



Workforce Gaps in Dementia Education and Training

Stakeholder Group Paper

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Additional information can be found at the Summit website (<https://aspe.hhs.gov/national-research-summit-care-services-and-supports-persons-dementia-and-their-caregivers>) or the National Alzheimer's Project Act website (<https://aspe.hhs.gov/national-alzheimers-project-act>). The opinions and views expressed in this report are those of the authors. They do not necessarily reflect the views of HHS, the contractor or any other funding organization.

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The views expressed in the report are of the Workforce Development Workgroup of the National Research Summit on Dementia Care: Building Evidence for Services and Support and do not represent the perspectives of the Office of the Assistant Secretary for Health, the Health Resources and Services Administration, the Centers for Medicare & Medicaid Services nor the United States Government.

National Research Summit on Dementia Care: Building Evidence for Services and Supports Workforce Development Workgroup Members

The Workforce Development Workgroup of the *National Research Summit on Dementia Care: Building Evidence for Services and Supports* is an interprofessional team of health professionals from academia, professional organizations, and the federal government with expertise in dementia workforce development.

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National Research Summit on Dementia Care: Building Evidence for Services and Supports

The number of persons living with dementia is increasing, with an estimated 5.5 million Americans currently living with the disease. Alzheimer's disease is now the sixth leading cause of death (Alzheimer's Association, 2017). Persons living with dementia, their families, and caregivers may be faced with high physical, emotional and financial costs resulting in the need to access a wide range of resources to ensure proper care and quality of life. Despite these high costs, there has been a lack of research in the area of dementia care, services, and supports. To address this need, the U.S. Department of Health and Human Services and the Foundation for the National Institutes of Health, through private sector support, are sponsoring a two-day *National Research Summit on Dementia Care: Building Evidence for Services and Supports*. The goals of the Summit are to a) improve the quality of care and support provided to persons living with dementia and their caregivers, b) accelerate the development, evaluation, translation, implementation and scaling up of evidence-based and evidence-informed services for persons living with dementia, their families and caregivers, and c) understand and ameliorate the current disparity in available resources for persons living with dementia, their families and caregivers. The Summit's six sessions will address these goals and include:

- Session I:** Research on Care Needs and Supportive Approaches for Persons with Dementia
- Session II:** Research on Supportive Approaches for Family and Other Caregivers
- Session III:** Involving Persons with Dementia and Caregivers as Members of the Research Team
- Session IV:** Involving Persons with Dementia as Study Participants
- Session V:** Research on Models of Care for Persons Living with Dementia and Their Families across the Disease Trajectory
- Session VI:** Thinking Outside the Box

Workforce was identified by the Summit Steering Committee as one of the key stakeholder groups that should recommend research focus areas for educating and training the workforce. Informal and formal caregivers are an integral part of the dementia care workforce. More broadly, informal caregivers are defined as family members, neighbors, friends, and fictive kin who provide unpaid care, while formal caregivers, covering the spectrum from home health aides to health care professionals, have some training in the care of persons living with dementia and are paid for their services. This paper, written by the Workforce Development Workgroup (WDW), focuses on gaps in educating and training the workforce to address the goals of the Summit. The WDW is an interprofessional team of health professionals from academia, professional organizations, and the federal government with expertise in dementia workforce development.

Background

In order to provide high quality, patient-centered dementia care, reciprocal relationships between primary care health delivery systems, community-based organizations (including long-term services and supports, or LTSS), and academia must be developed, implemented, and maintained to educate and train a skilled workforce. Ideally, such a multifaceted care delivery model would encompass the entire care continuum.

Research shows that the majority of people prefer to remain in their homes for as long as possible (Medicaid and Children's Health Insurance Program Payment and Access Commission, 2017a). In the United States, family caregivers provide approximately 80% of the care for persons living with dementia (Jackson et al., 2016). This results in a huge financial, personal, emotional, and physical burden on the caregiver. Many families are now hiring home health aides and companions to decrease caregiver stress and keep the person living with dementia in the home. To maximize this goal, it is essential that the health care workforce is competent in providing dementia care. The development of a dementia-capable workforce will allow more people to age in place longer, increase the availability of supportive services, assist families in their role as caregiver, reduce caregiver stress and burden, and increase the quality of care to the person living with dementia and their families and caregivers.

