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# Federal and State Policy Strategies for Developing a Quality Eldercare Workforce

Forging a strong quality eldercare workforce will require a strategic team approach among all geriatric specialties to properly implement the Affordable Care Act.

**W**ith the passage of the Affordable Care Act (ACA), the paid and unpaid caregivers who serve and support elders achieved modest policy successes. For a workforce relatively unaccustomed to policy achievements, this is cause for considerable celebration.

Such targeted advancements—from enhancement of the Geriatric Academic Career Awards, to new training resources dedicated explicitly to the direct-care workforce—did not occur by chance. It required a series of thoughtful investments, starting years before the Obama Administration chose healthcare reform as its signature legislative initiative. These investments were then advanced through an unprecedented degree of cooperation among providers, professional organizations, consumer and family caregiver organizations, and direct-care worker advocates.

## Shaping the Affordable Care Act

Early strategic decisions that eventually shaped the workforce elements of the ACA can be traced back to a wide array of “new models of care.” This experimentation envisioned both different roles for eldercare staff, as well as interdisciplinary team structures cutting across

the professions and caregivers. The new models were created in every type of setting where elders receive care and support. They included the Green House® Project (small-home models of nursing home care emphasizing self-managed

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teams), Cooperative Home Care Associates (redesigning the training and support of home-care workers), and the Geriatric Resources for Assessment and Care of Elders (home-based, integrated geriatric care).

All of these models shared a critical common characteristic: they each enjoyed significant philanthropic support from major health, aging, and workforce foundations. Indeed, while keeping strictly within their tax-exempt constraints of not directly influencing legislation, philanthropy’s role of informing public policy was central to the eventual inclusion of key eldercare workforce policy innovations within the ACA.

Philanthropy's core role supporting the eldercare workforce is also reflected in the critical decision, dating back to 2006, of the John A. Hartford Foundation and The Atlantic Philanthropies to build a consortium of nine foundations, and of AARP to commission an Institute of Medicine report explicitly on the eldercare workforce. Prior to that, with support from the Hartford and the Robert Wood Johnson Foundations, the American Geriatrics Society produced a report on the *Future of Geriatric Medicine* that, among other things, called for the Institute of Medicine (IOM) to produce a workforce readiness report focused on the care of older adults (Besdine et al., 2005). The resulting report, *Retooling for an Aging America*, set a precedent when it defined the eldercare interdisciplinary team as including not only all professions, but also family caregivers and the direct-care workforce.

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### ***Eldercare workforce policy will eventually find its true test at the state level.***

The IOM report documented strong evidence in support of “retooling” the eldercare workforce—drawing heavily on the various models of care already tested in the field. Rather than calling for significant additional research, the report made a strong plea for “fundamental reform,” listing a dozen recommendations ranging from explicit support for well-tested models, to enhanced geriatric training. Nor was the report hesitant in requesting significant new investments in wages and benefits for low-paid direct-care workers, as well as for enhanced federal reimbursements to states for more robust eldercare services.

Still, the foundations that funded the IOM retooling report were well aware that a single document—even from a source as prestigious as the IOM—rarely is sufficient to spark policy change. In 2008, the Hartford Foundation and The Atlantic Philanthropies invested in the next

strategic step, funding the formation of a coalition of twenty-eight national organizations called the Eldercare Workforce Alliance (EWA), a project of the Tides Center and The Advocacy Fund). Organized just as healthcare reform was being argued in the halls of Congress, the EWA entered the debate somewhat late, yet still in time to shape and then support several key workforce provisions drawn primarily from the IOM retooling report. Many of these provisions were championed by Wisconsin Senator Herb Kohl, Chairman of the U.S. Senate Special Committee on Aging.

