IOWA DIRECT CARE ADVISORY COUNCIL

Strategic Plan

May 2010

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May 14, 2010

Director Tom Newton:

On behalf of the Iowa Direct Care Worker Advisory Council, we submit the following strategic plan detailing the future activities of the Council. The Advisory Council is pleased for the passage of House File 2526, providing clear guidance to the Council regarding activities in support of the establishment a board of direct care workers by July 1, 2014.

This strategic plan is provided at the request of the Iowa Department of Public Health as part of the Council's work during State FY2010. Specifically, the report provides the context of recent Advisory Council discussions, plans regarding a pilot to test recommendations of the Advisory Council, and plans to undertake activities outlined in HF 2526, including estimation of the direct care workforce, identification of an information management system, and recommendations for representation on the board of direct care workers.

The Advisory Council also plans to continue work on the Iowa direct care worker curriculum. Presently, the Advisory Council is close to finishing the Iowa Direct Care Worker Core Curriculum that would be used to initially educate and train all direct care workers. This curriculum integrates the philosophies of care giving and person-centered and directed services to develop a comprehensive curriculum applicable across all settings and populations served by direct care workers.

We look forward to the ongoing work of the Advisory Council, and future discussions about how the Council can best support the Department as it leads state level health care reform efforts.

Sincerely,

Diane M. Frerichs

Diane Frerichs, Co-Chair

Suzanne Russell

Suzanne Russell, Co-Chair

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Introduction

Recent legislation passed by the Iowa General Assembly during the 2010 legislative session has set significant goals for the Iowa Direct Care Worker Advisory Council. The legislation, House File 2526, outlines a framework for planning activities of the Advisory Council through 2014. Such goals outlined in the legislation include reporting results of a pilot for training direct care workers, identification of an information management system to track and record direct care worker education and training, and the establishment of a board of direct care workers by 2014. The Advisory Council has much work ahead of it; this strategic plan provides additional detail regarding the most recent discussions of the Advisory Council, as well as describing upcoming activities that will serve as a strategic plan to guide the Council's work.

Recent discussions of the Advisory Council have focused on planning for a pilot to test the recommendations of the Council in different communities across the state. Much of this strategic plan is dedicated to providing details regarding the plans for the pilot and plans for concurrent Council activities. Clear guidance has been set forth by the Iowa General Assembly for the continuing work of the Iowa Direct Care Worker Advisory Council. House File 2526, passed during the 2010 legislative session, provides clear expectations for the Advisory Council through 2014. This strategic plan outlines initial plans of the Advisory Council to undertake these activities. A July 1, 2014, deadline has been established for creating a board of direct care workers. Additional guidance in HF 2526 requires the Advisory Council to:

- **Develop an estimate of the direct care workforce.**
- **Identify the information management system needs required to facilitate credentialing and estimate the cost for development and maintenance.**
- **Report on the results of a pilot.**
- **Report on activities for outreach and education.**
- **Recommend composition of the board of direct care workers and the elements of its work and credentials it will oversee.**

The urgency of the pilot and the significance of estimating the direct care workforce cannot be understated. While the General Assembly does not require the Advisory Council to meet specific deadlines prior to the July 1, 2014, date for establishing a board of direct care workers, the significance and challenge of the prescribed activities encourages the Advisory Council to take on their work with a renewed sense of urgency. It is the wish of the Advisory Council to emphasize the urgency and significance of their work.