The WDW has identified major gaps in workforce development in areas: education and training, recruitment and retention, use of technology, financing and cost, care coordination and care management, and translation and implementation of effective care. Quality geriatrics care is team-based and person/family-centered. Patient and family satisfaction are enhanced when all members of the health care team participate to the fullest scope of their licenses. This team is a comprehensive unit centered on the person living with dementia, as well as the family. Other team members include caregivers, direct service workers, community health workers, and traditional health care professionals. In addition, other sectors of the community are at times essential in delivering high quality care, because they touch upon the social determinants of health for persons living with dementia. These sectors include, but are not limited to, law enforcement, public safety, urban development, transportation, housing, and banking and finance. These other sectors are essential partners in delivering quality, cost effective care for persons living with dementia.

The gaps in education and training of the workforce relating to persons living with dementia are essentially the same as those for their caregivers. Therefore, the WDW has combined recommendations for sessions 1 and 2.

SUMMIT SESSION 1: RESEARCH ON CARE NEEDS AND SUPPORTIVE APPROACHES FOR PERSONS WITH DEMENTIA

SUMMIT SESSION 2: RESEARCH ON SUPPORTIVE APPROACHES FOR FAMILIES AND OTHER CAREGIVERS

Education and Training

Although each person's journey is different, people have been known to live with dementia for over 25 years after they first start showing symptoms. The average life expectancy is 9 years for someone diagnosed at age 65 years (Brookmeyer et al., 2002). Determining the survival following a diagnosis of Alzheimer's disease is critical to helping patients, families, and caregivers adapt as the illness progresses. The training needs of families and other caregivers of persons living with dementia are critical because unpaid caregivers are providing the majority of care for persons living with dementia.

AARP has estimated the cost to society for unpaid caregiving. In 2013, about 40 million caregivers provided 37 billion hours of care worth an estimated \$470 billion. Total estimated economic value of uncompensated care provided in 2013 surpassed total Medicaid spending (\$449 billion). In 2016, 15.9 million family and friends provided 18.2 billion hours of unpaid assistance to persons living with dementia, a contribution valued at \$230.1 billion. Two-thirds of these caregivers were women, 34% were age 65 or older, and 41% had a household income of under \$50,000 (Alzheimer's Association, 2017). The burden in financial cost and personal time can easily result in caregiver burnout. This exhaustion is experienced not only by families, but also across the professional health care workforce. Many graduating medical residents feel unprepared to counsel persons living with dementia (Alzheimer Association, 2017). This lack of confidence, in addition to dwindling numbers of providers in geriatrics, has created a huge gap in services to persons living with dementia and their caregivers.

Improving the geriatric competence of the health care workforce will significantly contribute to the success of the delivery of high-quality dementia care and long-term services and supports to persons living with dementia, their families, and caregivers (Montgomery, 2016). Caregivers need training because they often provide complex health care services formerly delivered only by licensed health care personnel in a hospital or other institutional setting (National Academies of Sciences, Engineering, and Medicine [NASEM], 2016). Fifty-one percent of caregivers for persons living with dementia are providing medical/nursing tasks without prior preparation (National Alliance for Caregiving & AARP, 2015). In addition, caregivers provide a range of services from assistance with daily activities and providing direct care to navigating complex health care and social services systems (NASEM, 2016).

Several programs have been developed to educate and train caregivers about self-care to improve their health and decrease the stress associated with providing individualized long-term care and supports to persons living with dementia. Three successful models include *Resources for Enhancing Alzheimer's Caregiver Health II (Reach II)*, *Savvy Caregiver*, and *Skills2Care*. *REACH II* provides the education, support, and skills training to improve caregiver knowledge, health, safety, and social support, and teaches caregivers ways to address problem behaviors. This program has been shown to improve caregiver quality of life as measured by decreased burden and depression, enhanced self-care and social support, and fewer behavioral problems of persons living with dementia. The *Savvy Caregiver* educates and trains caregivers to manage stress and perform the caregiving role more effectively. Outcomes include increased caregiver competence and decreased depression. *Skills2Care* develops a supportive environment through home modifications, caregiver education, and skill building. Outcomes include increased caregiver knowledge and expertise, confidence in managing behaviors, and increased caregiver self-care (NASEM, 2016; Belle et al., 2006).

