengthens the quality of professional personal care for all Pennsylvanians by providing education, advocacy, and support for the direct care worker profession.

I am also very proud to be a supportive member of the Direct Care Workers Alliance. Vera had talked earlier. The DCA provides direct care workers with advocacy and leadership training. They support all direct care workers in assisting in the development of associations and coalitions with technical support and leadership training. They also work toward improving the direct care workforce and support initiatives like the Direct Care Workforce Empowerment Act.

So what does this mean for all direct care worker? It means a better workplace and a better way of life. We are not alone. There are many of you who want to stay connected. We want to learn to give of ourselves. We learn to give to ourselves and celebrate our successes, love where we work, and work where we love.

So what is a good direct care worker worth these days? Anybody have a clue? Just ask your one and only best friend in the world, one of your residents, and they will say that you are absolutely priceless.

[The prepared statement of Ms. Kreider follows:]

Good Morning,

I would like to say thank you for the opportunity to be here today. I am a direct care worker and have been in long term care for 13 years. My background started in sales and I worked for 16 years in retail. I enjoy working with people and providing them one-on-one attention. I like to call it good customer service. The stress and long hours were getting hard to manage – add three children, a husband and keeping a house clean – it was just too much. So I started looking at making a career change.

Someone that worked with me had said they were hiring at the nursing home just down the street. So that was the start: I became a CNA and it's been a great career move for me. It has been very rewarding and I have been very blessed to be in this field. I believe that people want to provide a positive way of life for others. It is a way of giving back. In fact, it's almost a gift to give of yourself. I always think of it this way: Do unto others as you would have them do unto you. Treat someone with love and respect and they will do the same back to you. If you work in this mind set everything else falls into place. It's really sad that the federal law only requires 75 hours of training to work in this field. You really need so much more, including communication skills, compassion training, good customer service training, and how to juggle many tasks at the same time. It can be very hard to manage your time between 8-12 residents. The turn over of new aides is 60% in the first year and 80% in the second year. They are not prepared for all the physical work, emotional demands, and stress that

come with this line of work. So when there is a high turn over in staff, who suffers?

We all do. The residents are upset that someone new is now taking care of them. The quality of care that is provided to the elderly and to people with disabilities is so important that change is difficult on them. They form close relationships with their caregivers and become emotionally attached to them. We become a part of their lives and so many think of the caregivers as family. We are the eyes and ears of the many different places we choose to work for. It takes qualified, adequate, positive caregivers to stay focused on the issues. It requires team work, communication, and a great sense of humor. Direct care workers are 90% female, and many work more than two jobs to support their families. Many do not have health care, or it is so costly they can not afford it. Many are great care providers to others, but lack the ability to provide great care to themselves.

Stress takes a toll on the mind, body and spirit. It can consume you and leave you feeling burned out. This is also called compassion fatigue. Who takes care of the caregiver? We need to be kind to each other, have a peaceful work environment and work as a team. I am a member and co-chair of the PA Direct Care Workers Association. We promote compassion and quality care for persons who are elderly, living with a disabilities, and are chronically or terminally ill. The association strengthens the quality of personal care for all Pennsylvanians by providing education, advocacy, and support for the direct

care profession. We also are very proud and supportive of the Direct Care Alliance. The DCA provides direct care workers with advocacy and leadership training. They support all direct care workers by assisting in the development of associations and coalitions with technical assistance and leadership training. They also work towards improving the direct care workforce, and support initiatives like the Direct Care Workforce Empowerment Act, which was introduced by Congresswoman Linda Sanchez last week. The bill would extend minimum wage and overtime protections to home care workers; improve workforce monitoring and data collection; and improve recruitment and retention by providing grants to states.

What does this all mean to a direct care worker? It means a better work place and a better way of life. You are not alone; there are many ways for you to stay connected. Learn to give to yourself, celebrate your successes, love where you work, and work where you love. So what is a good direct care worker worth? Just ask one of the residents and I bet the answer will be...priceless.

Thank you, Connie Kreider

Senator CASEY. Connie, thanks so much.

I was struck by your testimony in a number of ways. One is just the language that you used to describe your work and the work of so many direct care workers across our Commonwealth and across the country. Words like you said at one point earlier in your testimony—I am not sure this is part of your prepared testimony. You said “the sense of giving to others. People want to provide a positive way of life for others, a way of giving back.”

