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WASHINGTON STATE'S ELDERCARE WORKFORCE

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Abstract

The population of Washington is aging. By 2030, nearly 20% of Washington residents will be age 65 and older; in rural communities nearly 30%. Are we prepared to meet the health care needs of our aging population? The William D. Ruckelshaus Center and the University of Washington Health Policy Center partnered on baseline research to examine this question and others. They inquired about types of health care providers for older adults in Washington; current and anticipated supply-and-demand for this workforce; and policy approaches to address capacity gaps. This fact sheet offers a summary of the research findings, with an overview of expected supply and demand for eldercare workers and a broadly inclusive breakdown of the formal and informal caregivers who comprise this workforce. A companion fact sheet, *Aging in Place: A Policy Approach for Aging Well*, offers an overview of key policy concerns regarding older adults' access to eldercare services, and a community-based approach for supporting both eldercare service providers and the adults who receive their services.

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Washington State's Eldercare Workforce

The William D. Ruckelshaus Center and the University of Washington Health Policy Center recently partnered on baseline research to examine a critical policy concern facing Washington State today: Are we prepared to meet the health care needs of our aging population?

As the baby boom generation advances into its elder years, Washington State is witnessing a striking increase in its older adult population. Policy makers and other stakeholders, including the Ruckelshaus Center and the Health Policy Center, are asking important questions about the health system's ability to support this demographic shift. Their joint research project focused on one such question: What is the capacity of Washington's health care workforce to meet the current and future demand of the state's older adults?

The partners' baseline study was designed to discover, assess, and aggregate generally available information and data about:

- Types of health care providers for older adults in Washington State
- Current and anticipated supply and demand for this workforce
- Policy approaches to address capacity gaps

Research activities included in-depth interviews with key stakeholders in health care for Washington's older adults, detailed reviews of 50 health care workforce-related websites for applicable information and data, and aggregate analyses of all collected information and data.

This fact sheet is a product of the study. It offers a summary of recent research findings in Washington State regarding the growing demand for health care services for older adults, and presents a broadly inclusive and detailed definition of the health care workforce that serves them—the *eldercare workforce*.

A companion fact sheet, *Aging in Place: A Policy Approach for Aging Well*, presents an overview of key policy concerns regarding older adults' access to eldercare services, and describes a community-based approach for supporting both eldercare service providers and the adults who receive their services. The companion fact sheet, and the interview script used in the study research, are available from the Publications page of the William D. Ruckelshaus Center's website at http://ruckelshauscenter.wsu.edu.

Our Aging Population

In 2011, the first of the nation's baby boom generation reached age 65, launching an "age wave" that will last until 2030. An average of 10,000 adults per day in the US will reach age 65 over that time period (Vincent and Velkoff 2010; Cohn and Taylor, 2010). But the older adult segment of the population had begun to grow in parts of the US even before this wave began. In the ten years before 2011, for example, the proportion of adults age 65 and older grew by 23.5% in the Western US, including Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming—the highest growth rate in the country (Werner 2010).

Like the rest of the nation, Washington State's population is aging. According to the Washington State Office of Financial Management (OFM), by 2030 the state will have nearly 700,000 more older adults than it does today, an expansion roughly equivalent to adding a population the size of the City of Seattle (OFM 2013a). The state's population will grow from one in seven residents age 65 and older to one in five (OFM 2013b). In many of the state's rural counties, the proportion will be even higher, at one in three (OFM 2012).

Supply of Eldercare Workers

Health care workforce supply has two key components: an adequate number of health care providers for the population being served and appropriately trained providers for that population. In Washington State and the nation, the supply of appropriately trained health care providers for adults age 65 and older is markedly insufficient now and is on a trajectory to worsen. In 2008, the Institute of Medicine (IOM) published findings from an in-depth study of the ability of the nation's health care workforce to care for older adults. The report asserted that the US has a "dramatic" undersupply of all types of health care workers today, and this workforce is not prepared to meet the health care needs of the growing older adult population now or into the future (IOM 2008).

Primary care providers, such as physicians, nurse practitioners, and physician assistants, are an important entry point to the health system for anyone seeking care, including older adults.

> ***There's a pipeline problem for primary care providers and registered nurses: there's a long training pipeline and not enough people in it. We've got the "age wave" and the ACA at the same time, and there aren't enough docs and nurses to meet all this demand.***
>
> *– Washington State Eldercare Stakeholder*

According to the Washington State Department of Health (DOH), federal "health professional shortage area" guidelines indicate that much of Washington State currently has insufficient numbers of primary care physicians in particular, as measured in three ways: where they work in the state, their availability to low-income residents, and their availability to the migrant worker population (DOH 2014a; DOH 2013). Large areas of the state also have a federal "medically underserved area" designation, which considers, in part, the supply of primary care physicians and the proportion of the population age 65 and over (DOH 2013; DOH 2014b).

