Innovative and Integrative Solutions to Strengthen Caregiving and Healthcare Workforces for the Aging Population

2023-2024 Health and Aging Policy Fellows Cohort

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Abstract

In June 2024, the 2023-2024 Health and Aging Policy Fellows (HAPF) cohort hosted the *HAPF Symposium: Innovative and Integrative Solutions to Strengthen Caregiving and Healthcare Workforces for the Aging Population.* National experts served as panelists during the three interactive sessions, which sparked robust conversation about the challenges of caring for older adults. This white paper provides a review of solutions for aging workforce shortages and related policy innovations and their real-world impact during the past decade. The HAPF cohort has also included policy recommendations for future consideration.

Disclosures

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These opinions are those of the 2023-2024 Health and Aging Policy Fellows (HAPF) and reflect neither those of the agencies and entities with whom the Fellows worked nor the Fellowship program or its funders. Dr. Smilovich and Dr. Syed have contributed to this paper as HAPF fellows; therefore, this article does not represent the views of the Department of Veterans Affairs or the United States Government.

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Innovative and Integrative Solutions to Strengthen Caregiving and Healthcare Workforces for the Aging Population

People are living longer than ever and are the beneficiaries of unprecedented innovations, medical advances, and public health initiatives. As the population ages in the United States, there is a growing demand for a care workforce to provide the support many of us will need in our longer lives. By 2031, the estimated number of direct care professionals needed to meet the caregiving demands of older adults and people with disabilities will increase to 9.3 million from the 4 million currently employed (PHI, 2024).

Moreover, recent surveys indicate that most nursing homes and assisted living facilities report significant workforce shortages (PHI, 2024). All 50 states are experiencing home care worker shortages, resulting in limitations on new admissions, and broad unmet health and well-being needs of millions of Americans (Burns et al., 2023). Despite the physical and emotional demands many direct care professionals face at work, they earn below the average living wage adjusted for their state of residence, and nearly one in eight live in poverty (PHI, 2024). Investing in the direct care workforce is crucial to improve the health and well-being of millions of older Americans and their families today and to prepare for future support of the baby boomers and all generations to follow.

The clinical and healthcare workforce similarly lacks sufficient geriatricians, gerontological nurse practitioners, and mental health practitioners experienced in working with older adults (Boyle, 2021; Park & Martin, 2023). The COVID-19 pandemic drew attention to this dwindling healthcare infrastructure and ageist health policies. Older adults and underserved communities lagged in mitigation resources while experiencing record-high mortality rates (Isasi et al., 2021). Consequently, there has been a growing recognition that integrating innovative

programs to address social determinants of health and support the workforce in healthcare is essential to substantially impact health outcomes for older adults (Isasi et al., 2021). In the past, at both national and state levels, policy innovations to support an aging population have received bipartisan support, signaling an opportunity to influence initiatives that affect older adults living in communities and long-term care settings.

An urgent need exists for innovative workforce programs that broadly disseminate evidence-based interventions without dramatically increasing the workforce burden to improve services provided to older adults. In this white paper, the 2023-2024 Health and Aging Policy Fellows (HAPF) cohort provides a selective review of solutions for aging workforce shortages and related policy innovations and their real-world impact during the past decade. Our white paper summarizes presentations by experts in the aging health policy sphere during the *2023-2024 HAPF Symposium: Innovative and Integrative Solutions to Strengthen Caregiving and Healthcare Workforces for the Aging Population* and includes policy recommendations for future consideration (see Appendix for symposium agenda and invited panelists).

National-Level Reforms

In recent years, multiple national-level efforts are focused on funding and programmatic reforms to address growing care needs for older adults and adults with disabilities. Policies that support consumer-directed care and community-based services approach the workforce issue by maximizing the capacity of individuals with disabilities to manage their own care. Panelists noted that Medicaid waiver programs have the potential to help people leave residential care and resume independent living in the community. To succeed, however, these programs require adequate funding to train consumers in the skills and technology needed to hire and manage their own caregivers and to navigate the programs themselves. Also, such programs can create new

workforce challenges for long-term care facilities. As people who can achieve independent living move out, facilities will have an increasing proportion of residents with higher acuity levels, placing even more demands on staff.