The Administration on Aging of the U.S. Department of Health and Human Services (2016) reported that racial and ethnic minority populations have increased from 6.7 million in 2005 (18% of the older adult population) to 10.6 million in 2015 (22% of older adults) and are projected to increase to 21.1 million in 2030 (28% of older adults). This generation of older adults will be the most racially and ethnically diverse the nation has ever seen. They will also have more education, increased longevity, more widely dispersed families, and more non-

traditional families. Therefore, their needs for all health care services will be much different from those of previous generations. Although health professions education has made progress in training the workforce to become culturally competent, significant work must be accomplished.

Thus, the WDW has identified the following research focus areas in regards to educating and training the workforce to address care needs and supportive approaches for persons living with dementia and their caregivers.

- Identify evidence-based trainings that are needed to prepare a dementia-capable workforce;
- Identify the minimal competencies needed by health care professionals, the direct care workforce, and family or informal caregivers to provide dementia-capable care;
- Identify the content needed to meet competency requirements that should be integrated into existing and new training programs and curricula;
- Identify content on dementia-friendly communities that should be integrated into health professions curricula at the formative and practice levels;
- Identify the circumstances for each of the various models or combinations of trainings (e.g., self-directed, simulation, hybridized, booster, just-in-time, face-to-face, combined, and continuing education) that result in the best value (e.g., in terms of quality of care, resource availability, geography, the development of interprofessional collaborative care, and development of person-centered plans) for persons living with dementia and their families and other caregivers;
- Study the effect of raising the level of dementia knowledge on patient outcomes;
- Study the effect of raising the required level of dementia knowledge on the ability of the workforce to obtain dementia training;
- Examine the advantages of dementia certification for the health care workforce, excluding those who are geriatrics specialists;
- Evaluate the impact of dementia certification on the individual worker, employer, and the health care system; and
- Identify the training needed to address the needs of an increasingly culturally and ethnically diverse caregiver population.

Recommendation 1: Academia, health professions accrediting organizations, health professions licensing bodies, federal agencies, and professional organizations should collaborate to develop core competencies, domains, and milestones to ensure that care is appropriate for persons living with dementia and their families and caregivers. Some areas for competency development include health inequities, cultural competence, health literacy, sex/gender appropriateness, caregiver stress, and accessing/navigating health care and supportive services.

Recruitment and Retention

With the number of potential family caregivers projected to decline over the next few decades, the United States faces a looming care gap just as the population rapidly ages and many older adults have longer periods of care needs (Redfoot, Feinberg, and Houser, 2013). Increasing the

number of people providing dementia care requires strategies for both recruitment and retention. Many caregivers are “recruited” to dementia care because of personal circumstances, perhaps when they choose to provide dementia care to a friend or family member. Others enter this workforce as a career. Ways to encourage both groups to join and remain in the workforce need to be identified. Understanding the motivations of caregivers and meeting their training needs will improve both their recruitment and retention rates.

Geriatric specialists are needed in all professions for their clinical expertise and because they educate and train the entire health care workforce in geriatric principles, practice, and policy. However only a small percentage of health care professionals specialize in geriatrics, primarily because of the extra years of training coupled with low reimbursement rates. Direct care workers, including certified nursing assistants and community health workers, are essential to provide first-line skilled geriatrics care in the home, community, and long-term care settings. However, these providers have high levels of turnover and job dissatisfaction due to low pay, poor working conditions, high rates of on-the-job injury, and few opportunities for advancement. Strategies need to be developed to recruit and retain these workers in dementia care.

The WDW has identified the following research focus areas in regards to recruitment and retention of the workforce to address care needs and supportive approaches for persons living with dementia.

- Investigate how the training needs of unpaid caregivers differ from those of paid caregivers;
- Establish how the training needs of male caregivers differ from those of female caregivers;
- Determine how best to recruit a diverse workforce that is reflective of the cultural and ethnic diversity of the population that is receiving care and services;
- Study how direct service workers, including certified nursing assistants and community health workers, family members, and other caregivers, can best be motivated, compensated, and empowered to become caregivers;
- Find incentives that are effective in recruiting and retaining caregivers; and
- Identify effective strategies to recruit and retain geriatrics specialists who are clinician educators.

