Potential Eldercare Workforce Improvements
The number of Americans over age 65 is expected to reach 72 million by 2030, representing a 71 percent increase from today’s 41 million older adults. By 2050 it is estimated that nearly 19 million people will be over 85. The aging of America requires policy solutions that address these unprecedented challenges. Older adults have unique and often complex care needs that demand a specially trained and supported health care workforce. The below proposed policies set out to meet some of those challenges.

Geriatrics Health Professions Training Programs
Administered by the Health Resources and Services Administration
Modest expansion of the Geriatric Academic Career Awards (GACAs) program, which funds the career development of physicians, nurses, social workers, psychologists, dentists, pharmacists, and allied health professionals in academia, could result in the training of an estimated 67,000 health professionals a year.

The Geriatric Training for Physicians, Dentists, and Behavioral and Mental Health Providers (GTPD) funds schools of medicine, osteopathic medicine, teaching hospitals, and graduate medical education to provide 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. Expanding eligibility for the two-year fellowships and modernizing the dental requirements can help reduce barriers for applicants.

Geriatrics Education Centers (GECs) fund health professions schools to provide interprofessional and interdisciplinary education and training to health professions students, faculty, and practitioners in the diagnosis, treatment, and prevention of disease, disability, and other health problems of older adults. Funding mini-fellowship programs and allowing GECs to train direct-care workers and family caregivers can help expand the competency of the workforce.

The Comprehensive Geriatric Education Program (CGEP) provides quality geriatric education to individuals caring for the elderly and 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. In 2013, there were 66 applicants for the program but only 18 were funded, compared to 27 in 2009. Expanding funding to CGEP to accommodate more applicants could result in the training of an additional 27,000 people.

Eldercare Workforce Legislation & Funding
Eldercare Workforce Alliance FY 2015 Appropriations Requests
EWA FY 2015 appropriations request recognize the current fiscal constraints, and therefore include just modest increases to the Title VII Geriatrics Health Professions training programs, the Title VIII Comprehensive Geriatric Education Program for nurses, both administered through the Health Resources and Services Administration (HRSA); and family caregiver support programs run through the Administration for Community Living (ACL).

The positions of the Eldercare Workforce Alliance reflect a consensus of 75 percent or more of its members. These endorsements reflect the consensus of the Alliance and do not necessarily represent the position of individual Alliance member organizations.
S. 1332/H.R. 2504: Home Health Care Planning Improvement Act of 2013
The legislation strengthens access to home health services under Medicare. The bill will allow advanced practice registered nurses (APRNs), including nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse midwives (CNMs), as well as physician assistants (PAs), to order home health services under Medicare in accordance with state law.

S. 1119: Positive Aging Act of 2013
The Positive Aging Act is designed to make mental health services for older adults an integral part of primary care services in community settings and to extend them to other settings where older adults reside and receive services. The evidence-based services under this legislation will be provided by interdisciplinary teams of mental health professionals working in collaboration with other providers of health and social services.

Older Americans Act
The Eldercare Workforce Alliance supports the reauthorization of the Older Americans Act (OAA), as it offers an important opportunity to help modernize the aging services network and its programs in order to build an eldercare workforce with the skills and training to meet the “whole person” needs of older adults for health care and long-term services and supports (LTSS).

Provisions with the Community-Based Medical Education Act of 2014 (S. 2728)
The Eldercare Workforce Alliance supports provisions within the Community-Based Medical Education Act of 2014 (S. 2728), noting that language in the legislation strengthens geriatrics training and supports the eldercare workforce.

Resources
EWA Advanced Direct Care Worker: A Role to Improve Quality and Efficiency of Care for Older Adults and Strengthen Career Ladders for Home Care Workers: http://www.eldercareworkforce.org/research/issue-briefs/research:advanced-dcw-brief/

EWA Toolkit for Advocates of Older Adults Who are Dually Eligible for Medicare and Medicaid: http://www.eldercareworkforce.org/advocacy/toolkits-for-advocates/legislation:duals/


EWA Videos: https://www.youtube.com/user/EldercareWorkforce


The Eldercare Workforce Alliance is a project of The Advocacy Fund.
As the Fiscal Year (FY) 2015 Labor, Health and Human Services and Education funding is being considered, the Eldercare Workforce Alliance (EWA) urges adequate funding for programs designed to increase the number of health care professionals prepared to care for America’s growing senior population and to support family caregivers in the essential role they play in this regard.

