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AMERICAN GERIATRICS SOCIETY

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

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

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

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

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

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

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

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

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

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

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

HEALTH PROVIDERS WITH TRAINING IN GERIATRICS

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

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

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

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

PROVIDER SHORTAGE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Support Loan Forgiveness Programs**

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

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

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

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

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

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

- **Medicare GME Incentive**

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

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

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

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

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

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

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

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

- **Ensure Appropriate Reimbursement and Incentives**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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

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

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

To this end we urge Congress:

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

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

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

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

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

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

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