### **The Future and Its Challenges**

The ACA provisions explicitly benefitting the eldercare workforce admittedly were not profound—unsurprising, because the ACA primarily addressed coverage and finance issues, focusing far less on service delivery. Plus,

politicians facing a relatively jobless recovery were unlikely to focus five years down the road, to a time of threatened workforce vacancies (Bluestone and Melnick, 2010). Nonetheless,

the targeted eldercare workforce victories within the ACA proved quite useful in directing congressional attention in general toward the needs of elders, and specifically toward the staff and family members who care for them.

Ironically, several other elements embedded in the ACA will, over time, likely have greater impact on the eldercare workforce than the explicit initiatives referenced above. These broader reforms include the following:

- Community Living Assistance Services and Support (CLASS) Act provisions (the late Senator Ted Kennedy's signature reform initiative providing a type of “social insurance” cash benefit for eldercare and disability services);
- The emergence of Accountable Care Organizations—Medicaid funding enhancements encouraging home- and community-based services; and

- Two newly created entities: the Federal Coordinated Health Care Office (FCHCO, focusing on consumers who are dually eligible for both Medicaid and Medicare services) and the Center for Medicare and Medication Innovation (“CMI” or “Innovation Center”).

While each will have a profound influence on the future of eldercare delivery, these and other large ACA initiatives are all still remarkably undefined.

Unlike the past few years, when reformers focused on new legislation, the emphasis over the next several years will primarily be on the defense and implementation of already authorized policy. At the federal level, the emphasis will be two-fold: deflecting efforts to dismantle the ACA (either through direct repeal, or by refusal to appropriate required funding); and influencing the crucial rule-making that will breathe specific detail into what currently are only broad legislative constructs. The legislative exceptions that should garner attention at the

federal level will be attempts to reauthorize the Older Americans Act (which shapes the Administration on Aging) and the Workforce Investment Act (which funds most of the Department of Labor’s workforce training system).

However, eldercare workforce policy will eventually find its true test at the state level, where care is received and where staffs actually work. Even acknowledging the promised new federal ACA resources, the current reality of eldercare and disability service systems varying significantly from state to state—and uniquely shaped primarily by each state’s Medicaid policy—will remain unchanged.

Furthermore, states’ budgets are under unprecedented pressure. Forty-eight states are addressing shortfalls in their budgets totaling \$191 billion (McNichol, Oliff, and Johnson, 2010). These state-level budgetary pressures place two very different types of obstacles in the path of workforce implementation. The more obvious is state budgets that will be hard-pressed to keep up with the per capita increase



in demand for eldercare services stemming from the demographic realities of an aging America.

Less obvious is states' staff capacity to manage all this imagined innovation and new systems development—particularly within state-level departments of health and labor, which have been severely weakened by repeated budget cuts (Weil and Scheppach, 2010; The Henry J. Kaiser Family Foundation, 2010). This instability in state infrastructure will be further exacerbated by the recent gubernatorial elections. Twenty-six new governors will be appointing new administrative teams to simultaneously manage both existing programs and a plethora of new ACA-funded initiatives.

The tension is clear: most states will certainly pursue new demonstration and program dollars from the federal government, if only because state coffers are dwindling as the demand for services has risen (Baumrucker and Fernandez, 2010). The Congressional Research Service (in a 2010 memo) outlined several ACA elements that could result in cost savings to states. These include increased federal matching rates for certain long-term services, and expansion of home- and community-based services as an alternative to institutional care. However, such “savings” are often generated by the relatively lower compensation paid to home-based workers, when compared to similar jobs in facility-based settings.

The challenge to policy makers and advocates will be to help states manage these new resources effectively despite the chaos of court challenges to the constitutionality of the ACA and weakened state infrastructures. The goal would be to help states produce the hoped-for innovations in care quality and cost efficiency.

### **Implementing the Affordable Care Act**

Challenged by constrained state budgets, split public opinion about healthcare reform, and political uncertainty over the ACA itself, federal agencies are faced with rolling out the various provisions of the ACA on a very aggressive timeline. Yet despite these challenges, those

implementing healthcare reform—at both the federal and state levels—must acknowledge that the workforce charged with delivering innovative care to frail elders is currently ill-prepared to do so (IOM, 2008). The eldercare workforce elements within the ACA are only one small element in what needs to happen to ensure a competent workforce.