The number of Americans over age 65 is expected to reach 70 million by 2030, representing a 71% increase from today’s 41 million older adults. That is why the Health Resources and Services (HRSA) Title VII and Title VIII geriatrics programs and the Administration for Community Living (ACL) programs that support family caregivers are so critical to ensure that there is a skilled eldercare workforce and knowledgeable, well-supported family caregivers available to meet the complex and unique needs of older adults.

We hope you will support a total of $44.7 million in funding for geriatrics programs in Title VII and Title VIII of the Public Health Service Act and $172.9 million in funding for programs administered by the ACL that support the vital role of family caregivers in providing care for older adults, and $3 million to support a decennial White House Conference on Aging. While our below requests take into account the current fiscal constraints, EWA believes increased funding to these programs is essential to meet the needs of older adults today and in the future.

### FY2015 ELDERCARE WORKFORCE APPROPRIATIONS

As the Fiscal Year (FY) 2015 Labor, Health and Human Services and Education funding is being considered, the Eldercare Workforce Alliance (EWA) urges adequate funding for programs designed to increase the number of health care professionals prepared to care for America’s growing senior population and to support family caregivers in the essential role they play in this regard.

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### TITLE VII GERIATRICS HEALTH PROFESSIONS ($39.7 million)

Title VII Geriatrics Health Professions programs are the only federal programs that increase the number of faculty with geriatrics expertise in a variety of disciplines who provide training in clinical geriatrics, including the training of interdisciplinary teams of health professionals. These offer critically important geriatrics training to the entire healthcare workforce. These programs include:

**Geriatric Academic Career Awards (GACA):** This program promotes the development of academic clinician educators in geriatrics. In the Academic Year 2012-2013, the GACA program funded 62 full-time junior faculty. These awardees delivered over 1,100 interprofessional continuing education courses specific to geriatric-related topics to over 53,000 students and providers. The number of instructional hours delivered by GACAs during Academic Year 2012-2013 was over 90,000. Additionally, they presented on research and other topics at 215 local, state and national conference and published 108 peer-reviewed publications. **$5.5 million request**

**Geriatric Training Program for Physicians, Dentists, and Behavioral and Mental Health Professions (GTPD):** This program supports interprofessional training designed to develop additional faculty in medicine, dentistry, and behavioral and mental health so that they have the expertise, skills and knowledge to teach geriatrics and gerontology to the next generation of health professionals in their disciplines. In Academic Year 2012-2013, a total of 64 physicians-including psychiatrists-, dentists, and psychologists, were supported through this fellowship program. Fellows delivered over 275 courses to 5,600 trainees. **$8.9 million request**

**Geriatric Education Centers (GEC):** GECs provide quality interdisciplinary geriatric education and training to practicing health care professionals of multiple disciplines, health care professions students. In Academic Year 2012-2013, the 45 GEC grantees developed and provided over 1,650 different continuing education and clinical training offerings to nearly 136,500 health professionals, students, faculty, and practitioners, significantly exceeding the program’s performance target. Three quarters of the continuing education offerings were interprofessional in focus. Of the sites that offered clinical training sessions, 2 out of every 5 of these sites were in a medically underserved community and/or Health Professional Shortage Area. **$20 million request**

**Alzheimer’s Disease Prevention, Education, and Outreach Program (GECs):** These funds support Geriatric Education Center providing interprofessional continuing education to health professionals on Alzheimer’s disease and related dementias. **$5.3 million request**
TITLE VIII GERIATRICS NURSING WORKFORCE DEVELOPMENT

PROGRAMS ($5 million)

These programs, are the primary 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.

Comprehensive Geriatric Education Program (CGEP): This program provides quality geriatric education to individuals caring for the elderly and 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. In Academic Year 2012-2013, a total of 18 Comprehensive Geriatric Education Program (CGEP) grantees provided a variety of services, including over 150 different continuing education courses to over 11,600 trainees. This program supports additional training for nurses who care for the elderly; development and dissemination of curricula relating to geriatric care; training of faculty in geriatrics; and continuing education for nurses practicing in geriatrics. **$5 million request**

Traineeships for Advanced Practice Nurses: Through the ACA, the Comprehensive Geriatric Education Program is being expanded to include advanced practice nurses who are pursuing long-term care, geropsychiatric nursing or other nursing areas that specialize in care of elderly. In Academic Year 2012-2013, a total of 74 grantees were awarded traineeships. One in every 4 grantee is considered an underrepresented minority in their prospective profession. **There is currently no additional funding for this program outside of CGEP.**

FAMILY CAREGIVER SUPPORT ($172.9 million)

These programs support caregivers, elders, and people with disabilities by providing critical respite care and other support services for family caregivers, training and recruitment of care workers and volunteers, information and outreach, counseling, and other supplemental services.