The Iowa Direct Care Worker Advisory Council was established in House File 2539 passed during the 2008 legislative session. The Advisory Council is charged with advising the Iowa Department of Public Health (IDPH) regarding regulation and certification of direct care workers. The work of the Advisory Council builds on recommendations from the Iowa Direct Care Worker Task Force that provided a framework for statewide standards for training and

education for the direct care workforce. All the following reports from the Advisory Council and Task Force can be found at www.idph.state.ia.us/hcr_committees/direct_care_workers.asp:

- *Direct Care Worker Contributions to Rebalancing Health, Support, and Long-term Care*, September 2009
- *Report to the Iowa Department of Public Health Regarding Implementation of a System for Certification of Direct Care Workers*, November 2008
- *Recommendations for Establishing a Credentialing System for Iowa's Direct Care Workforce*, May 2008
- *Iowa Direct Care Worker Task Force Report and Recommendations*, December 2006

Current Context of Iowa Direct Care Worker Advisory Council Discussions

In recent conversations of the Iowa Direct Care Worker Advisory Council, discussion has focused on the return on investment of direct care worker training and education; the services provided and the number and type of persons served by direct care workers; the evolution of the Council's model for credentialing direct care workers; and next steps for the Council. The following sections provide highlights from these discussions as well as a look ahead to anticipated Advisory Council discussions.

A direct care worker has been defined by the Iowa Direct Care Worker Advisory Council as an individual who provides supportive services and care to people experiencing illnesses or disabilities. Direct care workers are the front-line of Iowa's health, support, and long term care workforce, providing hands-on care and su pport to individuals of all ages and abilities in settings that range from acute care in hospitals to services in the home and community-based settings.

Direct Care Worker Training is a Valuable Investment

Research shows that training for direct care workers is a valuable investment that has positive implications for recruitment and retention. As the work of the Iowa Direct Care Worker Advisory Council moves forward, much of the responsibility for advocating in support of expanded direct care worker training and education will fall to the members of the Advisory Council. Thus, current discussions of the Advisory Council have focused on developing messages that clarify the impacts of expanded direct care worker training and education.

Studies show that enhanced training, especially when accompanied by additional compensation and responsibility, can make direct care workers feel more valuable and stay longer on the job.[1] Training that included realistic job previews has been shown to reduce turnover; new direct care workers provided such training had fewer unmet job expectations and were significantly less likely to leave the position in the first twelve months of employment.[2] For example, a Kentucky grant project headed by Support Providing Employee's Association of Kentucky (SPEAK) included an initial visit with the SPEAK coordinator, a site visit, and a family visit for a job preview. The state documented a reduction in turnover for project participants from 43 percent to 29 percent over a two-year period. [3]

Conversely, inadequate training has been found to negatively impact turnover rates for Certified Nursing Assistants (CNAs).[4] In a brief published by the Centers for Medicare and Medicaid

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1 PHI, 2005, *Workforce Strategies 3: The Role of Training in Improving the Recruitment and Retention of Direct-Care Workers in Long-Term Care*, http://www.directcareclearinghouse.org/download/WorkforceStrategies3.pdf.

2 CMS, 2006, ***Direct Service Workforce Demonstration: Promising Practices in Marketing, Recruitment, and Selection Interventions***; Larson, Lakin, & Bruininks, 1998.

3 Ibid.

4 Institute of Medicine (IOM), 2000, ***Improving the Quality of Long-Term Care***, Washington, DC: National Academy.

Services (CMS) and the Lewin Group, research has found that training, peer mentoring, support from coworkers, and continuing education have a positive impact on worker retention.[5] The brief also cites an Institute of Medicine report that asserts that current training is inadequate in terms of the number of hours and topics covered. Areas where training content is lacking include geriatrics, cultural competency, palliative care, and soft skills.[6] Additionally, it was found that there is a strong relationship between retention rates and the number of hours of training provided. [7]

The Iowa Caregivers Association, in its CNA Recruitment and Retention Project, found that nursing facilities that provided CNAs with training, a mentoring program, and an external network for support experienced significantly longer retention than comparison facilities.[8] The report also notes a significant 18-point increase in retention among direct service workers who were mentored.[9]

Enhanced training also has positive benefits for direct care workers providing services in the home. A study reviewing a skills enhancement training series for direct care workers providing personal assistance under a Medicaid home care services waiver found positive changes in job satisfaction, career commitment, and career resilience among participants. The workers were aware of the value of training and they placed the greatest value on training content that contributed to their personal and professional empowerment.[10]