Washington State's Health Care Personnel Shortage Task Force annually calculates expected shortages in health care providers. The projections cover a rolling five-year period, and because they are based on trends and national averages, they can change modestly from year to year. In its 2012 report, the task force projected that between 2015 and 2020 the state's greatest gaps in supply would include, among others, physicians, nurses, home health aides, vocational rehabilitation counselors, medical lab technicians, mental health counselors, dentists, physical and occupational therapists, and radiologic technologists (Health Care Personnel Shortage Task Force 2012). In its 2013 report, the task force added pharmacists and emergency medical technicians to the list, and removed physicians and nurses (Workforce Training and Education Coordinating Board 2013).

The non-clinical eldercare workforce also is experiencing shortages. For example, the University of Washington WWAMI Center for Health Workforce Studies estimates the state will need 77,000 additional home care aides by 2030 just to meet demand generated by growth in Medicaid clients. More such aides will be needed to care for older adults who are not Medicaid clients. Yet national estimates indicate a turnover rate among these providers of 25% to 200% or more per year, and Washington State data suggest that about 50% of home care workers leave their jobs annually (Palazzo et al. 2013).

Implementation of the federal Patient Protection and Affordable Care Act (ACA) has compounded the shortage of health care providers.

Between October 2013, when the state launched its new health insurance marketplace (*Washington Healthplanfinder*), and September 2014, over 700,000 people who had been uninsured became newly enrolled in either Medicaid (79%) or private health insurance (21%) (Washington Health Benefit Exchange 2014). Just over half of the new Medicaid enrollees were adults who became eligible when the state expanded Medicaid's age and income limits.

It is likely that many of these adults, along with those newly enrolled in private health insurance, delayed getting health care services for quite some time because they lacked health insurance. This is often referred to as "pent-up demand." Now, with the benefit of health insurance, their pent-up demand has been released, putting pressure on an already under-supply of health care providers across the state. This pressure shows up in several ways, such as difficulty finding a primary care provider or specialist who is taking new patients, and difficulty and long delays in getting appointments. An insufficient number of health care providers affects everyone, of all ages.

Another group of care providers that is ubiquitous, yet often unseen and seldom paid, is family and friends. According to the Congressional Budget Office (CBO), these *informal caregivers* are the single most important source of care for older adults across the nation (CBO 2013). In 2011, the national economic value of informal care was $234 billion, or 55% of the total economic value of care services provided to older adults (CBO 2013). Washington State alone has over 850,000 informal caregivers (King County Caregiver Support Network 2012).

The undersupply in health care workers has exacerbated a crucial deficiency within the workforce: lack of training in geriatric care. The American Geriatrics Society asserts that 17,000 more geriatricians are needed in the US to adequately serve today's population of older adults, and the number needed will nearly double by 2030 (2013). But virtually all health care professionals offer care to older adults in some way. Hence, improving geriatric competence *across* the health care workforce is essential (IOM 2008).

This will not be easy. For example, although nearly 75% of all medical schools in the US offer elective courses in geriatrics, only 4% of medical students enroll in these courses—a number far below what is needed for an adequately trained workforce (Bardach and Rowles 2012). This lack of geriatric training is mirrored in Washington State, where a 2012 statewide survey of physicians, nurse practitioners, and physician assistants revealed that only 1.3%, 3.9%, and 0.5%, respectively, reported general geriatrics as their primary specialty (Skillman et al. 2012).

Demand for Eldercare Workers

The undersupply of all health care providers, and of eldercare providers in particular, is directly related to the level of demand for their services. The surge in the number of older adults through 2030 isn't the only component of this demand. The IOM's 2008 research revealed, for example, that this cohort of baby boom older adults is different from previous generations in ways that will influence their health care wants and needs. Differences include increased longevity, more education, more widely dispersed families, and greater racial and ethnic diversity, all of which will affect the type, quantity, timing, location, and duration of the health care services these older adults will seek (IOM 2008).

Another important component of eldercare demand is the overall health status of older adults. As adults grow older, their health care needs become increasingly complex and acute. This leads to older adults using considerably more health care services than those who are younger, such as physician office visits, hospital stays, emergency medical services, and prescriptions (IOM 2008). In 2010, for example, adults age 65 and older comprised 13% of the US population but accounted for 34% of the nation's total personal health care expenditures (Lassman et al. 2014; Centers for Medicare & Medicaid Services, n.d.). Personal health care spending was three times higher for this age group than for working-age adults, and five times higher than for children (Lassman et al. 2014; Centers for Medicare & Medicaid Services 2014).