Family Caregiver Support Services: This program provides a range of support services to approximately 1,307,427 family and informal caregivers annually in States, including counseling, respite care, training, and assistance with locating services that assist family and informal caregivers in caring for their loved ones at home for as long as possible. **$154.5 million request**

Native American Caregiver Support: This program provides a range of services to Native American caregivers, including information and outreach, access assistance, individual counseling, support groups and training, respite care and other supplemental services. In FY2014 more than 32,000 units of services were provided. **$6.4 million request**

Alzheimer’s Disease Support Services: One critical focus of this program is to support the family caregivers who provide countless hours of unpaid care, thereby enabling their family members with dementia to continue living in the community. Funds will go towards evidence-based interventions and expand the dementia-capable home and community-based services, enabling additional older adults to live in their residence of choice. The program provided direct services to 35,000 individuals with Alzheimer’s disease and their family caregivers in FY2014. **$9.5 million request**

Lifespan Respite Care: This program funds grants to improve the quality of and access to respite care for family caregivers of children or adults of any age with special needs. **$2.5 million request**

WHITE HOUSE CONFERENCE ON AGING ($3 million)

The President’s FY2015 budget includes funding to the Administration for Community Living for the convening of a White House Conference on Aging. The decennial event will bring together stakeholders and consumers from across the country to discuss the range of aging issues facing America. **$3 million request**
CARING FOR OLDER ADULTS

OLDER ADULTS in USA [1]

<table>
<thead>
<tr>
<th>State</th>
<th>Population 65 and Older in 2010</th>
<th>Projected Population 65 and Older in 2030</th>
<th>Difference</th>
<th>Percentage Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nationally</td>
<td>40,267,984</td>
<td>71,453,471</td>
<td>31,185,487</td>
<td>77.4%</td>
</tr>
</tbody>
</table>

DIRECT-CARE WORKFORCE in USA [2]

Direct-care workers provide an estimated 70% to 80% of the paid hands-on care for older adults or those living with disabilities or other chronic conditions.³

![United States: Size of Direct-Care Workforce, 2012](source: PHNational.org)

Nationally, between 2010 and 2030, women aged 25 to 44 (the typical direct care worker) will increase by only 7%, creating a care gap.⁴ According to the Bureau of Labor Statistics, Personal Care Aides and Home Health Aides are among the fastest-growing occupations with demand expected to increase 49% by 2022.⁵

TITLE VII GERIATRICS HEALTH PROFESSIONS & TITLE VIII NURSING WORKFORCE DEVELOPMENT PROGRAMS [7]

Title VII funds physicians, nurses, social workers, psychologists, dentists, pharmacists, and other allied health professionals—including physical therapists.

Total FY2013 Title VII Geriatrics Funding Nationally: $28,502,677
Total FY2013 Title VIII Geriatrics Funding Nationally: $3,927,075

CURRENT and FUTURE GERIATRICIAN SHORTFALL [8]

<table>
<thead>
<tr>
<th>State</th>
<th>Certified Geriatricians</th>
<th>Estimated Current</th>
<th># Geriatricians we need to train</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA</td>
<td>6,943 / 17,258</td>
<td>10,315</td>
<td>23,680</td>
</tr>
</tbody>
</table>

In addition to shortage of geriatricians, of the 2.56 million registered nurses, less than 1%, are certified gerontological nurses, and of the 111,000 advanced practice nurses, only 3,500 or 3%.⁹
FAMILY CAREGIVERS in USA

Family caregivers nationally— all 42.1 million of them—provided more than 40.3 billion hours of unpaid care in 2009. The estimated economic value of US family caregivers’ unpaid contributions in 2009 was approximately $450 billion. Providing support and training opportunities to family caregivers is essential, especially during a time when nationally, 46% of family caregivers performed medical/nursing tasks for care recipients with multiple chronic physical and cognitive conditions. Family caregivers must be valued partners with health care professionals, with health providers identifying family caregivers, assessing their needs, and offering training and support.

Nationally in 2010, the family caregiver ratio was 7.2 potential caregivers aged 45-64 for every person in the high-risk years of 80-plus. In 2030, the ratio is projected to decline sharply to 4.1 to 1; and it is expected to fall to 2.9 to 1 in 2050.