Supporting family caregivers is complementary to supporting the direct care workforce, panelists noted. Family caregivers can do more when they are supported by policies and programs to expand respite care, increase access to paid family leave for caregivers, implement caregiver assessment tools, train caregivers in providing medical/nursing tasks, and help caregivers navigate medical and social care systems Additionally, policies and programs that support caregivers in managing their own health and financial challenges, and meet the needs of diverse and underserved caregivers are also beneficial. Panelists emphasized the importance of supporting family caregivers before they reach a crisis and bringing greater attention to family caregiving's societal and economic value.

State-Based Initiatives

Increasingly, states are incubators for innovative policies and programs. Multisector plans for aging (MPA) are efforts by states to anticipate the full, person-centered needs of the aging population over multiple years. These plans focus on the entire lifespan, not simply older adults, and can include people with disabilities, caregivers, the direct care workforce, healthcare providers, and others.

MPAs incorporate not only departments of aging, Medicaid, and public health, but also multiple other state agencies responsible for transportation, labor, emergency services, housing, and other essential entities. These agencies work together to create opportunities for efficient coordination, such as hand-offs between health and social services. MPAs are developed using state data to identify needs, and they continue to use data to ensure accountability for

implementation. *MPAs do not replace other aging or disability-related planning*—rather, they identify and leverage the initiatives and recommendations in State Plans on Aging, State Health Improvement Plans, age-friendly initiatives, dementia care, long-term services and supports reform, and any other work that has been ongoing in the state to coordinate efforts and create efficiencies.

While MPAs are not budget documents and not every item will necessarily be funded, they are blueprints for programs and services endorsed by stakeholders, providers, advocates, and across state departments and agencies. Thus, even aspirational initiatives in the MPA can be acted on quickly when or if an opportunity arises. For example, when the American Rescue Plan Act (ARPA) funds became available, states could turn to their MPAs and identify initiatives, such as free training for home care aides, that are ready for implementation.

States can also play a key role in supporting the direct care workforce. Beyond training and recruitment programs, retention bonuses, and other direct funding infusions, states are increasingly investing in evaluation to understand better workforce needs, set performance benchmarks, and identify best practices. The National Core Indicator - Intellectual and Developmental Disabilities (NASDDDS), for example, gathers data from adults receiving case management and services, families, and the caregiving workforce.

Expanding the Workforce

Programs and policies to strengthen the healthcare professional workforce for older adults pursue multiple strategies, including increasing geriatric education for primary care clinicians, expanding the role of nurse practitioners, exploring the role of peer support, and increasing the integration of mental health services.

Building Direct Care Careers

Efforts to alleviate the long-term care worker shortage focus heavily on recruitment. However, ensuring that recruited workers are being retained is just as important. One approach to increase worker retention is to maximize job quality for long-term care workers, panelists noted.

Research suggests that effective leadership is a critical predictor of job quality and reduced staff turnover in long-term care settings (Gandhi et al., 2021). Management can improve job quality by ensuring that workers have safe and reasonable workloads, and are sufficiently trained, adequately compensated, and supported in their work. Management can also ensure that employees have access to career advancement opportunities, such as career ladders and apprenticeships, enabling employees to find growth in their work. In addition, management should include all long-term care workers, not just registered nurses, in individualized care plans so all workers can value and understand their respective contributions to the well-being of their care recipients.

Additionally, future policies addressing the long-term care workforce shortage must incorporate both residential and home and community-based services (HCBS) settings, as long-term care workers frequently move between the two areas. Policies should also increase transparency and accountability in how funds are being spent by long-term care service providers and whether they meet the needs of residents and are reaching long-term care workers.

Currently, foreign-born workers make up 31% of the home care workforce, 21% of the residential care aide workforce, 21% of the nursing assistant workforce, and 30% of the nursing home housekeeping and maintenance workforce (Chidambaram & Pillai, 2025) Immigration caps on employment categories and country of origin limit the inflow of workers, including

qualified nurses and caregivers who have completed their training in their home country and want to come to the United States.