Return on Investment: Improved Job Satisfaction and Quality of Care and Services

Research suggests that training increases direct care worker job satisfaction and improves quality of care and services. Win a Step Up, a workforce development intervention aimed at improving the working situation of nursing assistants in North Carolina, resulted in increased job satisfaction and morale, reduced turnover, and improved quality of care. The intervention included 30 additional hours of training for CNAs and coaching and supervision training.[11] Better Jobs Better Care, a research and demonstration program funded by the Robert Wood Johnson Foundation and The Atlantic Philanthropies, found that cultural competency training improved the perception of workplace cultural competency, which was associated with increased job satisfaction.[12]

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5 Wright, Bernadette. Centers for Medicare and Medicaid Services (CMS) and the Lewin Group, ***Strategies for Improving DSW Recruitment, Retention, and Quality: What We Know About What Works, What Doesn't, and Research Gaps.***

6 The Institute of Medicine (IOM), 2008, ***Retooling for an Aging America: Building the Health Care Workforce*** (Chapter 5).

7 Smyer M., Brannon D. and Cohn M., 1992, ***Improving Nursing Home Care Through Training and Job Redesign***. Gerontologist 32:327.

8 ASPE, 2004, ***Recent Findings on Frontline Long-Term Care Workers: A Research Synthesis 1999-2003***, http://aspe.hhs.gov/daltcp/Reports/insight.pdf.

9 Ibid.

10 Coogle, Parham, & Joblonski, 2008, ***Enhanced Care Assistant Training to Address the Workforce Crisis in Home Care***.

11 Konrad et. al, June 2009, ***Workplace Interventions, Turnover, and Quality of Care Report***, www.winastepup.org.

12 Better Jobs Better Care, 2008, ***Solutions You Can Use: Transforming the Long-Term Care Workforce***, http://www.bjbc.org/solutions.asp.

Conversely, the Centers for Medicare and Medicaid Services (CMS) and the Lewin Group cites that while adequate training has a positive effect on recruitment and retention, poor training is linked to poorer resident health and functioning, abuse and neglect, and poor quality of care.[13] Additionally, a survey of more than 1,700 nurse aides in five states, found a strong association between job satisfaction and turnover or intent to leave. Training, rewards, and workload were cited as the most important aspects of the nurse aide's job.[14]

There is a relationship between the level and type of training that nursing assistants receive and the quality of care that they provide. Experts argue that more research in this area is essential, but note that improved training and job quality has been found to decrease turnover. In turn, lower turnover positively impacts both quality of care and quality of life for residents.[15] Additionally, Better Jobs Better Care found that residents were more satisfied with their relationships to nursing staff and their quality of life where a higher proportion of nursing assistants were committed to their jobs. [16]

Persons Served by Direct Care Workers

As the Iowa Direct Care Worker Advisory Council begins the significant work to estimate the current direct care workforce, a critical place to start is with the number and types of persons served by direct care workers in Iowa. The following section outlines preliminary numbers on some of these consumers and the setting in which they are served. This information holds certain limitations, as it is not comprehensive and is not controlled for duplicated numbers across funding and settings. Another limitation is the lack of data on private pay services. While this information is valuable for providing a picture of consumers served by direct care workers, the greater task ahead will be to determine the number of direct care workers serving these individuals.

Medicaid HCBS Waiver Populations Served

The following chart depicts the numbers served through Medicaid Home and Community Based Services (HCBS) waivers in 2009.

Medicaid Home and Community Based Waivers	Numbers Served
AIDS/HIV (Adults and children)	56
Brain Injury (Adults)	1,056
Children with Serious Emotional Disturbance	614
Older Adults	9,779
Intellectual Disability (Adults and children)	10,662
Physical Disability (Adults and children)	842
Mental Illness	3,339
Total Persons Served on HCBS Waivers	**26,348**

13 Smyer M., Brannon D. and Cohn M., 1992, ***Improving Nursing Home Care Through Training and Job Redesign***. Gerontologist 32:327.