Chronic diseases and conditions, such as heart disease, stroke, cancer, diabetes, obesity, and arthritis (among others), are a key factor in older adults' increased need for health care services. These diseases are common in this age group: a quarter of the nation's adults age 65 and older has one chronic condition, over a quarter has two, and a third has three or more (Ward et al.). The Centers for Disease Control and Prevention (CDC) has documented the contribution of chronic diseases and conditions to long-term disability and a compromised quality of life (CDC 2014a). These diseases and conditions comprise seven of the top ten causes of death in the US (CDC 2014b). And they are expensive: 75% of the nation's health care dollars goes to treating these diseases and conditions (CDC 2014a).

Who Works in the Eldercare Workforce?

The IOM's 2008 report advocated for expanding the definition of the eldercare workforce to include all individuals and services involved in an individual's care, even those not always classified as "health care." The report suggests including direct-care workers; informal caregivers, who are usually family and friends; and even patients themselves (IOM 2008).

> ***The providers we have now need better training on issues of older adults, in understanding what older adults need to survive and thrive into late life.***
>
> *– Washington State Eldercare Stakeholder*

The national advocacy group Eldercare Workforce Alliance offers a similarly broad definition of the eldercare workforce: it includes health care professionals such as physicians, nurses, direct-care workers, psychologists, social workers, pharmacists, and physical therapists, as well as employers of eldercare providers, family caregivers, and health care consumers (Eldercare Workforce Alliance n.d.). The Alliance asserts that high-quality care for older adults requires bringing together a coordinated, interdisciplinary team with diverse skills to address physical health, mental health, and social and emotional well being (Eldercare Workforce Alliance n.d.).

This fact sheet offers a broad definition of the eldercare workforce developed specifically for Washington State. The definition is presented in detail in Tables 1-4, which follow the "What's Next" section below. These tables include three workforce categories:

- Individuals Who Provide Health Care and Direct-Care Services to Older Adults (Tables 1 and 2). Individual providers include, for example, physicians, nurses, physician assistants, and others outlined in Table 1, and home health aides, nurse assistants, informal caregivers, and others outlined in Table 2.
- Employers of Individual Health and Direct-Care Providers (Table 3). Employers include, for example, "brick and mortar" establishments (such as assisted living facilities and hospitals), agencies (such as home health agencies and in-home care services agencies), and programs (such as adult day care), as outlined in Table 3.
- Administrators Directly Involved in Ensuring Access to Services (Table 4). These are administrators of publicly sponsored health care programs directly involved in ensuring access to services, as outlined in Table 4.

The broad definition outlined in the tables illustrates the interconnectedness and complexity of the health care and social service needs of Washington State's older adults. As their numbers increase, so does their need not just for clinical health care services, but for the kinds of care that allow them to age with comfort, stability, and dignity. These services affect quality of life and, by extension, quantity.

The eldercare workforce definition encompassed by these tables offers an entry point for thinking about an array of eldercare concerns: *Who* provides care; *what* care is needed and *when*; *where* can care best be offered; and *why* provide this care, at this time? The tables also illustrate the importance of considering *how* to best meet all these components of demand—*who, what, when, where,* and *why*—while keeping both the supply and cost of appropriate services in mind.

What's Next?

As the proportion of older adults in Washington State grows ever larger, demand for health care services by this population will increase in kind. Yet demand from all other age groups also is on the rise, spurred by implementation of the ACA. In both cases, the supply of health care workers is lagging, but for older adults the supply of eldercare workers who are appropriately trained in some level of geriatric care is critically short.

The confluence of these two growing sources of health care demand in Washington State—overall demand and demand from a growing elder population—presents an opportunity to apply thoughtful and collaborative planning to identify, understand, and address health care workforce policy issues. The capacity of the workforce to meet the population's needs—that is, the supply, training, and distribution of health care providers—is an essential place to start. To ensure the success of policy responses, stakeholders will need to address issues such as employee compensation, retention, and career advancement.

Washington State's universities are well suited to help advance solutions in eldercare policy by convening diverse and multi-disciplinary stakeholders for collaborative problem solving. With access to information, ideas, and resources from top researchers and academic leaders from every discipline involved in this complex issue, the state's universities can readily fuel a meaningful conversation that looks toward finding solutions.