Within the U.S. Department of Health and Human Services, the following three agencies will be critical to ACA implementation, and each must focus on critical workforce issues:

#### **Centers for Medicare and Medicaid Services**

From Accountable Care Organizations to demonstration projects under the Innovation Center to the Federal Coordinated Health Care Office to enhancing physician quality reporting: the Centers for Medicare and Medicaid Services (CMS) will have to implement much of the system redesign that is the promise of healthcare reform. The ACA has appropriated more than \$10 billion over ten years for system redesign (U.S. Congress, 2010). To bend the cost curve, the CMS must work to ensure that every element of implementation includes attention to workforce preparedness.

Questions the CMS staff should consider as a part of the design and implementation of all ACA elements include the following:

- Is there a commitment to a team-based approach, with all team members practicing “at the top of their license” and working together to provide well-coordinated care?
- Who is on the team? Are the patient, his or her family, and his or her informal caregivers at the center of the care team?
- Is workforce compensation—a means to increase the stability and efficiency of the eldercare workforce—seen as integral to bending the cost curve?
- Is there training for all members of the team so they are fully competent to deliver eldercare within a redesigned healthcare system?

- Are private sector and state partners (e.g., credentialing and licensing boards, universities, and community colleges) fully engaged and working to ensure the workforce is competent to care for frail elders?
- Are there built-in system incentives for social and medical systems service providers to work together to deliver well-coordinated care?
- Do quality metrics for practitioners and providers recognize the complexity of caring for frail elders with multiple chronic conditions?
- Is the workforce trained to provide culturally competent care that addresses the variety of languages, ethnicities, cultures, and health beliefs of older adults and is it effectively able to serve all older adults regardless of their race, sexual orientation, gender identity, disability status, and geographical location?

### Administration on Aging

As of this writing, the Administration on Aging (AoA) will likely be charged with designing how the CLASS Act provisions of the ACA will be implemented. The CLASS provisions will create a new social insurance program self-funded by individuals participating through their employers or electing to participate directly. The premiums individuals pay can be drawn down to support home- and community-based services when needed, increasing with level of need.

Under CLASS provisions, states are required to ensure an infrastructure is in place to support a personal-care-attendant workforce well prepared to care for America's frail elders and those with disabilities. This workforce is one of the fastest growing in the country—PHI projects that we will need 1.1 million additional direct-care workers between 2008 and 2018. As the program is designed, the AoA staff should consider the following:

- How can the role of personal-care attendant be redesigned so it can assume

greater responsibility within the care team for the safety and quality of the services we provide?

- Are effective labor-market intermediaries, such as registries and matching services that help consumers and workers find each other, being created?
- How is the quality of the workforce, including employer practices such as sustainable wages, balanced work hours, benefits, qualifications, competencies, training programs, recruitment practices, and retention strategies being assessed?
- Should standards or guidelines for employment relationships between beneficiaries and personal-care attendants be established?

The upcoming reauthorization of the Older Americans Act (OAA) offers the AoA an opportunity to redesign the services offered through the aging network so they are complementary to the programs being implemented under the ACA. Currently, no agency within the U.S. departments of Health and Human Services and Labor is explicitly responsible for policies and programs to support a stable and qualified long-term-care workforce. Given the sheer size of the direct-care workforce, which will reach more than 4 million workers by 2018, the AoA should work toward the creation of an Inter-agency Coordinating Committee on the Direct-Care Workforce (PHI, 2008). The AoA's leadership in this area is essential, as this workforce is central to its mission of ensuring services for our nation's elders.