14 Castle, Engberg, Anderson, and Men, 2007, ***Job Satisfaction of Nurse Aides in Nursing Homes; Intent to Leave and Turnover.***

15 Institute of Medicine (IOM), 2000, ***Improving the Quality of Long-Term Care***, Washington, DC: National Academy Press.

16 Brandeis, ***Better Jobs Better Care, Retention: Importance of Career Enhancements***.

As reported by Cornell University in their 2008 Annual Disability Status Report, Iowa has a disability prevalence rate 11.8 percent for all ages.[17] According to the Kaiser Foundation, the total number of people with disabilities who received Social Security benefits between the ages of 18 and 64 totaled 73,251 in 2008. [18]

According to Iowa Medicaid Enterprise, the Consumer Directed Attendant Care (CDAC) option under six of the seven waivers is currently serving 2,217 people through agencies, 3,906 people through individuals, and 739 people through assisted living, as of 2009. 1,259 individuals were utilizing the Consumer Choices Option (CCO) as of November 9, 2009.

CDAC and CCO Options Utilized under HSBC Waivers	Numbers Served
CDAC through Agencies	2,217
CDAC through Individuals	3,906
CDAC through Assisted Living	739
CCO through Individuals	1,259
Total Persons Served through CDAC and CCO Options	**8,121**

Persons Served Through Medicaid

The following chart depicts the number of people served through Medicaid for the specified services as reported in the Iowa Department of Human Services June 2009 Fiscal Year-to-Date Report. The Medicaid services identified below are those services more likely to utilize direct care workers for service provision. Based on this criterion, Medicaid services such as physician services have not been listed.

Medicaid Service	Numbers Served
Home Health	38,979
Intermediate Care Facility	18,352
Intermediate Care Facility – MR	2,255
Residential Care Facility	2,488
Habilitation Services	3,725
Remedial Services	18,527
Adult Day Care	1
Assisted Living	NA*
Total Persons Served through DCW-provided Medicaid Services	**84,327****

*NA = Data not listed in report

**Total is not accurate due to unavailability of data for assisted living.

17 Cornell University, 2008, 2008 ***Disability Status Report: Iowa.***

18 The Henry J. Kaiser Family Foundation, 2008, ***Iowa State Profile***, http://www.statehealthfacts.org.

The Iowa Department of Inspections and Appeals estimates that approximately 10,000 people utilize assisted living services in Iowa annually. The total capacity of assisted living in Iowa is estimated to be 17,000. Capacity is determined according to facility square footage, so may not accurately represent the number of individuals served.

According to the Iowa Adult Day Services Association, adult day programs in Iowa serve an estimated 1200 individuals annually.

Long-Term Care Facilities in Iowa

The following chart depicts Iowa Department of Inspections and Appeals data for the total number of entities in Iowa as of April 2010 by type of long-term care facility and their maximum occupancy.

Type of Facility	Total Entities in Iowa	Maximum Occupancy
Free-standing nursing and skilled nursing facility	397	28,775
Free-standing nursing facility	10	1,244
Free-standing skilled nursing facility	3	142
Intermediate Care Facility – MR	141	3,127
Intermediate Care Facility – PMI	1	25
Residential Care Facility	97	3,555
Residential Care Facility – MR	52	678
Residential Care Facility – PMI	13	284
3-5 Bed Residential Care Facility – MR/MI/DD	27	134
Hospital	42	9,439
Critical Access Hospital	82	2,498
Psychiatric Medical Institute for Children (PMIC)	33	532
Chronic Confusion and Dementing Illness (CCDI) Unit	117	2,316
Totals for Long-Term Care in Iowa	**1,015**	**52,749**

According to the Kaiser Foundation, the total number of residents in Iowa certified nursing facilities numbered 25,772 in 2008. The total number of certified nursing facility beds was 31,897 in the same year. Medicaid provides the primary payer source for certified nursing facilities, covering 48 percent of residents, with private pay (44 percent) and Medicare (8 percent) accounting for the rest. According to the Iowa Department of Inspections and Appeals, however, facilities can vary greatly in the funding sources they accept and from whom they receive most of their funding. Additionally, Medicare only covers a limited number of days (100 maximum) in a nursing facility, so if a resident exhausts his or her Medicare funding, then the payment must come from Medicaid or private pay.