> ***Most family caregivers do not directly receive reimbursement, yet family caregivers are a critical provider for all these services, a critical component of care.***
>
> *– Washington State Eldercare Stakeholder*

Combining Washington State University and University of Washington expertise and perspective into an effective, university-based, neutral third party may help to address eldercare policy issues that involve diverse stakeholders, such as:

- State public health and social service agencies and departments
- State legislators and their committee staff
- Health care providers and professional associations
- Public and private-sector payers, including insurers and health plans
- Consumer advocates
- Labor unions
- Foundations and other community partners

The new era of health care reform ushered in by the ACA encourages new care delivery, coordination, and payment methods, as well as a need for collaborative innovation. University-based centers such as the William D. Ruckelshaus Center and the University of Washington Health Policy Center are uniquely poised to act as neutral conveners to help stakeholders share ideas, address conflicts, and build innovative and effective public policy solutions.

Tables: Washington State's Eldercare Workforce

Table 1: Individuals Who Provide Health Care Services to Elders

The eldercare workforce includes numerous health care professions. This table describes health care providers who offer clinical and other health care services in a variety of settings.

PROVIDER	DESCRIPTION
Physicians	Prevent and treat human illness and injury by providing a broad range of health care services. Some physicians provide specialty services for specific conditions. Some act as medical directors of eldercare establishments (see Table 3). *Provider Types:* Primary care, family practice, geriatric, and specialists (such as dermatology, internal medicine, ophthalmology, surgery, emergency medicine).
Nurses	Give a wide range of direct and supportive clinical care and supervision to elders. APRNs are among the primary care providers that serve older adults. *Provider Types:* Advanced practice registered nurses (APRNs), registered nurses (RNs), licensed practical nurses (LPNs).
Physician Assistants	Prevent and treat human illness and injury by providing a broad range of health care services under the direction of a physician or surgeon. Physician assistants are among the primary care providers who serve older adults.
Mental Health Professionals	Provide services to support the mental health of older adults. Services may include diagnosis, case management, therapy, medication prescriptions, and providing prescribed medications. *Provider Types:* Social workers, psychiatrists, geriatric psychiatrists, certified counselors, neuropsychologists, clinical psychologists.
Oral Health Care	Provide prevention and intervention services for dental and oral health needs of older adults. *Provider Types:* Dentists, dental assistants, dental hygienists.
Pharmacy Care	Manage prescriptions, provide consultation. Sometimes provide general health screenings, prevention services, and health information (for example, blood sugar and pressure screenings, flu shots, and medication management advice). *Provider Types:* Pharmacists and pharmacy technicians.
Allied Health Care Workers	Health care professionals distinct from nursing, medicine, and pharmacy who typically provide diagnostic, technical, therapeutic, and direct patient care and support services for other health professionals and their patients. *Provider Types:* Medical assistants, dietitians, nutritionists, emergency medical technicians (EMTs), audiologists, cardiographic technicians, optometrists, massage therapists, and others.
Rehabilitation Service Providers	Care professionals who help with remediation of impairments and disabilities in order to return individuals to their highest level of functioning, through examination, evaluation, diagnosis, and intervention. Therapy sometimes is long term. *Provider Types:* Physical therapists, occupational therapists, speech therapists.

Where are gerontologists? Gerontology is the study of the social, psychological, and biological aspects of aging. It is distinguished from geriatrics, which is the branch of medicine that studies the diseases of older adults. Although some gerontologists may provide care, in general, gerontologists are not considered key individual eldercare workforce providers.

Where are direct-care workers? Direct-care workers are described in Table 2, below.

Where are social services providers? Social service providers affiliated with public agencies are included in Table 4, below.

Table 2: Direct-Care Workers for Elders

Direct-care workers provide hands-on, personal-care services. In some cases they also will provide limited health care services. Although there are several different job titles, the services they provide can be very similar. This is a consequence of the way the job is defined by law, administrative rule, and payment source.

PROVIDER	DESCRIPTION
Home Health Aides	Assist individuals with activities of daily living (ADLs), which typically include bathing, dressing, eating, and toileting. May assist with instrumental activities of daily living (IADLs) such as food preparation, housekeeping, chore services, transportation, and leisure activities. May assist with medication administration or provide clinical or therapy-related services while supervised by an RN or a licensed rehabilitation therapist.
Nurse Assistants	Assist individuals with ADLs. Perform clinical tasks under the supervision of an RN, such as taking blood pressure. In Washington State, can administer oral medications. *Provider Types:* Nursing aide, geriatric aide, orderly, hospital attendant. These individuals are differentiated from other categories of direct-care workers (and are excluded from the long-term care worker category described below) based on where they provide services. They work in hospitals, skilled nursing facilities, and other acute care settings.
Personal Care Aides	Help older adults maintain their independence and remain in their homes and communities by providing assistance with both ADLs and IADLs. Can perform health-related tasks under the supervision of the client or an RN, but also can work with no RN supervision (unlike home health aides and nurse assistants). *Provider Types:* Personal care attendant, personal assistant, direct support professional.
Informal and Family Caregivers	Provide a range of assistance to older adults and persons with disabilities, including personal care services, health-related tasks, and many other supportive services, without pay. *Provider Types:* These caregivers include relatives, friends, neighbors, and other volunteers who provide unpaid services.
Respite Care Workers	Provide temporary supervision, companionship, and personal care services usually provided by primary caregiver (often informal caregivers) of an older adult or person with disabilities.