### Health Resources and Services Administration

The Health Resources and Services Administration (HRSA) is being asked to implement those elements of the ACA that are explicitly workforce-related, including programs targeted at enhancing development of geriatrics faculty and the capacity of geriatrics and gerontology programs to train the entire workforce. The HRSA will also house the National Workforce

Policy Studies Center, which is charged with longitudinal tracking of the workforce.

Also, for the first time in its history, the HRSA will be charged with designing and implementing a program focused on personal-care attendants. The Personal and Home Care Aide State Training Program will provide funding to six states to develop core competencies, pilot training curricula, and certificate programs for personal-care and homecare aides.

The ACA also includes provisions that will expand programs supporting primary care clinicians (e.g., the National Health Service Corps, the primary-care bonus, expansion of primary-care residencies) and community-based services (e.g., the Area Health Education Center Program).

In addition, funding within the ACA for the Prevention and Public Health Fund could be used to support grants to expand and enhance the capacity of the workforce to care for older adults.

Throughout their work on implementation, HRSA staff should consider the following questions:

- How can concepts related to the care of older adults be infused into the training offered through the Area Health Education Centers, as well as through existing primary-care training initiatives overseen by the HRSA?
- How to best allocate funding available within the ACA (e.g., the Prevention and Public Health Fund) to programs focused on preparing a workforce competent to care for older adults?
- How to create incentives, in collaboration with the CMS, for workforce training specifically focused on the unique healthcare needs of older adults?

### **How Congress Can Support the Eldercare Workforce**

Many ACA elements specific to the geriatrics health professions under Title VII and Title VIII—as well as to training of direct-care workers

on the unique healthcare needs of older adults—are unfunded mandates within the ACA. Congress must ensure these programs are adequately funded through the annual appropriations process. In addition, the CMS, AoA, and the HRSA should draw on the special expertise of those with advanced training in geriatrics and gerontology. These experts could advise them on systems design to address the highest cost beneficiaries and prepare the entire workforce to competently care for older Americans.

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### ***Congress should also consider enhancements of workforce training during reauthorization of the OAA.***

As a benchmark for annual funding of these programs, the Eldercare Workforce Alliance has called on Congress to invest \$71.7 million in fiscal year 2011 in geriatrics health professions and direct-care workforce training programs under Titles VII and VIII of the Public Health Service Act (Eldercare Workforce Alliance, 2010).

Congress should also consider enhancements of workforce training during reauthorization of the OAA, as well as recommendations emerging from the Medicare Payment Advisory Commission (MedPAC). The MedPAC is charged with advising Congress on issues affecting the Medicare program. These include payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, as well as access to care, quality of care, and other issues affecting Medicare. Recently, MedPAC has begun to look at how graduate medical education dollars are used and how financing basic geriatric competency could benefit older patients (MedPAC, 2010).

### **An Ongoing Role for Eldercare Workforce Advocates**


Advocates for the eldercare workforce can point with some pride to key advancements in workforce policy made under ACA. These

include programs supporting the development of workers with special expertise in caring for older adults, increased training for direct-care workers, and a new form of social insurance supporting elders and their families.

In looking to the future, advocates should be mindful of the need to defend the ground gained under ACA. This will require consistent, interdisciplinary advocacy efforts to ensure funding is appropriated for the geriatrics health professions and other training programs under Title VII and VIII.

At the same time, advocates should pay close attention to the sweeping system redesign that is the promise of ACA. Specifically, eldercare workforce advocates should be attentive to the crucial rule-making already underway at the various agencies charged with implementation: agencies have incorporated ACA provisions into existing programs (e.g., HRSA immediately redesigned the Geriatric Academic Career

Awards to reflect changes under the ACA) and most policy analysts anticipate a very aggressive timeline for rolling out the programs and demonstrations authorized under the ACA.

To date, eldercare workforce advocates should be commended for their ability to work together to articulate with one voice what is needed to ensure we are providing the highest quality care for older Americans. This team approach, the heart of a well-coordinated delivery system, will serve advocates in good stead as ACA moves to implementation. 

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