Recommendation 2: Academia, federal agencies, and professional organizations should collaborate to identify recruitment and retention strategies for expanding the caregiver workforce. An adequate caregiver workforce is essential to providing high quality care to persons living with dementia. These strategies should include, but are not limited to, cultural, gender, educational, and socioeconomic issues, as well as addressing health literacy disparities.

Technology

Caregivers use technology to help monitor health issues (blood sugar, blood pressure, breathing function, mood), manage medications, refill prescriptions, receive alerts, and communicate with providers. This technology is used to ensure safety, manage behavior, and provide for

distance monitoring. Advances in technology have provided ways for persons living with dementia, as well as for their families and caregivers, to maximize independence, improve quality of life, reduce neuropsychiatric symptoms, and reduce caregiver burden.

Health care providers have also embraced technology. Their use of information technology has made patient care safer and more reliable. New software allows medical professionals to track, retrieve, and utilize data quickly. Technology has made it possible to access and analyze population data to improve quality and efficiency of care. Electronic health records allow transparency and quick sharing of data, while also allowing providers to communicate with patients, families and caregivers. Telehealth is being used increasingly by health care providers and is another means to effectively communicate with persons living with dementia, their families, and caregivers. The Health Resources and Services Administration of the U.S. Department of Health and Human Services (2017) defines telehealth as “the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.”

Technology is here to stay. Integrating technology innovations into health care has the potential to empower persons living with dementia, their families, and caregivers to be active participants in their health care and improve the quality of their lives. The dementia health care workforce must be educated to use technology to monitor the function and health status of persons living with dementia, their families, and caregivers with a goal of providing safe and effective health care. Research focus areas identified by the WDW concerning the use of technology by the health care workforce are listed below.

- Determine the training needs of the workforce in technology applications and data management to support care coordination, care management, and care transitions;
- Establish the impact that technology has on quality of care for persons living with dementia, their families, and caregivers;
- Ascertain what persons living with dementia, their families and caregivers want from home-monitoring technologies;
- Study how current technologies can be used to assist persons living with dementia, families, caregivers, and health care professionals to facilitate function for all involved with caregiving;
- Identify the limitations of technology on dementia care management; and
- Identify the ethical considerations of the use of technology in providing dementia care.

Recommendation 3: Academia, federal agencies, health information technology organizations, and professional organizations should collaborate to determine the impact of the use of technology on providing high quality care to persons living with dementia and their families and caregivers.

Financing and Cost

Forty-six percent of nursing facility residents and 21% of seniors living in the community have probable or possible dementia. Medicaid currently provides federal matching funds with no pre-set limit to help states cover costs for seniors with low incomes (The Henry J. Kaiser Family Foundation, 2017). Nearly 60% of individuals living in nursing homes have a cognitive impairment. In 2015, Medicaid funded 53% of LTSS, with the remainder being financed by out-of-pocket (17%), private insurance (11%), and other public/private (20%) sources. Though most Medicaid beneficiaries with dementia are dually eligible for Medicare, Medicare does not cover all of the services, particularly LTSS, which they might need. Some states have taken advantage of the Affordable Care Act's Medicaid health home option to target services to people with dementia. Medicaid beneficiaries with dementia may qualify for home and community-based services (HCBS) waivers, some of which may include services targeted to persons living with dementia. The financing of dementia-capable health care workers is borne primarily by Medicaid spending.

The costs of health care, including LTSS, for persons living with dementia are substantial. Total payments in 2017 for all individuals with dementia are estimated at \$259 billion, including out-of-pocket spending of approximately \$56 billion. With an average income of \$45,700, caregivers report not only emotional strain but also financial strain (National Alliance for Caregiving & AARP, 2015).