Where are "long-term care workers"? In Washington State, the term long-term care worker has a specific meaning for Medicaid and other publicly sponsored programs. In state law and administrative rules, long-term care worker actually is not a single job title but a broad category that encompasses several job titles. The direct-care workers described above may be included or excluded from the long-term care worker category based on several factors, including the type of facility within which they work, whether the state is paying for the services they provide, whether the state has licensed the facility within which they work, and when they first became employed in the state. Hence, some direct-care workers could be considered long-term care workers in some scenarios but not in others.

Where are "home care aides"? This is a professional credential required by Washington State since January 2011 (with finalized requirements established effective January 2012) for all newly hired long-term care workers who do not have another professional credential (such as an RN, LPN, NAC, nurse technician, or advanced registered nurse practitioner) or do not meet other specific exemptions.

Table 3: Employers of Individual Health Care and Direct-Care Providers

Employers of individuals who provide health care and direct-care services to elders can be categorized into three types: a "Brick and Mortar" Establishment, an Agency, or a Program. This table describes each.

Employers: Brick & Mortar Establishments		Who Works Here?
Adult Family Homes (AFHs)	Privately owned homes in residential areas licensed to provide living arrangements and personal care for up to six non-related individuals (commonly called "residents"). Provide room, board, laundry, necessary supervision, and help with ADLs, personal care, and limited social services. Vary in type of care offered and in levels of care assistance provided. Also may receive one of three Washington State specialty certifications in mental health, dementia, or developmental disabilities.  Licensed by the Washington State Department of Social and Health Services.  Some accept Medicaid; others are funded through private pay only.	*Ownership* Registered or licensed nurses, nursing assistants, or a family, single person, or business partner(s) *Staffing Requirements* - 1 staff to 6 residents at a minimum *Likely Employees (see Tables 1 and 2)* - Individual provider specialists, such as mental health professionals and physical therapy/ rehabilitation - Nurse assistants - Home health aides - Personal care aides - Other long-term care workers as defined by the State (see note below Table 2) *Things to Note* Less likely to serve clients with acute nursing care needs
Assisted Living Facilities (ALFs) Also called: • Board & Care • Community-Based Retirement Care • Personal Care Homes • Adult Foster Care • Adult Residential Care	A home or other facility in a residential area licensed to provide living arrangements and care services for seven or more residents. Provide room, board, laundry, and necessary supervision. Vary in levels of care assistance provided; may offer personal care or supportive health services; some provide nursing care. Also may receive one of three Washington State specialty certifications in mental health, dementia, or developmental disabilities.  Licensed by the Washington State Department of Social and Health Services. Note: Some were formerly called "boarding homes."  Some accept Medicaid for housing and contracted service packages; others are funded through private pay only.	*Ownership* Varies widely in Washington State: can include individuals, business partners, large corporations *Staffing Requirements* - Due to varying sizes of facilities, staffing requirements are broad and can include many health care, direct-care, and other professions - All ALFs are required to employ an administrator who is responsible for overall 24-hour operation - Staff are required to demonstrate specific Washington State-defined training credentials *Likely Employees (see Tables 1 and 2)* - RNs, LPNs - Allied health professionals - Direct-care workers - Activity coordinators/directors - Long-term care workers as defined by the State (see note below Table 2)
Tribally-Licensed Assisted Living Facilities	Home or other facility in residential areas, licensed by federally recognized Indian Tribes to provide living arrangements and care services for residents.  Licensed and regulated by tribes recognized as sovereign nations.  Can contract with Washington State to accept Medicaid payments. Also can be funded through private payments or tribal payment mechanisms.	*Ownership* Tribes or individuals *Staffing Requirements* - Tribes set their own staffing requirements, unless the facility wants to contract with the State—then it must meet the requirements outlined for other, non-tribal assisted living facilities *Likely Employees (see Tables 1 and 2)* - RNs, LPNs - Allied health professionals - Direct-care workers - Activity coordinators/directors - Long-term care workers as defined by the State (see note below Table 2)

Table 3: Employers of Individual Health Care and Direct-Care Providers, cont.