A little later in your testimony, “Love and respect, compassion.” You used that word several times “compassion.” You used that word on page 2 as well.

We don’t often see that language associated with the profession and with healthcare. God, we need more of it. We need a lot more of that kind of passion for the work that you are doing and passion for the care that you and others have provided.

I wanted to ask you about some of the mechanics of how you prepare. This has always mystified me, and I know that you mentioned it about the 75 hours of training not being enough.

Now 75 hours of training is not insignificant. That is basically two solid weeks of doing nothing but training. So I don’t want to downgrade it, but it is clearly not enough for the work that you have to do and others have had to do to care for people where, let us face it, in that long-term care setting with that resident, you are providing most of the care. Most of the kind of hands-on care, I will say.

But talk for a moment about that training question because I know, for example, in Pennsylvania, in other professions that often don’t involve as much direct care giving, per se, the requirements are much, much higher. Also in professions that don’t provide any care giving.

For example, my recollection is to be a barber or a beautician in Pennsylvania, you need my recollection is 1,000 hours, but I could be wrong about that. But it is a lot more than 75. It is multiple times higher than 75. My recollection was more than 1,000.

So talk to me about the hours of care—or the hours of training. Not just that, but the preparation itself in a broader way. Or lack of preparation, as I would characterize it.

Ms. KREIDER. Right. You know, the 75 hours gives you the basic. Really, your hands-on care and your hours of working with a seasoned caregiver is really where your training comes from and from having an open line of communication with your family members and your residents, also with the required in-service hours that you put forth in your year of training.

There is also several programs out there that have continuing education that is really essential to tap into also.

Senator CASEY. Connie, I think what causes so many of us to be in awe of the work that direct care workers do every day, although our policy doesn’t always reflect that awe and respect that we have, and we need to change that. That is why I and others have legislation to move in that direction.

But we do have a tremendous respect for what you do. We do have a sense of awe. It is work that I would like to be able to think I could do, but I am not sure I could. I hope I could, but I am not sure I could. I think that is true of a lot of people.

What drives someone to enter this field of providing direct care and staying with it, despite all of the obstacles, all of the ways that our country has not put in place policy to be reflective of the care that you give. What motivates people to do it and to stay with it?

Ms. KREIDER. Well, that is a very good question. I originally went into this field because of the convenience of it. But I quickly fell in love with this field. Early on, I wanted to think that perhaps it would lead into LPN or an RN position, but I quickly changed my mind after a couple of weeks.

I think it has a lot to do with the relationships you have with your residents, just to work with them and to get to know them and to know their histories. Some of them are vets, and some of them have a long history of incredible stories to share, and just that relationship that you have with them is just priceless. They teach you lessons far beyond any textbook or history book you will ever be exposed to.

So it is really fun, a learning experience. It humbles me many, many times because they have so much to offer and so much to give because they have seen so much.

Senator CASEY. I remember years ago—I will tell a very quick story—my father was in a long-term care setting, and we would go to visit him. All four of his sons, when one or more of us were in the room, we are all pretty big, all over 6 feet tall and should have some degree of strength.

He would be in the bed, and he would be on one side and, of course, would need to be turned. He was at a point where he didn't have the strength to turn himself in a way that was appropriate, and he was someone who really valued expertise in a certain area or certain skill level.

Once in a while, we thought we could be helpful, and we would pull—what seemed like an easy task, pulling the sheets or the pads underneath him to try to turn him. Invariably, we would do it, and we would do it wrong. So wrong that he would look at us like you made the situation worse, but he wouldn't complain.

Then a direct care worker came in the room, and invariably almost every one that I remember was a woman. She was a foot shorter and hundreds of pounds lighter, and she would pull that pad with a skill and expertise to make him feel comfortable. I couldn't do it. My three brothers couldn't do. My sisters couldn't do it. It looked like we could, but we couldn't.

So that gave me an insight into just one, tiny—one small part of the work that gets done every day. Just to make someone feel comfortable in that bed was a big task, and he stopped asking us for help in that part of his care. He wanted a professional to do it, a direct care worker.

Melissa, I wanted to ask you a question as well. You referred as well to what drove you to get into the business of caring for people and providing that kind of help in their homes. If you had an opportunity to write a piece of legislation or to draft a policy, what do you think is most needed as it relates not just to this field more broadly, but in particular to the work that you do, what you see every day? What do you think is our most pressing need or pressing challenge?