OLDER AMERICANS ACT FAMILY CAREGIVER SUPPORT PROGRAMS [13]

Total FY2013 National Family Caregiver Support Program Funding Nationally: $144,724,010
Total FY2013 Native American Family Caregiver Support Funding Nationally: $6,023,189
or
$3.52 per caregiver in USA


The positions of the Eldercare Workforce Alliance reflect a consensus of 75 percent or more of its members. Statements reflect the consensus of the Alliance and do not necessarily represent the position of individual Alliance member organizations.

Source: AARP Public Policy Institute, The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers
Care coordination has emerged as a promising element of successful health care and long-term service delivery models. It unites a team of providers to meet individual needs, improves health care access and outcomes, and synchronizes the variety of long-term services and supports. In these models, a care coordinator works closely with the individual, family caregivers, primary care provider, and other health care professionals to improve communication, resulting in improved individual well-being and outcomes.

Initiatives aimed at improving care coordination are especially timely. The prevalence of multiple chronic conditions and functional impairment within the aging population is increasing. Older individuals with multiple chronic conditions need health care that is well coordinated with any needed long-term services and supports. At the same time, the Center for Medicare & Medicaid Innovation (CMMI), created by the Affordable Care Act (ACA), is tasked with testing and rapidly disseminating innovative health care delivery models and alternative payment structures over the next eight years to improve quality while reducing cost.

THE PROMISE OF CARE COORDINATION

Eighty percent of Americans 65 and older have one chronic condition, and almost 50% have multiple chronic conditions. For individuals with certain chronic illnesses who are hospitalized, 33 to 50% are rehospitalized within 90 days. The 15 percent of Medicare enrollees with both chronic conditions and functional limitations who need long-term services and supports account for one-third of Medicare spending. Care coordination can help to improve care for this population, and reduce the cost of treating them, if the most effective elements of care coordination models are identified, and challenges are addressed. The best care coordination models have much to contribute toward the goals of the ACA and CMMI; they are well-coordinated, and person- and family-centered, across service settings, and promote better communication and interaction among the respective members of the interdisciplinary team, individual, and family caregiver. EWA and N3C believe that CMMI’s objectives can only be achieved if quality – quantified by results such as reduced hospitalizations and improved quality of life – remains a major focus of the models tested.

DISTINGUISHING BETWEEN CARE COORDINATION & DISEASE MANAGEMENT PROGRAMS

Recent research and evidence reviews have identified some of the elements of care coordination models which are most effective. A weakness of some recent reviews, however, has been failure to note the difference between care coordination and disease management programs, to address the oftentimes significant role of families in coordinating care, and to adequately value the impact of the interventions examined on improving care quality. Care coordination is different from disease management in that it takes a holistic approach to coordinating care and supportive services for the individual overall, rather than focusing on a particular disease. Successful care coordination programs also incorporate significant in-person interaction with the individual and family caregiver; whereas, many disease management programs are telephone based.

A January 2012 Congressional Budget Office report titled, “Lessons from Medicare’s Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment,” concluded that, on average, the interventions examined did not reduce Medicare spending or generate sufficient savings to offset program fees. It should be noted, however, that 22 of the 34 programs analyzed reduced hospital admissions by more than 6 percent, including four programs that
reduced admissions by 15 percent or more. Such reductions represent a significant increase in quality of life for the individuals who avoided hospitalization.

Also noteworthy are differences among the 34 programs CBO analyzed. The Medicare Coordinated Care Demonstration (MCCD) is separate from the remaining five that include less successful Disease Management Demonstrations. The disease management programs analyzed mostly rely on telephonic interventions, show minimal success in randomized trials, and have not generated savings. In contrast, independent policy researchers report that cost reductions and savings found in effective care coordination programs within the MCCD share common components linked to improved outcomes.

Care coordination is centrally important for the success of Medicaid managed care models in place in an increasing number of states, as well as Patient-Centered Medical Homes, and Accountable Care Organizations.