The Kaiser Foundation reports that there were 2,454 special care beds in Iowa certified nursing facilities in 2008. Special care beds include special units designated to care for specific services

or conditions, such as Alzheimer's and dementia, AIDS, Hospice, rehabilitation, ventilator, and dialysis.

In 2008, Iowa was home to 504,944 Medicare beneficiaries. These individuals were provided with 695,105 total days of care from short-stay hospitals. A total of 13,062 Medicare beneficiaries received hospice services in 2006 and used 742,591 days of care. According to the Iowa Department of Inspections and Appeals, there are 85 certified hospice agencies in Iowa. In 2008, 22,000 people were served through Medicare home health services, and total visits equaled 548,000. According to the Institute of Medicine, more than 60 percent of older adults living in the community obtain long-term care services nationally, and 70-80 percent of care to older adults receiving long-term care services is provided by direct care workers.[19] According to an Iowa Department on Aging report, the Iowa Aging Network provided service to 73,932 Iowans in 2009. For services not requiring client registration, the Aging Network served 168,281 older Iowans (age 60+) and their caregivers.

Certified Home and Community Based Facilities and Programs

The following chart depicts Iowa Department of Inspections and Appeals data for the total number of entities in Iowa as of May 2010 by type of home and community based facility or program and their maximum capacity. Capacity is determined according to facility square footage. The data do not include those agencies that provide private duty nursing.

Certified Home and Community Based Facility or Program	Total Entities Certified in Iowa	Total Capacity
Home Health Agencies (HHAs)	176	0
Rehabilitation Agencies (Rehab)	37	0
Elder Group Homes	7	33
Assisted Living Programs	231	12,311
Assisted Living Programs for Persons with Dementia	67	5,298
Adult Day Services	31	927
Totals for Certified Home and Community Based Facilities and Programs in Iowa	**549**	**18,569**

The Iowa Direct Care Worker Advisory Council has been charged with estimating the direct care workforce to inform the establishment of a professional board. Some estimation of workers is currently underway, although much more limited in scope than that charged to the Advisory Council. Iowa, as a State Profile Tool and Money Follows the Person Demonstration project grantee, has been selected by the Centers for Medicare and Medicaid Services (CMS) for technical assistance to establish a minimum data set for what they term the "direct service

19 Institute of Medicine, ***Retooling for an Aging America: Building the Health Care Workforce***, 2008, accessed at http://www.nap.edu/catalog/12089.html.

workforce" or DSW. Direct service workers are defined as workers who provide personal care or nonmedical services to individuals who need assistance with activities of daily living. The recommended minimum data set for this project will include workforce volume (number of full- and part-time workers), workforce stability (turnover and vacancy rates), and worker compensation (average hourly wage and benefits). Other recommended data sets include population groups receiving long-term care, long-term care service types, care settings, and job titles. The report from this initiative is expected in June of 2010. The Advisory Council will look closely at this report to serve as a starting point for estimating the direct care workforce in entirety.

Important caution regarding the data provided in this section:

- The data provided in this section verify that direct care workers serve a broad spectrum of people providing them with a wide variety of supports and care. It is not intended to serve as an accurate profile of persons served in Iowa. The data presented in this section are not unduplicated. Rather, this information is intended to provide a picture of the populations served and services provided by direct care workers.