Employers: Brick & Mortar Establishments, cont.		Who Works Here?
Nursing Homes Also called: • Skilled Nursing Facilities • Nursing Facilities (NFs) • Convalescent Homes • Rehabilitation Facilities	Any licensed home, place, or institution that operates or maintains facilities that provide 24-hour supervised convalescent care or chronic care, or both, for a period in excess of 24 consecutive hours for three or more patients. Does not include hospitals. Provide 24-hour supervised nursing care, personal care, therapy, nutrition management, organized activities, social services, room, board, laundry. Nursing care tasks may include medication administration, preparation of special diets, bedside nursing care, dressings and bandage application, and carrying out treatment prescribed by a licensed health practitioner.  Licensed by the Washington State Department of Social and Health Services.  If client is Medicaid-eligible, medically necessary services can be paid through Medicaid; also accept Medicare and private pay.	*Ownership* Varies widely in Washington State: can include individuals, business partners, large corporations *Staffing Requirements* - A full-time RN director of nursing - Designated RN or LPN as charge nurse - Certified dietician - Each resident's care must be supervised by a physician *Likely Employees* - Physician specialists - Physician medical directors - RNs, LPNs - Allied health professionals - Rehabilitation service providers - Direct-care workers - Long-term care workers as defined by the State (see note below Table 2)
Hospitals	Provide medically necessary, acute, post-acute, or general health care for older adults. Services may include inpatient or outpatient, nursing, pharmacy, food, and necessary ancillary services.  Licensed and regulated by the Washington State Department of Health.  Can be paid for by Medicare, Medicaid, private insurance, or out-of-pocket payments.	*Likely Employees (see Tables 1 and 2)* - Physicians and physician specialists - APRNs, RNs, LPNs - Allied health professionals - Rehabilitation service providers - Mental health professionals - Social workers - Direct-care workers
Hospice Care Centers	A home-like medical institution where hospice services are provided for clients with a life-limiting illness. Services include symptom and pain management for individuals, and emotional, spiritual, and bereavement support for clients and their families. Centers provide continuous care for a minimum of eight hours a day, general inpatient care, inpatient respite care, or routine home-based care.  Licensed and regulated by the Washington State Department of Health.  Facilities certified by Medicare accept Medicare payments; also can accept Medicaid, private insurance, or private pay.	*Staffing Requirements* - Care must be under the direction of an interdisciplinary team including at least a nurse, social worker, physician, spiritual counselor, and volunteer - A full-time director of clinical services must be available 24 hours a day, seven days a week - RN supervisor for RNs, LPNs, or home health aides - Licensed therapist supervisor for therapy assistants *Likely Employees (see Tables 1 and 2)* - Physicians - ARPNs, RNs, LPNs - Home health aides - Medical social workers - Mental health professionals - Rehabilitation service providers - Spiritual/pastoral and family counselors - Trained volunteers

Table 3: Employers of Individual Health Care and Direct-Care Providers, cont.

Employers: Brick & Mortar Establishments, cont.		Who Works Here?
Comprehensive Outpatient Rehabilitation Facilities (CORF)	Outpatient facilities primarily engaged in providing rehabilitation for Medicare beneficiaries who are injured, disabled, or recovering from illness. Provide coordinated rehabilitation programs that include physician services, physical and occupational therapy services, speech and language therapy services, social and/or psychological services.  Not licensed by Washington State but can be certified by Medicare.  Facilities that are certified by Medicare accept Medicare payments; also accept private insurance or private pay.	*Staffing Requirements* - Must have adequate staffing to provide at least physician, physical therapy, and social and/or psychological services - Physician medical director - On-call physical therapist during all operating hours *Likely Employees (see Tables 1 and 2)* - Physicians - Rehabilitation service providers - Mental health professionals - RNs, LPNs, nurse assistants *Things to Note* See "Rehabilitation Agencies" below
Employers: Agencies		**Who Works Here?**
Home Health Care Agencies	Recruit, train, supervise, and pay staff persons who attend to clients' medical and personal care needs in the clients' place of residence. Place of residence can include private homes or other places, such as ALFs and AFHs (see above), and independent living facilities. If a private residence, the home health care agency assumes responsibility for the care provided.  Licensed by the Washington State Department of Health.  Some home health services can be covered by Medicaid; other companies accept Medicare or private pay.	*Likely Employees (see Tables 1 and 2)* - RNs, LPNs - Home health aides - Personal care aides - Long-term care workers as defined by the State (see note below Table 2) *Things to Note* Brick & Mortar Establishments (see above) can contract directly with these agencies to hire appropriate staff for meeting state regulations for service care requirements, or they can hire necessary staff directly
Hospice Agencies	Provide care to relieve physical, emotional, and spiritual suffering. Provide medical care to relieve pain and other symptoms of a life-limiting illness. Also offer mental health counseling and education for clients and caregivers and spiritual counseling for end-of-life issues. Services most often provided in client homes. Also offer services in freestanding hospice centers, hospitals, nursing homes, and other long-term care facilities such as ALFs (see above). Agencies assume overall responsibility for care provision.  Licensed and regulated by the Washington State Department of Health.  Hospice services are covered under Medicare (when certified by Medicare), Medicaid, and through private insurance or private pay.	*Staffing Requirements* - Requirements for hospice agencies follow the same regulations as hospice care centers (see Brick & Mortar Establishments, above) Likely Employees (see Tables 1 and 2) - Physicians - ARPNs, RNs, LPNs - Home health aides - Social workers - Mental health professionals - Rehabilitation service providers - Spiritual counselors - Trained volunteers