Expanding Geriatrics Expertise Across Care Settings

Training capacity also poses a challenge for maintaining or growing a clinical workforce skilled in caring for older adults. The Veterans Health Administration (VA) has created several innovative programs within the *Geriatric Research Education and Clinical Centers (GRECCs)* to build the geriatric workforce and extend knowledge of geriatric principles. The *Geriatric Scholars Program* provides an intensive core experience for physicians, nurses, social workers, mental health professionals, and pharmacists who care for older adults in the primary care clinics, culminating in a quality improvement project. The GRECC network of 20 centers of excellence ties VA geriatric centers to nearby research universities to expand training in caring for older adults to students across healthcare disciplines. This exposure can include VA sites adopting Age-Friendly Health Systems principles and geriatric emergency medicine.

The *Geriatrics Workforce Enhancement Program* (GWEP), authorized by the Public Health Act, was created during the 2015 fiscal year when four geriatric training programs were combined into one program. Competitions were subsequently held in FY 2019 and FY 2024. The GWEP focuses educating and training the health care and supportive care workforces to care for older adults by a) collaborative with community partners, b) maximizing patient and family engagement to address care gaps and improve health outcomes for older adults, and c) integrating geriatrics with primary care and other appropriate specialties using the Age-Friendly Health Systems Framework (John A. Hartford Foundation & The Institute for Healthcare Improvement, 2009-2023).

GWEP training focuses on clinicians and trainees as well as patients, families, and caregivers. Trainees learn about patient-centered care and what matters most to older adults and their families. GWEPs help geriatric specialists maintain their certifications while training other healthcare professionals to provide age-friendly and dementia-friendly care using the 4Ms framework (i.e., what matters, medication, mentation, and mobility). In the Academic Year 2023-2024, the last year of the 2019 cohort, GWEP grant recipients delivered 2,3020 courses and trained 1,130,534 (Health Services and Resources Services Administration, 2024).

Despite such programs to expand general geriatric knowledge in primary care settings, the United States will have a projected deficit of 26,980 full-time geriatricians in 2025 (United States Department of Health and Human Services, Health Resources and Services Administration, 2017). Of the 20,344 geriatric-trained primary care providers in 2022, 7,500 were geriatricians, and the remaining providers were nurse practitioners (United Health Foundation, 2023). Nurse practitioners are licensed to provide care in diverse care settings and can directly bill most insurance payers, including Medicare. They provide 60% of medical care rendered to the 1.3 million nursing home patients (Goodwin et al., 2021).

Nurse practitioner certification requires a master's degree; however, entry-level doctorate programs are becoming increasingly popular. The primary and acute care adult/gerontological nurse practitioner tracks require intensive didactic and clinical experiences in foundational geriatric principles, including geropharmacology. Nurse practitioners have contributed to decreased hospitalizations, emergency department visits, polypharmacy, and falls (Goodwin et al., 2021). Likewise, studies report that nurse practitioners have improved nursing home quality care measures, enhanced patient and family satisfaction, and increased patient and family engagement in advanced care planning (Goodwin et al., 2021; Kim et al., 2022)

Increasing Geriatric Mental Health Capacity

Since the COVID-19 pandemic, a growing awareness of the mental health needs of older people has been acknowledged. The National Council on Aging estimates that about two-thirds of older people with mental health problems fail to receive treatment. Additionally, suicide rates among older people exceed the national average for all age groups (National Council on Aging, 2025). These data emphasize the need to improve and expand the mental health workforce.

In January 2024, the Mental Health Access Improvement Act, included in the final version of the Congressional Consolidated Appropriations Act, incorporated licensed mental health counselors and licensed family therapists as independent Medicare-approved mental health providers. The Mental Health Access Improvement Act included 30,000 mental health providers, approximately 10% of the total licensed mental health workforce. This addition of providers represents an opportunity to channel professionals toward working in support of older adult mental health, panelists noted. Integrating mental health counselors and family therapists in federally qualified health centers (FQHCs) and other integrated care settings will play an important role. These professionals will need to consider how to work against stigma so that all aspects of aging are considered a normal part of the life course rather than a medical challenge to overcome.

An opportunity exists within the ageing services network to learn about the newly available mental health services and providers. For example, a grant-funded team from the Administration for Community Living examines aging service network stakeholders, senior centers, Area Agencies on Aging, and other places with community trust and buy-in. These places understand aging but have not had a connection to mental health care. It is imperative to

identify ways to build community partnerships that can expand access to mental health services for older adults and their families.

