Workforce Size, Composition, Retention, and Competence

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#DementiaCareSummit

Assumptions

- Workforce Composition
  - Clinical – (physicians, NPs, PAs, nurses, social workers, pharmacists, therapists, behavioral health, etc)
  - Long-term services and supports – direct care workers – (certified nursing aides, home health care aides, personal care aides, etc)
  - Family and other unpaid care partners
  - Innovations: Handyman*, community health workers, care assistants, etc
- A Workforce Prepared to Care for Older Adults with Dementia
  - Co-morbidity common: workforce needs skills caring for older adults and for people with dementia
  - Better workforce data are needed to drive policy change and guide expansion of new care models

*Health Affairs 35,2016:1558-1563

Workforce Size

- **Numerous sources of data and projections:**
  - **IOM Reports:** *Retooling for an Aging America* (2008); *Future of Nursing* (2010); *The Mental Health and Substance Abuse Workforce for Older Adults* (2012)
  - **Professional organizations:** e.g., AAMC, AAN, APA, AAFP Graham Center, ACP, ANA, NASW, etc.
  - **HRSA:** U.S. Health Workforce Chart book; Health Workforce Research Centers
  - **Provider Organizations:** Leading Age: Center for Workforce Solutions
- **Major Conclusions:**
  - The future health care workforce is likely to be inadequate in its capacity to meet the needs of persons with dementia, especially in rural areas
  - Family and other unpaid caregivers will continue to be a significant part of the healthcare workforce

Workforce Composition

- Influencing factors:
  - Team care with each clinician working to the full extent of their training
  - New models of care – care coordination assistants, etc
  - Changes in racial or ethnic patterns of long-term care services or shift towards non-institutional care*
- Example: Social Work in Integrated Primary Care**
  - Literature review of 26 RCTs of integrating social workers into primary care
  - SW roles: behavioral health, care manager, referral role
  - Documented improvement in behavioral and physical health
- Example: CMS Medicare-Medicaid Integrated Care Demos***
  - Qualitative Study of Dementia Care Coordination in 7 States
  - Flexible definitions of care coordinators' requirements
  - Little specificity about experience with dementia

*Health Affairs 34,2015:936-945
**UNC Sheps Center, www.healthworkforce.unc.edu
***UCSF Health Workforce Center, https://healthworkforce.ucsf.edu

Workforce Retention

- Turnover rates are high for direct care workers*
  - 40 – 60% of HHA leave after 1 year; 80 – 90% after 2 years
  - ALU staff turnover 42%/year; NH CNAs 71%/year
  - Recruitment costs related to high turnover are considerable
  - A few studies have linked high turnover with lower quality
- Factors influencing turnover*
  - Low wages, few benefits, stressful work, risk for injury, poor relations with supervisors, lack of respect, little opportunity for advancement
- Example: California's Medicaid In-Home Services**
  - Consumer directed – can choose family member, friend, or HHA
  - Nearly 2/3 choose family members; turnover rate ½ of friend or HHA

*IOM.2008. Retooling for an aging America.. Washington DC: The National Academies Press. p. 209
**UCSF Health Workforce Center, https://healthworkforce.ucsf.edu

Workforce Competence

- **Faculty** with expertise and experience caring for adults with dementia: Number of specially trained faculty has increased over past 20 years; but numbers remain small
- **Competencies** developed and **curriculum** exists in most health profession schools, but insufficient and inadequate (not enough breadth and depth) to provide dementia capable care.
  - Study of 7 "leader states" training Medicaid funded direct care workers – defining competencies (1/7 specifically mentioned dementia care)*
- **Dissemination:** Professional organizations and CMS have supported training for practitioners, for example: CMS MMCO has funded ten dementia training webinars over past 3 years for thousands of clinical staff in 10 states serving 400,000 adults**
- **Impact:** Direct care workers who are better trained are more satisfied and demonstrate more person-centered attitudes***

*UCSF Health Workforce Center, https://healthworkforce.ucsf.edu
**www.resourcesforintegratedcare.com/GeriatricCompetentCare/2017_GCC_Webinar_Series/Series_Overview)
***Zimmerman, S, et al. Gerontologist, 2005;45:96-105.

Research Recommendations

- Analysis of geographic distribution of critical workforce; identify areas with inadequate supply
- Impact of ethnic diversity on workforce recruitment, training, and acceptance
- Impact of new care models on required workforce composition
- Clarify factors leading to retention of qualified HHAs, PCAs, and nursing assistants
- Impact of paid family caregivers on care quality, retention, and family caregiver well-being
- Define essential skills required for care coordination