Table 3: Employers of Individual Health Care and Direct-Care Providers, cont.

Employers: Agencies, cont.		Who Works Here?
In-Home Care Services Agencies	Recruit, train, supervise, and pay staff persons who attend to clients' personal care needs, ADLs, and IADLs. Do not typically provide medical or health services unless under delegation from an RN. Employees care for clients in their private homes or other place of residence, including ALFs and AFHs (see above), or independent living facilities.  Licensed by the Washington State Department of Health.  Medicaid may pay for services by aides designated as an "individual provider;" also accept private pay.	*Likely Employees (see Tables 1 and 2)* - Personal care aides - Long-term care workers as defined by the State (see note below Table 2) *Things to Note* Brick & Mortar Establishments (see above) can contract directly with these agencies to hire appropriate staff for meeting state regulations for service care requirements, or they can hire necessary staff directly
Rehabilitation Agencies	Provide integrated interdisciplinary rehabilitation programs to improve physical functioning of clients. Programs may include physical and occupational therapy, speech and language services, psychological and social or vocational adjustment services. Services provided in client homes or place of residence. Agencies may also operate in out-patient or other facility centers.  Not licensed by Washington State but can be certified by Medicare.  Facilities certified by Medicare accept Medicare payments; also accept private insurance or private pay.	*Likely Employees* - Rehabilitation service providers - Mental health professionals - Social workers - RNs, LPNs, nurse assistants - Physicians
Employers: Programs		**Who Works Here?**
Adult Day Care	Daytime program for adults who need some level of care and would benefit from socialization, but do not need medical care from an RN or a rehabilitation service provider. Located in community-based establishments such as senior centers or community centers; sometimes located in ALFs (see above) and retirement communities and offered to both residents and non-residents. Also can be in a stand-alone facility. Services include personal care assistance, social services and activities, general therapeutic activities, health education and counseling, routine health monitoring, nutritious meals, and assistance with transportation. Sometimes medication administration, first aid, or emergency care services are available.  No licensing required in Washington State.  To receive Medicaid payment, the program must comply with state regulations and thereby receive designation as an adult day center. Adult day care programs also accept private pay.	*For state-designated adult day centers, adult day care program staffing must include:* - Minimum one staff person to six participants - Administrator or program director - Activity coordinator - Consulting RN - Consulting social worker *Likely Employees (see Tables 1 and 2)* - Direct-care workers - Support or consulting staff

Table 3: Employers of Individual Health Care and Direct-Care Providers, cont.

Employers: Programs, cont.		Who Works Here?
Adult Day Health	Supervised daytime program for adults who need skilled nursing care or rehabilitative specialty care under the direction of a physician. Services are provided in addition to core services listed in adult day care above. Located in community-based establishments such as senior centers or community centers; sometimes located in assisted living facilities (see above) and retirement communities and offered to both residents and non-residents. Also can be in a stand-alone facility.  No licensing required in Washington State.  To receive Medicaid payment, the program must comply with state regulations and thereby receive designation as an adult day center. Adult day health programs also accept private pay.	*For state-designated adult day centers, adult day care program staffing must include:* - Minimum one staff person to six participants - Administrator - Program director - RN - Activity coordinator - Rehabilitation service provider *Likely Employees (see Tables 1 and 2)* - Direct-care workers - Support or consulting staff

Where are Independent Living Facilities? Independent living facilities do not offer specific arrangements for regular health care or personal care services. Thus, they do not employ members of the eldercare workforce as defined in this table.

Where are Continuum of Care Retirement Communities/Centers? These residential communities are umbrella establishments that offer residents a wide range of care options, from independent living to assisted living and up through skilled nursing services, each of which is described in the table above.