**CARE COORDINATION: Effective Elements**

Elements of care coordination models found to be effective in improving quality of care and coordination of social supports while reducing system cost or remaining cost-neutral are:

### Person- and Family-Centered Care
- The team should include providers across disciplines and settings, the individual, and family caregivers. Direct-care workers can serve an invaluable role on the care team due to their frequent and ongoing interactions with individuals receiving care.
- In-person interaction among the individual, family caregiver, care coordinator, and providers encourages better communication regarding the individual's needs and care. Significant in-person interaction between the individual and care manager is associated with reduced hospital admissions and Medicare spending.
- Care coordination targeted to individuals with certain health conditions, hospitalization patterns, and functional limitations can generate Medicare cost savings of approximately $100-$120/month per individual.
- Having the individual and family caregiver centrally involved in care plan development improves outcomes. Particularly for older adults, a family caregiver may play a central role in ensuring that the plan of care is implemented. Literature regarding effective self-management support emphasizes personal empowerment or activation, in addition to active participation, when setting goals and developing treatment plans.
- Effective models, including many of the ones named in this brief, offer tools and supports specifically for family caregivers, as well as caregiver assessments.

### Team-Based Care
- Close interaction between care coordinators and interdisciplinary team members, including physicians, results in fewer hospital admissions.
- Encounters with registered nurses, as members of the interdisciplinary team, can lead to a reduction in emergency department visits and unnecessary office visits.
- Involvement from social workers, as members of the interdisciplinary care team, can help to meet the social support needs of frail individuals with chronic illnesses, as well as ensure successful transition from hospital to home.
- Integration of direct-care workers into care coordination teams can help create partnerships among providers, individuals, and their families.

### Promising Care Coordination Models*

<table>
<thead>
<tr>
<th>Comprehensive</th>
<th>Transitional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Management Plus (CMP)</td>
<td>Better Outcomes for Older Adults</td>
</tr>
<tr>
<td>Geriatric Resources for</td>
<td>through Safe Transitions (Project</td>
</tr>
<tr>
<td>Assessment and Care of</td>
<td>BOOST)</td>
</tr>
<tr>
<td>Elders (GRACE)</td>
<td>The Bridge Model</td>
</tr>
<tr>
<td>Guided Care</td>
<td>Care Transitions Intervention (CTI)</td>
</tr>
<tr>
<td>Home Based Primary Care (HBPC)</td>
<td>Interventions to Reduce Acute Care</td>
</tr>
<tr>
<td>Improving Mood-Promoting</td>
<td>Transfers (INTERACT II)</td>
</tr>
<tr>
<td>Access to Collaborative</td>
<td>Re-engineered Discharge (RED)</td>
</tr>
<tr>
<td>Treatment (IMPACT)</td>
<td>Transitional Care Model (TCM)</td>
</tr>
</tbody>
</table>

* Please see Appendix A: Program Details of Featured Comprehensive and Transitional Care Coordination Models
Comprehensive teams can better meet the individual’s needs, such as teams in which pharmacists participate to assist with medication management.  

Collaborative care models for depressive disorders, in which psychiatrists and psychologists collaborate with primary care providers, reduce depression and increase the individual’s satisfaction with care across multiple populations, including older adults.  

When care coordination is team-based, interdisciplinary and maintains open communication, individuals feel most supported and quality of care improves.

**Evidence Base**

Care coordination programs with positive, rigorously evaluated and broadly replicable results include comprehensive and transitional care models. While both approaches feature elements in common such as conducting an initial comprehensive assessment and implementing an evidence-based care management plan (including coaching, self-care education, and maintaining links with medical and community-based services), they are differentiated with regard to where the intervention takes place, who performs the intervention, and for how long. Additionally, targeting the highest-risk individuals yields the greatest success.

**CARE COORDINATION: Lessons Learned**

Key points to consider for implementation of effective care coordination models include:

- Successful care coordination is more likely when the interdisciplinary team has access to timely data on care delivery, especially in regard to hospital admissions.
- Focusing on smooth transitions between care settings is crucial.
- Targeting the highest-risk individuals yields the greatest success in terms of improved quality of care and reduced cost.
- Attention to mental health and psychosocial issues must be incorporated into care coordination models.

**MEETING FUTURE CHALLENGES: Recommendations for Care Coordination Research & Policy**

In order to realize the full potential of care coordination to improve quality of care – especially for an aging population – EWA and N3C make the following recommendations for policy changes and future research:

- Encourage payment and delivery models that support improved coordination and communication among members of the interdisciplinary team of providers, direct care workers, the individual, family caregivers and others chosen by the individual.
- Strengthen family caregiver capacity to manage care, as appropriate, and provide support to the individual, as well as assess family caregiver capacities, needs and coping ability.
- Ensure that the individual and family caregiver are involved in shared decision-making at each step of care and transitions between settings.
- Target the highest-risk individuals, especially those at risk of hospitalization.
- Develop, support, and use technology, such as health information technology (HIT) and interoperable electronic health records (EHRs) to support effective care coordination and individual and family caregiver engagement. Encourage policies that will enable individuals, family caregivers, and providers to use this technology.
- Craft policies which ensure efficiency, transparency, individual self-determination and safeguards, while supporting access to high quality, coordinated care.
- Promote care coordination models that emphasize care coordination across disciplines and settings of care, including long-term care and other non-medical settings.
ADVANCED DIRECT CARE WORKER:
A Role to Improve Quality and Efficiency of Care for Older Adults and Strengthen Career Ladders for Home Care Workers