For certain types of care, the Medicaid program accounts for a larger portion of total U.S. spending than any other payer. National Health Expenditures (NHE) data show that in 2014, Medicaid paid for 32% of nursing home care and 56% of the category of other health, residential, and personal care that includes HCBS (Medicaid and Children's Health Insurance Program Payment and Access Commission, 2017b). Another analysis that divided NHE data into different categories found that Medicaid accounted for 61% of all LTSS spending in 2012, \$134 billion out of \$220 billion. Newer data indicate that federal and state Medicaid spending on LTSS was about \$152 billion in 2014. Many states have made successful efforts in recent decades to "rebalance" HCBS and institutional care; the percentage of Medicaid LTSS attributable to HCBS continued to increase, and the percentage of total LTSS spent on HCBS increased to 53.1%, with institutional spending remaining flat (Eiken, Sredl, Burwell, and Saucier, 2016). According to 2012 estimates, among people aged 65 and over, an estimated 70% will use LTSS, and people 85 and over are four times more likely to need LTSS compared to people aged 65 to 84.

Better training of health care professionals, persons living with dementia, and their families and caregivers is needed to help the health care system meet the goals of improving population health, improving the patient experience, and reducing per capita cost. Some early research has been done to assess the cost of providing targeted benefits to unpaid caregivers for persons living with dementia that include education, care linkages, person-centered planning, adult day care, counseling, caregiver education/training, support groups, and respite care. Preliminary results indicate improved satisfaction combined with savings that exceed program costs ((Reuben et al., 2013)).

As noted above, costs have been studied for many aspects of providing dementia care. However, the costs of educating the workforce to provide dementia-capable care including persons living with dementia, families, caregivers, the direct service workforce, and the health professions workforce has not been researched. The reported costs of dementia training to individuals across the educational continuum, health care systems, and public programs is lacking. These unreported costs for educating the workforce added to the current dementia health care costs are formidable.

Research focus areas in financing and cost to inform this recommendation include:

- Evaluate the cost savings/cost benefits of providing dementia-related training to paid caregivers, health care system, individuals, and public programs;
- Study the costs associated with dementia certification versus a learning certificate in dementia care;
- Identify the financial implications and health impacts to persons living with dementia, their families and caregivers, and accountable entities (e.g. states, managed care plans) in expanding options for paid caregiving in Medicaid and for self-directed service delivery; and
- Investigate the cost saving/cost benefits of updating existing health professions curricula, providing additional health professions dementia training, and having a specialty certification to the individual, the workforce, the accountable entity, and the health system.

Recommendation 4: Academia, federal agencies, and professional organizations should collaborate to evaluate the costs and benefits of educating and training health professions students, faculty, practitioners, the direct service workforce, and persons living with dementia, their families, and caregivers about dementia care and services.

SUMMIT SESSION 5: RESEARCH ON MODELS OF CARE FOR PERSONS LIVING WITH DEMENTIA AND THEIR FAMILIES ACROSS THE DISEASE TRAJECTORY

The U.S. Agency for Healthcare Research and Quality (AHRQ) defines care coordination as, “the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services (McDonald et al., 2007).” Care coordination and case management implementation are essential to provide person and family-centered care across the disease trajectory.

Several data-driven models of care coordination have been shown to reduce cost and improve health care outcomes. Three models include the *Transitional Care Model* (TCM), the *Hospital Elder Life Program* (HELP), and the *Program for All-Inclusive Care of the Elderly* (PACE). TCM addresses the management of care during the transition from an acute care setting to the home or other care setting. TCM reduces hospital readmissions, improves function following hospitalization and enhances patient and family satisfaction (Hirschman et al., 2015). HELP is designed to minimize the negative outcomes that are associated with delirium and coordinates care in the hospital (Hospital Elder Life Program, 2017). PACE allows people who need nursing

home-level care to remain in their homes and communities (Lynn, 2016). PACE programs coordinate and provide all needed preventive, primary, acute, and long-term care services. The successes of these programs have paved the way for the development of dementia-specific care coordination models.

A lack of knowledge about dementia and a lack of skills needed to care for persons living with dementia has been associated with poor patient outcomes, along with increased caregiver burden and depression. Care coordination and service interventions that are adapted to meet individualized needs, and that target persons living with dementia, their families, and caregivers, reduce caregiver burden, increase skills and knowledge, and enhance satisfaction of the caregiver, while preventing or delaying institutionalization of the person living with dementia (Brodaty et al., 2003; Semiatin & O'Connor, 2012).