Older adults with a lived experience of mental illness represent a potential resource to expand support outside of clinical settings. A recent pilot study evaluated a three-month telephonic intervention delivered by certified older adult peer support specialists (Fortuna et al., 2025). The intervention incorporated evidence-based self-management strategies for adults aged 62 years and older with serious mental illnesses such as schizophrenia, schizoaffective disorder, bipolar disorder, or treatment-refractory major depressive disorder. Participants in the intervention group demonstrated significant improvements in independent living skills and medication adherence at six months compared with participants receiving usual peer support. This study underscores the promise of integrating certified older adult peer support specialists into mental health care delivery, potentially offering a more impactful alternative to standard peer support interventions.

Reforms to Medicare Part B (42 CFR §410.26) now permit healthcare providers to bill for peer support as an ancillary service for Medicare and dually eligible patients, which includes older Americans and individuals with disabilities. This change, effective on January 1, 2024, marks the most significant update in peer support funding in nearly two decades. Peer support in behavioral health involves active listening, role modeling, and sharing personal experiences related to behavioral health challenges, coping strategies, recovery, and chronic conditions. These revisions have the potential to address the escalating behavioral health crisis in the United States.

Certified peer support specialists represent one of the fastest-growing segments within the behavioral health workforce. These specialists, who have personal experience with mental

health or substance use issues, undergo training and certification to provide Medicaid-reimbursable peer support services (CPT code: H0038) primarily within behavioral health centers across 26 states. With the new Medicare Part B regulations, certified peer support specialists are now eligible for Medicare reimbursement (G0146 & G0140) nationwide. This expansion allows them to deliver services in various settings, including primary care and specialty care practices, alongside Medicare prescribing providers.

Policy Recommendations

After the 2024 HAPF Symposium, the cohort of fellows developed a list of recommended policy changes, including increasing the availability of immigrant workers, expanding Medicaid HCBS waivers and MPAs, granting nurse practitioners full practice authority, and robust utilization of mental health services. It is essential that accountability is attached to initiatives involving federal and state dollars. Oversight of private equity and for-profit facilities should also be in place, so that profits are not prioritized at the expense of quality care.

Immigrant Worker Supports

The U.S. Department of Labor (DOL) should boost legal services to immigrants in the U.S. who are working in chronic workforce shortage areas, including the long-term care sector. These individuals often need legal help in navigating the immigration system. The DOL should produce, translate, and disseminate a range of resources, such as sample employment agreements, to ensure that direct care workers and other care workers understand their rights and that employers comply with them. The executive branch should pass executive orders and regulatory changes to support immigrant workers and their families, such as improving the efficiency of visa applications, helping workers maintain employment authorization amid

application processing delays, giving temporary workers the option to find new employment, and expanding options for visa renewals.

Other recommendations:

- Expedite visas for nurses and other immigrants with high-demand skills; allow entry to paid and unpaid caregivers of older adults without imposing an education requirement.
- Create legal pathways for families to enter and work in the U.S. (e.g., instead of one family member obtaining a work permit and sending money home to support their family, provide a work permit for all adult family members [including as a caregiver], and let the children attend school, with all family members on a path to citizenship).
- Re-assess training and residency requirements for physicians from other countries who want to enter the U.S.
- Allow foreign-born students who obtain degrees in healthcare to remain in the U.S. on an extended visa with a path towards citizenship (instead of requiring that they leave when their student visa expires and start a new formal process to re-enter the U.S. if they wish to stay).

Medicaid Home and Community-Based Services Waivers

The federal government should support the expansion of HCBS across and within states and require the provision of HCBS under Medicaid. This could be accomplished by expanding HCBS to all qualified individuals with incomes below 300% (about 221% of federal poverty level) of Supplemental Security Income (SSI), and permit individuals with incomes over 300% of SSI to purchase one of two benefit packages by paying a monthly premium through fully integrated plans or providers (e.g., Medicare Advantage special needs plans, Program of All-

Inclusive Care for the Elderly). When fully implemented, individuals not eligible for Medicaid HCBS could enroll and pay a premium.