CONCEPT
In its historic 2008 report, *Retooling for an Aging America: Building the Health Care Workforce*, the Institute of Medicine (IOM) recommended changes both to how care is delivered and the preparation of the healthcare workforce to provide that care. Specifically, it urged expansion of team-based approaches to health care delivery, with care provided by a better-prepared healthcare workforce, all working to the top of their skill sets. In line with the IOM recommendations, the Eldercare Workforce Alliance (EWA), with input from its member organizations, has identified gaps in care and inefficient uses of the current workforce. In this brief, EWA proposes one solution for improving care for older adults.

The Alliance believes that with the appropriate training, supervision, and support, some home care workers can play an enhanced role, with more responsibility for improving safety and quality of care for older adults and their family caregivers. We recommend fostering an Advanced Direct Care Worker (DCW) role that both improves the quality of person- and family-centered care and addresses current and future demand for a high-functioning eldercare workforce. Developing such a role and deploying workers in this capacity can lead to better health, better care, and potential cost-savings.

DISCUSSION
Our focus in this discussion is on advanced roles for direct care workers within the home care setting, although we recognize there may be opportunities for advanced roles within other settings. And, while our focus here is on direct care workers, we believe that all members of the care team should be supported to work to the top level of their skill set. Finally, while our proposal is for a subset of home care workers to receive additional training to perform advanced functions, we believe that all direct care workers should be well-trained and supported in their role and we echo the IOM's call for strengthening training standards and improvements in training programs for the workforce as a whole.

In the interest of a clear, targeted dialogue and because of the anticipated surge in demand for home care, our discussions focused on the potential for an Advanced Direct Care Worker role in the home-care setting, with the understanding that this is a developing concept and no one model will meet the varied needs of every consumer. Further, implementation of advanced roles for direct care workers will likely occur at the state, local and provider level. Federal demonstration projects may be an effective means of testing the concept. EWA’s goal is to outline a concept, which represents a consensus by varied members of the health care team and can be drawn upon by those developing advanced direct care worker roles to achieve the highest-possible quality of care and support for older adults and their family caregivers.
NEED
Every 8 seconds, a person turns 65 in our country; that’s more than 10,000 people a day. Within twenty years, 1 in 5 Americans will be over 65 and by 2050 an unprecedented number - 19 million - will be over 85 years old. Trends suggest these individuals will want to age in place. Most of these individuals will have one or more chronic conditions – potentially increasing hospitalization rates - that requires skilled care. Currently, direct care workers provide an estimated 75 percent of the paid hands-on care. However, if no action is taken to stabilize the eldercare workforce, vacancies and will only become more acute in the future as the need for services and supports increases.

One solution is to allow all health care providers to provide services to the full extent of their current knowledge, training, experience, and skills where evidence indicates services can be provided safely and effectively. The proposed Advanced Direct Care Worker role calls for expanding roles for home care workers commensurate with their demonstrated competency to take on additional responsibilities. Indicators of competency could include the amount of time on the job, successful completion of certain classes, level of education achieved, evaluations from individuals and families served, and evaluations by agency supervisors.

Wages would be commensurate to the Advanced Direct Care Worker’s training and experience and higher than those of current direct care workers, creating an incentive to remain in this field. By creating a meaningful career ladder for home care workers who wish to advance within their field, we will be better able to attract and retain a quality workforce, potentially keeping experienced workers in the field. This can help to create a home care workforce able to provide supports and services that improve quality and continuity of care for the consumer while reducing burdens on family caregivers.

METHODS & BACKGROUND
Between November 2010 and June 2013, the Eldercare Workforce Alliance convened a series of roundtable discussions to explore the perspectives of various members of the interdisciplinary care team with regard to advanced roles for direct care workers. With support and input from member organizations, EWA conducted in-person roundtable discussions with representatives from the direct care, nursing, social work, and physician workforces. Through an online survey, family caregivers identified areas of needed support, which helped to identify potential Advanced Direct Care Worker roles. A summary of the findings specific to these roundtable discussions and survey can be found in the addendum (Appendix B).