Implications of this Data

The data presented in this section have significant implications for the work of the Advisory Council. Implications of this data have been identified as the following:

- **Current data on the direct care workforce is greatly lacking. Collecting accurate, comprehensive data on the entire direct care workforce in Iowa will be extremely challenging. The significance of this task cannot be understated.**
- **The data provided in this section illustrate the additional challenge of tracking individuals served and services provided under private pay. Estimating the number of direct care workers employed and providing services under private pay will present an additional challenge for the Advisory Council as they seek to count the entire direct care workforce.**
- **The data presented here, although duplicative, reflect the multiplicity of services individuals may be receiving at one time. This highlights the diversity and broad dispersion of direct care workers throughout the long-term care, health, and support sectors.**
- **Direct care workers play an integral role in providing Medicaid and Medicare services, as shown by the data in this section. Compiling correct numbers on the direct care workforce in Iowa may, in the future, influence CMS to increase federal reimbursement for services.**

Evolution of the Advisory Council's Model for Credentialing Direct Care Workers in Iowa

In the 1980s, there was recognition that direct care workers, particularly CNAs, needed more training to meet the evolving needs of consumers. Early on, there were several CNA curricula in the state, but it was recognized that the curricula needed to be consistent in the interest of

the consumer served. There is currently no requirement for a single CNA curriculum, but, over time, stakeholders have come to agree on a single curriculum that is updated to reflect changes in the field and meet the changing needs of residents in facilities.

Historically, services for individuals with disabilities have been provided in institutional settings until funding for service changes led to the creation of community-based facilities such as sheltered workshops, day activity centers, and group homes. Over time, the system evolved to empower the individual, moving further towards consumer-directed services. The United States Supreme Court ***Olmstead*** decision (***Olmstead v. L.C. and E.W.,*** 1999) affirmed the right of consumers equal pay for services provided in home and community settings. The waiver system of services was developed that enabled people to access Medicaid funding in community settings. Training for direct care workers in disability settings evolved with the services. With the advent of Consumer Directed Attendant Care (CDAC) and Community Choice Option (CCO), options within six of the seven waivers, consumers can now choose the care they receive and how they are served. Often this choice involves the services of a direct care worker. Microboards, an emerging trend in how individuals with disabilities are served, further reflect the movement of self-directed care and service provision for individuals with disabilities.

Training for direct care workers in the disability field is minimally required by Iowa Code, although some training must be approved by the Iowa Department of Public Health, such as training on the Health Insurance Portability and Accountability Act (HIPAA). There is a movement to identify core competencies that align with setting and role on the national level. To be credentialed as a Direct Support Professional (DSP) by the National Alliance for Direct Support Professionals (NADSP), the worker must take a minimum number of modules, but is not required to complete them in any certain order. Requirements for credentialing at the highest level by NADSP are significant, and include the submission of a portfolio and evidence of 3000 on-the-job work experience in direct support. While national credentialing is not required to receive Medicaid reimbursement, these individuals are considered experts in the field by peers.

Current training for direct care workers in the health sector looks much different. While still inconsistent across employers, training for direct care workers in health care and long-term care settings is at a later stage of development. The standard model for health sector direct care workers, the Certified Nursing Assistant (CNA) certification, is portable within the state and is considered an exemplary training for direct care workers. CNA certification is widely accepted in the state not only because it is a federal designation, but because there exists an Iowa standard curriculum for CNA. The Advisory Council recognizes, however, that the CNA has its limitations and that the Council must work to raise the profile of training for direct care workers in the health emphasis.

The Advisory Council's model for credentialing direct care workers has taken on many reiterations over the years. While the underlying philosophy of credentialing according to function rather than setting or job title has not changed, the visual depictions of the model have morphed through many different variations over time. All of the early models were built on

the assumption of a single, standardized Iowa curriculum for direct care workers. The Advisory Council's first model for credentialing adopted a tiered certification structure. Training modules would build on one another and culminate in the health monitoring and maintenance module, or CNA. Advisory Council members expressed sensitivity to hierarchy in the credentialing system, and an alternative model was developed that originated a core training module and tracks for universal direct care workers, disability direct care workers, and health direct care workers. The career pathway model, emphasizing professional tracks for workers, took many forms – from a circular representation, to a branched structure and a fanned structure.