- Congress should consider provisions to ensure that eligible older adults and people with disabilities have a choice of care and support options between home care and institutional care.
- Congress should consider allotting dedicated Medicaid funds to states to stabilize their HCBS delivery networks, recruit and retain HCBS direct care workers, and meet the long-term service and support needs of people eligible for Medicaid HCBS.

Multisector Plans for Aging

Every state should develop an MPA to ensure that all Americans have access to coordinated care and support services that enable them to age with health, dignity, and connection. An MPA is a 10+ year blueprint for restructuring state and local policies and convening a wide range of cross-sector stakeholders to collaboratively address the needs of the older adult populations.

Full Practice Authority for Nurse Practitioners

Some states restrict nurse practitioners' scope of practice, decreasing the number of healthcare providers trained to meet the needs of older adults and increasing costs associated with physician oversight. All states should grant full practice authority to nurse practitioners. With full practice authority, nurse practitioners can assess patients, order and interpret diagnostic tests, diagnose and treat illnesses (including prescribing medications), and order specialty consultants without state imposed regulatory restrictions.

Integration of Peer Support for Mental Health Services

Recent reforms to Medicare Part B (42 CFR §410.26) now allow healthcare providers to bill for peer support services as an ancillary benefit for Medicare and dually eligible patients, including older Americans and individuals with disabilities. However, several limitations need to be addressed. The current reimbursement rate is capped at $130 per month per patient, with specific billing limits of 60 minutes per month and an additional 30 minutes if more than one condition is involved. Services are restricted to certain conditions like cancer, HIV, severe mental illness, substance use disorder, chronic obstructive pulmonary disease, and cardiovascular disease. Additionally, while services can be provided virtually, the administrative responsibilities for referrals, billing, and supervision lie with medical healthcare providers, which could lead to potential burdens. Ongoing evaluation will be crucial to assess the effectiveness and scalability of peer support within the Medicare-billing infrastructure.

Despite these limitations, there are significant opportunities to enhance the impact and sustainability of peer support services. Integrating peer support into care teams as a fundamental component rather than an ancillary service could ensure that peer support is effectively utilized and sustained even with limited resources. Medicare Advantage special needs plans, which target complex conditions, present an opportunity for broader implementation of peer support services. Additionally, Medicare Advantage and Accountable Care Organization plans might consider offering peer support as a supplemental benefit for special needs populations, such as people who qualify for dual eligibility, potentially using administrative funds to support this service. Addressing these limitations and exploring these opportunities can significantly improve the delivery and effectiveness of peer support services.

Discussion and Conclusion

A growing population of older adults and adults with disabilities demands quality services to meet their needs. The healthcare needs of present and future populations of older adults are nuanced (e.g., management of multiple chronic conditions, attention to mental illness) and require a caregiving workforce prepared to meet these special, and often individuated, needs.

The present workforce is inadequate to meet these needs, both in training and in sheer numbers. One important solution to this shortage is recruiting, training, and retaining the immigrant workforce. Training the immigrant workforce to care for a geriatric population will create efficiencies in care provision, and if community and facility leadership embrace career development opportunities and adequate staffing as the norm rather than the exception, a trained and appropriately compensated workforce will remain and improve their services. Providing appropriate compensation and maximizing job quality, particularly for long-term care staff, will help stabilize the caregiving workforce and will attract others. Appropriate compensation will also help the care workers and their family, both now and in the future.

Emphasis should be placed on recruiting, training, and retaining the geriatric workforce, concepts embraced by the VA Geriatric Research, Education, and Clinical Centers (GRECCs) and Geriatric Workforce Enhancement Programs (GWEP). The scarcity of geriatricians and other geriatric trained health providers can result in patient harm. Increasing Medicare reimbursement can assist in attracting physicians to specialize in geriatric medicine. A federal mandate granting full practice authority to gerontological nurse practitioners would also decrease healthcare barriers. These measures will help improve overall care and care management, fill the gap of professionals who provide this level of care for older patients, and attract others to this unique and important profession.