Where are Supportive Services? A range of services are provided within communities that complement the services of the eldercare workforce. They include, for example, senior centers; meal providers; personal emergency response systems; durable medical equipment suppliers; home/environment modification providers; and providers of evidence-based programs for quality of life and mobility, such as Staying Active & Independent for Life (SAIL), Program to Encourage Active, Rewarding Lives for Seniors (PEARLS), and EnhanceFitness.

Table 4: Administrators Directly Involved with Ensuring Access to Services

Government agencies, including staff and contracted employees, are responsible for managing access to care and for providing case management and care coordination for clients of publicly funded programs. Public administrators are also responsible for regulating facilities and ensuring applicable policies involved with eldercare are met.	
Department of Social and Health Services (DSHS) **Aging and Long-Term Support Administration** **Home and Community Services Division (HCS)**	HCS is divided into three geographic regions, each headed by a regional administrator. HCS determines functional and financial eligibility for Medicaid-funded long-term care services (see below) and care settings, and provides and contracts for case management, care planning, and service authorization for individuals receiving publicly funded long-term care services in their home or other residential setting within the community. HCS Local Offices offer financial workers, social workers, and community nurses who provide Medicaid direct-care services to persons age 18 and above in 43 locations statewide. HCS operates the state's Adult Protective Services program, oversees and administers federal and state programs related to older adults, and oversees services provided through the Area Agencies on Aging (AAAs) and Aging Network providers. HCS develops rules and training curricula for community-based personal care providers (e.g., home health aides) and training for staff and providers for Medicaid long-term care services.
DSHS **Residential Care Services Division (RCS)**	RCS is responsible for licensing and overseeing adult family homes, assisted living facilities, and other state-licensed establishments (see Table 3). Services include licensing, surveying sites for compliance with state and federal requirements, planning and policy development, participation in quality assurance programs, development of services integrated into the Medicaid long-term care system, and provider management coordination.
Area Agencies on Aging (AAAs)	AAAs were created through the federal Older Americans Act in 1973. They are responsible for planning, coordinating, and advocating for a comprehensive service delivery system within states at the local level. Washington State has 13 AAAs that are operated by local governments and tribes. The AAAs receive state and federal funds to contract with DSHS to provide state-defined long-term care services to older adults. AAAs also can receive private funds and grants. The AAAs provide services through subcontractors who offer single or multiple services to clients. Services offered include in-home, community, and support services, including in-home coordination of nursing, personal, or home care services, and adult day care services. They also provide access to information and resources, nutrition services, transportation, caregiver support education, and ombudsmen services.
Health Care Authority (HCA) **Apple Health (Medicaid)**	HCA administers Washington State's Medicaid program, called Apple Health. Medicaid finances health care services—including long-term care services (see below)—for older adults who have income restrictions. Medicaid funds can be used to pay for living arrangements at state-licensed facilities such as adult family homes and assisted living facilities, some caregiver services such as assistance with activities of daily living, and general medical care.
DSHS & HCA **Health Home Coordinators**	Health Home Coordinators (or Health Home Care Coordinators) are a new service being phased in across Washington State by DSHS and HCA for clients of Medicaid alone or of both Medicaid and Medicare. Home Health Coordinators partner with these clients, their families, health care providers, and other social and supportive service providers (such as food, housing, and transportation—see note under Table 3) to coordinate and ensure their clients' access to all the services they need.

What are long-term care services? These are specific services defined by Washington State that are reimbursable through Medicaid. The Washington State Plan on Aging 2010-2014 offers a helpful definition:

"A coordinated continuum of diagnostic, therapeutic, rehabilitative, supportive and maintenance services which address the health, social and personal care needs of individuals with a chronic illness or disability which limits their capacity for self-care. Services are designed to facilitate the maximum potential for personal independence. Services are provided consistent with consumer choice and the desire to have options from which the consumer can choose the setting and services that are most aligned with individual preferences and goals. Services and supports may be delivered for only a brief period or for a relatively long and indefinite period." (Available via www.aarp.org or www.nasuad.org, for example: http://www.nasuad.org/sites/nasuad/files/hcbs/files/216/10783/Washington_State_Plan.pdf.)

Disclaimer

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FOR MORE INFORMATION ABOUT IMPLEMENTATION OF THE ACA IN WASHINGTON STATE, SEE THE WASHINGTON STATE UNIVERSITY FACT SHEET: PROVISIONS OF THE AFFORDABLE CARE ACT AND WASHINGTON'S HEALTH INSURANCE EXCHANGE. (MANDAL B. FACT SHEET FS121E. 2013 OCT.)

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