In the interest of a clear, targeted dialogue and because of the anticipated surge in demand for home care, our discussions focused on the potential for an Advanced Direct Care Worker role in the home-care setting, with the understanding that this is a developing concept and no one model will meet the varied needs of every consumer. Further, implementation of advanced roles for direct care workers will likely occur at the state, local and provider level. EWA’s goal is to outline a concept, which represents a consensus among varied members of the health care team, that can be drawn upon by those developing advanced direct care worker roles to achieve the highest-possible quality of care and support for older adults and their family caregivers.

Finally, the development of advanced roles for some direct care workers does not negate the essential role of traditional home health aides, home care workers, and personal care attendants, and of the invaluable supports they provide. Nor does it negate the ongoing need for nurses and social workers and the important roles that they play in home care service delivery and care coordination. The Advanced Direct Care Worker concept is intended for the segment of direct care workers who have the experience, knowledge, and training, demonstrated competency, aptitude, and desire to take on more advanced roles. For a growing number of older adults who wish to age in home- and community-based settings, advanced care will be needed and can benefit their quality of life.
FINDINGS

Points of consensus stemming from the roundtable discussions and survey input are as follows:

**Need for Improved Respect, Engagement and Training for All Direct Care Workers:** All direct care workers should be recognized as integral members of the care team with valuable and unique information to contribute. Workforce development strategies that ensure all direct care workers receive high-quality, comprehensive training, supervision, and support will enhance direct care workers’ effectiveness within the interdisciplinary team and will maximize the biopsychosocial well-being of older adults and family caregivers. Direct care workers play an important role in interdisciplinary team work, contributing first-hand information and hands-on experience.

**Training:** One key to successful implementation of advanced roles for direct care workers is support from the interdisciplinary care team and demonstrated competency to meet the responsibilities of an advanced role. For Advanced Direct Care Workers working with older adults, training specific to geriatric syndromes and unique needs and symptoms of older adults is necessary for this role to effectively improve outcomes. Additionally, training for the advanced direct care worker in effectively communicating with the interdisciplinary care team, the consumer and family members - as well as for the team members in communicating with the advanced direct care worker - is essential.

Due to the evolving development of this concept, EWA does not currently recommend a specific number of training hours to be required for an Advanced Direct Care Worker role. Rather, we emphasize more generally that an expanded role should be commensurate with demonstrated competency to take on additional responsibilities. This will be essential for realizing the full potential of advanced roles for direct care workers. Training should exceed levels required for current direct care workers and address cultural diversity, person-centered care, advanced illness and palliative care, communication, disease education and interventions, and competency in skills needed for the role. It may be advisable to require demonstrated competency for Advanced Direct Care and to require continuing education for certification renewal.

**Support and Supervision:** Ongoing support and appropriate levels of supervision (and/or oversight) for advanced direct care workers is important in achieving the desired health and quality outcomes, strengthening the workforce, and reducing liability. Oversight should be provided by the most appropriate person or interdisciplinary care team member, with consideration given to program purpose, design, and when applicable, level of consumer direction. In many cases this could be a registered nurse or social worker. Current efforts, such as nurse delegation models could mean an expanded supervisory role for registered nurses.

**Observe, Record, Report:** An Advanced Direct Care Worker can fill crucial gaps in care. Because of their regular in-person interaction with consumers, often over an extended period of time, all home care workers are in a unique position to identify shifts in consumers’ health. With additional training in particular illnesses and conditions, and with the consent of the consumer, an Advanced Direct Care Worker can observe, record, and report changes in consumer status or function to the appropriate team member. Early detection of these changes can be key to discovering or treating geriatric syndromes, chronic disease, cognitive changes, and complications. Recognizing changes in mobility, appetite, fluid intake, weight, skin color or condition, activity, mood, energy, and communication, and then reporting the information to the other team members can better meet the medical and social needs of the consumer. Such detection and communication could also help to prevent avoidable hospitalizations, readmissions, or institutionalization. Advanced roles, combined with technology and tele-health services, could be especially beneficial to consumers living in rural areas.
Assist with Tasks: Increasingly, family caregivers and some home care workers are being asked to perform medical and nursing tasks, often with minimal or no training. An Advanced Direct Care Worker could be provided additional training in order to safely assist with more advanced tasks and provide individualized, hands-on support and guidance to family caregivers. Subject to state scope of practice laws and contingent upon appropriate training and demonstrated competency, tasks performed by an Advanced Direct Care Worker could include: inserting, removing, and maintaining catheters; overseeing nebulizer treatments; administering enemas and suppositories; assisting with minor cuts, abrasions, and wound care; taking readings and measurements, such as those from a pulse oximeter; monitoring insulin levels, including performing finger sticks; and supporting pain management. Tasks and procedures should be supervised by a registered nurse or other member of the interdisciplinary care team. With training, supervision, and demonstrated competency, Advanced Direct Care Workers could perform many of the tasks currently performed by family members or consumers.