Today, the model has evolved further and reflects much more integrated thinking on behalf of the Advisory Council. In recognition of the evolutionary variations of the disability and health sectors, the Iowa Direct Care Worker Advisory Council recommends that the two disciplines be likewise reflected in the credentialing model. The credentialing model will look different for each of the training emphases, reflecting their current stage of sector development. Recognizing the Iowa standard curriculum for CNA and the value that has brought to training for health care services, the health emphasis for direct care workers will be standardized and meet the requirements of the CNA. As the Council identifies Iowa competencies for both the health and disability emphases, the health emphasis training will most likely integrate traditional disability sector competencies that are not currently reflected in Iowa CNA curriculum. This supports better portability across sectors and settings. Additionally, in consideration of national portability of the health emphasis, the Advisory Council must consider the total hours of training for both emphases. Currently, the Iowa CNA training is 75 hours – the federal minimum training hours required for CNA. The Institute of Medicine currently recommends a minimum of 120 hours for CNA, and many states have adopted this recommendation. What's more, the Advisory Council must also consider eliminating the challenge test for CNA certification, a provision that decreases the national portability and credibility of Iowa's certification.

The disability emphasis will look much different and also provide for a well-trained workforce. The Advisory Council recommends common core competencies be developed for the Iowa disability emphasis that align with national competencies for Direct Support Professionals (DSPs). Utilizing a competency-based model for the disability emphasis would allow the use of multiple curricula for training direct care workers looking to focus on serving individuals with disabilities. This has been a recent discussion of the Advisory Council, but members believe that this represents the best model for recognizing the validity of the differences while integrating the two disciplines in one single credentialing system. The Advisory Council has suggested that in the future, it may be possible for the disability emphasis to develop an Iowa standard curriculum and that, eventually, the two disciplines may converge more seamlessly to allow for greater portability for the worker across disciplines and populations.

The Advisory Council's goal is to develop a system of direct care worker credentialing that promotes quality and consistency in training and education for all direct care workers. Credentials must be portable across settings, states, and employers. With consideration of direct

care workers' current status in the workplace, training must be accessible and low-cost, but of high quality to ensure credibility with employers. The Advisory Council believes that the current credentialing model reflects these goals and provides the flexibility necessary for the unique character of this workforce.

Next Steps for the Iowa Direct Care Worker Advisory Council

Clear guidance has been set forth by the Iowa General Assembly for the continuing work of the Iowa Direct Care Worker Advisory Council. House File 2526, passed during the 2010 legislative session, provides clear expectations for the Advisory Council through 2014. A July 1, 2014, deadline has been established for creating a board of direct care workers. Additional guidance in HF 2526 requires the Advisory Council to:

- **Develop an estimate of the direct care workforce.**
- **Identify the information management system needs required to facilitate credentialing and estimate the cost for development and maintenance.**
- **Report on the results of a pilot.**
- **Report on activities for outreach and education.**
- **Recommend composition of the board of direct care workers and the elements of its work and credentials it will oversee.**

This strategic plan provides details regarding plans for a pilot to test the recommendations of the Advisory Council and plans for concurrent Council activities, including continuation of work on curriculum, identification of an information management system, and estimating the Iowa direct care workforce.

The urgency of the pilot and the significance of estimating the direct care workforce cannot be understated. While the General Assembly does not require the Advisory Council to meet specific deadlines prior to the July 1, 2014, date for establishing a board of direct care workers, the significance and challenge of the prescribed activities encourages the Advisory Council to take on their work with a renewed sense of urgency. It is the wish of the Advisory Council to emphasize the urgency and significance of the work detailed in this strategic plan to the Iowa Department of Public Health.