Dementia care programs are now being developed to provide comprehensive, coordinated, patient-centered care for persons living with dementia, their families and caregivers. For example, the *UCLA Alzheimer's and Dementia Care Program* facilitates transitions in care through patient recruitment, dementia registry, structured needs assessment, dementia care planning, and access to 24/7 365 days a year assistance and advice (Reuben et al., 2013). In addition, *Partners in Dementia Care* involves Veterans Affairs Medical Centers and local Alzheimer's Association chapters with care coordinators at the two locations working as a team using a shared electronic information system and regular meetings. The focus is on helping persons living with dementia, their families, and caregivers navigate medical and social services, with at least one contact per month. Coordinators help persons living with dementia develop simple action steps, with reassessment at least every 6 months (Bass et al., 2013; 2014).

Several randomized studies have shown that dementia-capable care coordination is an effective intervention for persons living with dementia, their families, and caregivers that can improve quality of care and reduce health care costs (Hollister et al., 2017). Effective care coordination and referral to services and supports for persons living with dementia, their families, and caregivers is of particular importance and can decrease unnecessary medical services utilization, delay institutionalization, and improve the quality of life of both persons living with dementia and their caregivers (Hollister et al., 2017). The utilization of trained dementia care navigators to assist persons living with dementia and their caregivers in accessing dementia supports and services is growing in both for-profit and not-for-profit sectors (Jamieson et al., 2016).

Education and Training for Models of Care Coordination and Management

Care coordination and care management can only be achieved through interprofessional collaboration and the development of reciprocal working partnerships between service providers and among all team members. Successfully linking needs, avoiding duplication, and filling gaps in services requires coordination to address all concerns. Training a workforce to be aware of multiple needs and services and to be able to coordinate and manage that care requires specialized training. Practice structure and process must be considered in relation to providing appropriate oversight and direction to newly emerging entities such as dementia care navigators and health coaches. Whether addressing care transitions or linking with long-term

services and supports, direct care workers and dementia care navigators need to work with a knowledgeable health care professional to help guide their decisions and address issues that arise until a suitable competency level and knowledge base is attained.

The WDW has identified the following research focus areas to inform the recommendation of education and training for care coordination and management.

- Collect baseline information on interprofessional education and training needs of the workforce regarding care coordination and collaborative practice;
- Identify the education and training that is required to optimize navigation of care across settings;
- Examine how care coordination, care management, and collaborative practice models can be adapted to provide better care for persons living with dementia, their families and caregivers;
- Investigate how the workforce can be trained to successfully link clinicians to effectively use home and community-based services, especially during care transitions;
- Research how telehealth can be used effectively to promote caring for persons living with dementia, their families, and other caregivers;
- Study the implications of telehealth technologies for expanding dementia care;
- Examine effective strategies to introduce advanced care planning to all socioeconomic and cultural groups; and
- Determine ways to effectively integrate caregivers into care coordination and management to enhance the well-being of the person living with dementia in multiple care settings.

Recommendation 5: Academia, health systems, primary health care delivery systems, community-based organizations, professional organizations, and federal, state, and local agencies should educate and train the workforce to be competent to coordinate care and facilitate care transitions with a goal to improve the delivery of dementia care and services, increase satisfaction with care, and reduce costs.

SUMMIT SESSION 6: THINKING OUTSIDE THE BOX

Translation and Implementation of Effective Care

Research drives education, practice, and policy. Without a well-developed dissemination and implementation plan, research will not be used for the greater good. Dissemination and implementation are complex processes, involving many disciplines and partners. No single strategy is universally applicable in every situation. Carpenter et al. (2005) identified six components of a dissemination plan that include:

- a) Research findings and products – what is going to be disseminated?
- b) End users – who will apply it in practice?
- c) Dissemination partners – through what individuals, organizations, or networks can you reach end users?
- d) Communication – how do you convey your research outcomes?
- e) Evaluation – how do you determine what worked?, and

f) Dissemination work plan – where do you start?