Mr. LEAR. Our pressing need is still staff. It is very hard to find nurses who want to come to the home care because I don't think that they know enough about it. The other huge barrier that we have is what I mentioned with the physicians being the only ones right now in Pennsylvania who can sign home care orders.

There are lots of wound care clinics that serve predominantly geriatric patients who are run by nurse practitioners, and their patients can't get access to home care without a physician to sign off on it. The nurse practitioner is the one who sees the patient. The nurse practitioner is the one who should be ordering the home care and signing off on it so that we can get out there and do the dressing changes. So it is really slowing down that delivery system.

I think those would be the most important things from a nursing standpoint. I am certainly onboard with the training for the home health aides and that component. Home health aides are near and dear to my heart. I mean, my 75 employees, 90 percent of them are home health aides.

To the credit that some facilities have high turnover and things like that, we retired our first home health aide last year after 10 years of service, recognized two others, and we have two more this year who are serving 10 years.

Senator CASEY. I guess, over time, that profession, that part of our workforce will be growing substantially, right? As more and more people prefer to want to be cared for in the home, as more and more public policies incentivize that so you are getting in some ways less and less nursing home or institutional care, that workforce will become ever more important. Isn't that correct?

Mr. LEAR. It is ever more important. But I think it is not something that is—you don't see the face of us a lot. We are standing next to you in the supermarket, and you don't know who we are or what we do because we don't look like other healthcare professionals. So I don't think we are drawing enough young people into this.

I frequently get calls for nurses who want to work in home care because they are burned out from their hospital setting, and they think that—I don't know what they think, that we don't see patients. But they want—they are looking for that desk job or case management job now that I can't give them. People just don't have—I can't think of anyone in my graduating class who is working in home care besides me. That is kind of sad.

Senator CASEY. You said very little of your training was directed at that, huh?

Mr. LEAR. Very little of my?

Senator CASEY. Very little of your own training.

Mr. LEAR. Oh. No, one day. I spent one day in home care and hospice, and they shared it. I saw one home care patient, one hospice patient.

Senator CASEY. I was noting in your testimony, you didn't have a chance to go through all of it, but you had three major categories. The first one, in terms of the focus of your testimony, meeting the increased need for senior care and support was one. The second was preparing a workforce to support a growing elderly population. Third was retooling our healthcare system, including long-term care.

Is there anything that you wanted to, any point you wanted to make that you didn't have a chance to before in either or one of those three areas?

Mr. LEAR. I think maybe two points. I just think that somewhere in the Medicare system, it would be nice to fund chronic care conditions. Maybe not the traditional 60-day payment, well, that I am familiar with. We get one lump sum to care for somebody after hospital stay.

If we could get in there before the hospital stays and provide some support, we have had a lot of success in home care with HIV patients who are frequent fliers in the hospital, of medication management patients who are frequent fliers in the hospital because they can't get it right.

But under the Medicare system, there is no vehicle to pay for that. So if we didn't look at maybe traditional Medicare, but some kind of a new—and I say that cautiously, some kind of a new payment system to manage those chronic care conditions, that would be hugely important to keeping people at home.

Senator CASEY. OK. Well, thanks very much. I know we are out of time. It is about 5 after 12 p.m. That is a record that we are pretty much on time. That is pretty good.

We will have more questions for both of you. We will submit them for the record and ask that you answer them in writing, but we are grateful for your testimony and grateful for the testimony of all of our panelists.

For those who were here for the basically 2 hours of testimony and discussion, we are grateful. I was saying as I was coming in here today, we don't get a chance to do this very often. People think this is very common to have hearings like this in states like Pennsylvania or across the country. Its not, unfortunately it should be more common and even in Washington we have lots of hearings but sometimes not enough that are as focused as this one is, and has been and we are grateful for that. So thanks for your testimony and we are adjourned.

[Whereupon, at 12:08 p.m., the hearing was adjourned.]

A P P E N D I X

DR. HEINRICH'S RESPONSES TO SENATOR CASEY'S QUESTIONS

Question 1. Pennsylvania has the fourth highest percentage of residents over age 65. This gives us a tremendous opportunity to play an important role as the nation decides how to care for our older citizens. How can we work together to allow Pennsylvania to be a model for other states with younger populations?