While restrictions differ from state to state, an Advanced Direct Care Worker could help support medication adherence by helping to monitor and/or administer medications, potentially including injectable, topical, oral, and suppositories. Appropriate training could include the recognition of side effects, knowledge of negative drug interactions, and the reporting of individuals’ and families’ medication-related concerns.

Generally speaking, many states will permit family members to be trained to perform health maintenance tasks, but will not allow paid direct care workers to be taught to perform them. Thus, family caregivers may have to rush home from work at lunchtime to administer medication or a tube feeding that direct care workers are prohibited from administering. Hiring a nurse to perform these routine procedures, typically performed several times a day, is not feasible nor efficient. Therefore, allowing nurses to train and delegate these tasks to advanced direct care workers could ease the burden on family caregivers.

Provide Health Information & Resources: Communication among interdisciplinary team members, including health care professionals, consumers, and their family caregivers, is vital to quality care. An Advanced Direct Care Worker could enhance channels of communication by serving as a link for consumers and family members to the other team members and by helping individuals and family members to navigate the health care system, when it is their wish and with their consent. With support from other members of the care team, an Advanced Direct Care Worker could educate consumers and their family caregivers on particular health conditions, share information on community resources and supportive services, navigate health coverage and schedule appointments, and when desired, advocate for the consumer and provide emotional support.

Additionally, the Advanced Direct Care Worker could serve as a significant resource by helping to provide continuity through care transitions across settings. By communicating with the interdisciplinary team and identifying and reporting status changes, the Advanced Direct Care Worker can help prevent avoidable hospitalizations or miscommunication. To address privacy concerns, it should be clear to the consumer what information would be shared with other members of the care team, and occur only with their consent.

Promoting healthy practices, through nutrition and dietary planning, physical activity, oral health and hygiene, vaccination, and disease and health self-management, can also be valuable roles for the Advanced Direct Care Worker to play. Additionally, assisting individuals with doing exercises, such as range of motion activities prescribed by a physical or occupational therapist or physician, could improve health outcomes and quality of life. Such health promotion and behavioral management can be especially beneficial for: management of diabetes, heart disease, and mental health conditions; prevention of pneumonia, flu, and falls; and maintenance of general mobility and socialization.
**Condition-Specific Roles:** While any direct care worker should be trained to recognize and report signs of mental health issues, advanced illness and palliative care needs, and early signs of dementia, an Advanced Direct Care Worker with specific skills could significantly improve quality for individuals with these specific needs. For example, an Advanced Direct Care Worker specializing in advanced illness and palliative care can support the individual’s advance directives, support a pain management plan, and support individuals and their families. The same is true for Alzheimer’s and dementia care, for which an Advanced Direct Care Worker could learn to recognize and defuse behavioral symptoms of distress, reduce triggers for agitation or confusion, stimulate the individual through non-medical engagement, and support families. While maintaining a whole-person approach, an Advanced Direct Care Worker with condition-specific training could provide critical guidance and expertise within the care team, enhancing the quality of care provided.

**CONCLUSION**

At this point, demonstration projects should be created to test the viability and functionality of Advanced Direct Care Worker roles. Quality care for older adults, now and in the future, depends upon the quality of the workforce providing that care, as well as other factors. In order to achieve our goals of better care and lower cost, it is essential to raise the skill level, especially with respect to geriatrics and gerontology, of all healthcare providers. The future cost and quality of healthcare will be determined in part by whether we have a well-trained, coordinated workforce. An Advanced Direct Care Worker has the potential to help meet the needs of our burgeoning older adult population by providing person- and family-centered care effectively and efficiently.

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1. Older adults, within this paper, are also referred to as “consumers” as well as “person” within the phrase “person-and family-centered care.”

*The positions of the Eldercare Workforce Alliance reflect a consensus of 75 percent or more of its members. Statements reflect the consensus of the Alliance and do not necessarily represent the position of individual Alliance member organizations.*

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