As mentioned above, the experience of COVID-19 shed light on the fragmented or non-existent mental health services for older adults and adults with disabilities. The social isolation and loneliness that quarantines and social distancing created have reverberated to the present, and the needs are great. Older adults and adults with disabilities must have access to mental health providers. These services have been minimized or denied for far too long. The creative provision of services, such as those provided by peers and by marriage and family therapists, who are adequate in number and training, will help dispel the stigma surrounding older adults with mental health problems.

Not to be forgotten in a discussion on the workforce, is that most caregivers helping older adults are family members, friends, or neighbors. Their work is essential yet challenging. Policies that support family caregivers will enable this unpaid or underpaid workforce to perform caregiving tasks, while responsible for other roles, such as employment outside the home and caring for multiple generations of family members.

Person-centered or person-directed care must be at the heart of service provision for the HCBS and the long-term care workforce. The present population of older and disabled adults has come of age when individualism is central to their quality of life. Age-friendly and dementia-friendly options for living will only be available if HCBS waivers are plentiful to meet the needs of a population that wants healthcare provided at home. The workforce must provide care that recognizes the fact that older adults and adults with disabilities would rather direct their own care, even if that means withholding care or stopping care once commenced. The workforce that provides person-centered care is now challenged to respect the dignity of choice that previous generations of older adults were sometimes denied.

The expansion of a workforce caring for older adults and adults with disabilities is imperative, and the need is imminent. Recruiting, training, and sustaining this workforce demands adopting creative and innovative strategies. When policies are approved and funding accompanied by evaluation and accountability is available, states must be prepared to pursue and implement them through coordinated efforts such as MPAs. Respect for the population of older adults and people with disabilities demands no less than an age-friendly workforce, one made possible by attention to the important and creative strategies discussed in this paper.

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Appendix

2024 Spring Symposium Agenda

Innovative and Integrative Solutions to Strengthen Caregiving and Healthcare Workforces for the Aging Population

June 10, 2024

Opening Remarks

Speaker: **Harold Pincus MD**, Professor of Psychiatry, Co-Director of the Irving Institute for Clinical and Translational Research at Columbia University, and Director of Quality and Outcomes Research at New York Presbyterian Hospital

Panel 1: *Solutions for Caregiving and Personal Care Worker Shortages: Part 1*

Panelists: **Michael Gamel-McCormick, PhD**, Disability Policy Director, Senator Bob Casey, Senate Special Committee on Aging; **Carrie Graham, PhD**, Director of Aging and Disability Policy, Center for Health Care Strategies; **Nicole Howell, BA**, Director of Workforce Policy, LeadingAge; **Lori Smetanka, JD**, Executive Director, Consumer Voice

Session moderated by Marian Liu, PhD, Associate Professor, Purdue University & Quratulain Syed, MD, Assistant Professor, Emory University School of Medicine

Panel 2: Solutions for Caregiving and Personal Care Worker Shortages: Part 2

Panelists: **Karen L. Fortuna, PhD**, Assistant Professor, Dartmouth; **Tracie Harrison, PhD**, Professor, University of Arkansas for Medical Sciences College of Nursing; **Michael Reese Wittke,** Vice President, Policy & Advocacy, National Alliance for Caregiving; **April Young, MSW**, Senior Director of Strategic Initiatives, ADvancing States

Session moderated by Jane Lowers PhD, Assistant Professor, Emory University School of Medicine & Courtney Polenick, PhD, Assistant Professor, University of Michigan

Panel 3: Solutions for Shortage of Geriatric Trained Healthcare Providers

Panelists: **Natalie Baker, DNP**, Professor, University of Alabama at Birmingham, School of Nursing; **Matthew Fullen, MDiv, PhD**, Associate Professor, Virginia Tech; **Marianne Shaughnessy, PhD**, Director of Geriatric Research, Education, and Clinical Centers, VA Office of Geriatrics & Extended Care; **Jennifer Solomon, MA**, Public Health Analyst, Health

Resources and Services Administration/Bureau of Health Workforce in the Division of Medicine and Dentistry

Session moderated by Arlene Bierman, MD, MS, Chief Strategy Officer, Agency for Healthcare Research and Quality

Closing Remarks

Speaker: **Maureen Henry, JD PhD**, Assistant Professor of Health Policy and Management, Columbia University Mailman School of Public Health