Answer. We recognize that one of the major health care challenges facing the United States is providing appropriate care to the increasing number of older Americans with complex health needs. The Census Bureau estimates that the number of adults age 65 and older will almost double from 2005–2030.¹ HRSA recognizes the need for additional health care providers with knowledge and training in the unique health needs of older Americans, and has several funding opportunities that support geriatric workforce development. Pennsylvania residents and institutions (including educational institutions) are eligible to apply for the varied funding opportunities that the Federal government has relating to elder care. HRSA offers consultation and technical assistance to anyone interested in these funding opportunities.

Question 2. What HHS resources could be made available to the Scranton-Wilkes-Barre region to help guide our health professions training schools and healthcare providers in taking full advantage of the federal grant programs you cite in your testimony? How do we ensure that a comprehensive system of services and qualified healthcare professionals are available to this population, and that all of the programs you mentioned are leveraged, and not a few hit or miss?

Answer. HRSA has an array of resources available to help identify grant opportunities to support health professions schools and healthcare providers in the Scranton-Wilkes-Barre region, as well as all other parts of the nation. The best starting place is HRSA's website, <http://www.HRSA.gov>, which has information about HRSA's programs and links to additional sources of information. It is also a good place to identify additional sources of assistance—toll-free numbers, written products, and contact information for federal program staff.

Question 3. You mentioned in your testimony several federal grant programs that are assisting this region or that could soon assist this region in improving the healthcare of our older adults and their families. In issuing grant guidelines for applicants of HHS, HRSA, NIH or AHRQ programs, is there any preference afforded to new medical schools? What about a set-aside of a percentage of funds for new grantees, so repeat grant recipients are not the only ones being able to take advantage of scarce federal resources?

Answer. None of HRSA's programs have a statutory preference for new medical schools or set-asides for new grantees. We cannot address this question as it pertains to NIH or AHRQ.

Question 4. You referenced several provisions to address the challenges we face in training frontline health care workers and especially direct care workers. What steps do you think a state like Pennsylvania with a high percentage of older citizens should do to best respond to these initiatives and become a model for other states around the nation?

Answer. Pennsylvania is clearly a leader among States in caring for older Americans and poised to build upon this experience. HRSA encourages all qualified applicants to submit applications for funding opportunities like the State Health Care Workforce Development grant program. This program, created by the Affordable Care Act, will enable State partnerships to plan and implement innovative strategies to expand their primary care workforce by 10 to 25 percent over ten years to meet increased demand for primary care services.

Question 5. Is our nation's current approach to medical education sufficient to meet the growing demand for health care services? And related to that, what do you

¹65+ in the United States: 2005, released by the U.S. Census Bureau.

think is the best way to expand the number of residency slots to meet the forthcoming physician shortage?

Answer. Current projections suggest that there will be a shortage of providers, particularly primary care physicians, in the years ahead. The Administration has responded to the shortage by announcing \$250 million for its workforce initiative, which is designed to increase the number of health care providers and strengthen the primary care workforce. Resources, made available by the Affordable Care Act and the American Recovery and Reinvestment Act, will support the training and development of more than 16,000 new primary care providers over the next five years. HRSA plays a key role in managing this initiative, and is currently implementing a multi-pronged approach to strengthen the numbers of primary care providers, including physicians, nurse practitioners and physician assistants.

In addition, the Affordable Care Act funded several new grant opportunities for primary care providers, including the teaching health center program which will provide GME payments to support community-based training. Teaching Health Center GME payments will cover the costs of new residency programs in community-based ambulatory primary care settings such as health centers. This will have a strong positive effect on the number, and quality, of primary care physicians in this country.

Question 6. In many ways new medical schools present a clean slate for many of the new models we will be testing and utilizing under health care reform. How can we work together and with these schools to harness those resources and work to develop residency programs that complement what these students learn in medical school?

Answer. HRSA recognizes that new medical schools are uniquely poised to create and implement innovative curricula. Residency programs and medical school curricula can be molded to incorporate competency-based models of care, including interprofessional team-based competencies and patient-centered medical homes. HRSA training programs for physicians are available to support these efforts and we look forward to working creatively with you and the medical school community to achieve these goals.