Education is an essential partner in any dissemination and implementation plan. Academia and others who educate the workforce are in key positions to share this information with health professions students, faculty, practitioners, the direct care workforce, persons living with dementia, and their families and caregivers. These educational entities are adept at taking complex information and communicating in a culturally appropriate manner at the educational level of the learner. Educators also have significant expertise in evaluating educational outcomes as well as patient, practice, and health system outcomes. With the advent of educating and training the workforce in health care delivery systems, educators are now evaluating how their learners are improving patient care, increasing patient satisfaction, and reducing costs.

The WDW has identified the following focus areas to inform the recommendation of translating and implementing effective care.

- Determine the education and training that the workforce should receive regarding translational research to empower persons living with dementia, their families and caregivers to adopt experiential and collaborative practice and team-based learning, especially in early and middle stages of dementia;
- Ascertain the most effective way for educational programs to deliver research outcomes and models of dementia care, services, and supports including the most effective mediums, frequencies, and doses;
- Identify the characteristics of an effective dissemination and implementation plan in relation to research on dementia care, services, and supports; and
- Identify the short and long-term impacts of educational interventions for disseminating and implementing research on dementia care, services, and supports.

Recommendation 6: Academia, health systems, primary health care delivery systems, community-based organizations, professional organizations, and federal, state, and local agencies should collaborate to develop creative and innovative dissemination and implementation plans that translate research on dementia care, services, and supports into educational models that transform practice and inform policy.

SUMMARY

Research shows that the majority of people prefer to remain in their homes for as long as possible. A dementia-capable workforce is key to allowing more people to age in place longer, increasing the availability of supportive services, assisting families in their role as caregiver, reducing caregiver stress and burden, and increasing the quality of care to the persons living with dementia and their families and caregivers.

The goal of the WDW is to increase the size and level of expertise of a dementia-capable workforce. To that end, the WDW has identified several gaps in workforce development. Six topic areas where gaps occur were identified. They are:

- 1) Workforce education and training in dementia care;

- 2) Recruitment and retention of a dementia-capable workforce;
- 3) The use of technology by persons living with dementia, their families and caregivers, direct service workers, and health professionals;
- 4) Financing and costs of workforce training and education;
- 5) Interprofessional education and training for care coordination and management of dementia care; and
- 6) The translation and implementation of effective dementia care.

Specific research focus areas have been identified to fill gaps in each of these six areas. The WDW challenges both new and experienced researchers to explore these questions, thereby joining the ever-expanding dementia-friendly community that strives to provide dementia-capable care for persons living with dementia, their families and caregivers. The recommendations put forth by the WDW to advance the goals of the *National Research Summit on Dementia Care: Building Evidence for Services and Supports* in relation to workforce development are:

Recommendation 1: Academia, health professions accrediting organizations, health professions licensing bodies, federal agencies, and professional organizations should collaborate to develop core competencies, domains, and milestones to ensure that care is appropriate for persons living with dementia and their families and caregivers. Some areas for competency development include health inequities, cultural competence, health literacy, sex/gender appropriateness, caregiver stress, and accessing/navigating health care and supportive services.

Recommendation 2: Academia, federal agencies, and professional organizations should collaborate to identify recruitment and retention strategies for expanding the caregiver workforce. An adequate caregiver workforce is essential to providing high quality care to persons living with dementia. These strategies should include, but are not limited to, cultural, gender, educational, and socioeconomic issues, as well as addressing health literacy disparities.

Recommendation 3: Academia, federal agencies, health information technology organizations, and professional organizations should collaborate to determine the impact of the use of technology on providing high quality care to persons living with dementia and their families and caregivers.

Recommendation 4: Academia, federal agencies, and professional organizations should collaborate to evaluate the costs and benefits of educating and training health professions students, faculty, practitioners, the direct service workforce, and persons living with dementia, their families, and caregivers about dementia care and services.

Recommendation 5: Academia, health systems, primary health care delivery systems, community-based organizations, professional organizations, and federal, state, and local agencies should educate and train the workforce to be competent to coordinate care and facilitate care transitions with a goal to improve the delivery of dementia care and services, increase satisfaction with care, and reduce costs.

Recommendation 6: Academia, health systems, primary health care delivery systems, community-based organizations, professional organizations, and federal, state, and local agencies should collaborate to develop creative and innovative dissemination and implementation plans that translate research on dementia care, services, and supports into educational models that transform practice and inform policy.

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