Plan for a Pilot to Test the Recommendations of the Iowa Direct Care Worker Advisory Council

Much of the Advisory Council's recent discussions have focused on planning for a pilot that would test its recommendations. It is the intention of the Council to engage a diverse sample of direct care workers, employers, and educators to test and evaluate their recommendations, and revise any recommendations based on lessons learned from the pilot. Over a timeframe of three years, the Advisory Council will provide planning, oversight, and leadership to the pilot and serve as partners in materials dissemination; direct care worker, employer, and instructor recruitment; curriculum development; awareness activities; and evaluation. All members of the Advisory Council have expressed their commitment to the implementation and success of the pilot, recognizing its importance in furthering the work of the Council and ensuring the development of an effective and efficient model for credentialing direct care workers in Iowa.

The Advisory Council is currently seeking funding opportunities to fully plan for, implement, and evaluate the pilot to test their recommendations. This section provides details regarding plans for the pilot. The Advisory Council has discussed the pilot in depth, taking the initiative to plan for the activities of the pilot to best lay the groundwork for immediate action upon receipt of funds. The Advisory Council recognizes that significant resources must be allocated to ensure success of the pilot, but have begun planning for the pilot in consideration of its importance.

Pilot Goal

- To engage a diverse sample of direct care workers, employers, and educators to test and evaluate the recommendations of the Iowa Direct Care Worker Advisory Council.

Timeframe

- Three years for planning, implementation, and initial evaluation

Geographic target

Direct care workers provide care and services in every community across the state. A statewide system of direct care worker credentialing will impact all communities – urban, rural, and suburban. Thus, the pilot must ensure that a sample of direct care workers in communities of all sizes is engaged in the pilot. The Advisory Council recognizes the importance of engaging a broad spectrum of direct care workers and employers in the pilot, as well as engaging key stakeholders such as community colleges, regional Iowa Workforce Development (IWD) and Workforce Investment Act (WIA) offices, and organizations represented on the Advisory Council. These partners will be vital to the success of the pilot across the state.

The Advisory Council recommends that the pilot be implemented initially in two regions aligning with community college and workforce development regions. Such an alignment would take advantage of the natural catchment area of these regions and the resources that will

be critical for information dissemination, stakeholder outreach, and direct care worker and employer recruitment. The Advisory Council recommends that, if appropriate, larger employers that cross regional boundaries be recruited to maximize direct care worker participation. To ensure retention of employers, partners, and direct care workers, the Advisory Council recommends an application process similar to an "agreement to participate" be used.

Initial Geographic Targets

- **Two regions aligning with community college and workforce development regions**
- **Larger employers that cross regional boundaries may be engaged to participate**
- **Urban, suburban, and rural representation**
- **Engagement of key stakeholders, including community colleges, IWD and WIA offices, and organizations represented on the Advisory Council**
- **An application process similar to an "agreement to participate" will be used to maximize retention of participants and partners**

Workforce Target

The Advisory Council has set a workforce target of 750 to 1,000 workers for participation in the pilot. Any recruitment for the pilot should target direct care workers with the intent to reflect the broad diversity of the workforce. The sample of direct care workers participating in the pilot should represent all settings in which direct care workers are employed or provide services, including nursing facilities, hospitals, home care, Home and Community-Based Services (HCBS), intermediate care facilities, residential care facilities, assisted living programs, and adult day programs; and all types of direct care workers, including full-time, part-time, new, incumbent, and direct care workers that provide services and care to individuals with health conditions as well as disabilities. Recruiting a diversity of direct care workers will ensure that the pilot effectively tests the functions that represent the Advisory Council's recommended credentialing model. It will also be important to engage a diversity of employers, including for-profit and non-profit facilities and agencies, as well as employers of varying sizes.

The Advisory Council is sensitive to the fact that some individuals currently working as direct care workers may not intend to stay in the profession into the future. The Advisory Council recommends that individuals on a track to a profession other than direct care should be excluded from the pilot to direct resources to workers that will benefit most from the education and training.

Initial Workforce Targets

- **Direct care workers providing care and services in a diversity of settings, performing a diversity of functions**
- **All types of direct care workers, including full-time, part-time, new, and incumbent workers**
- **Diversity of employers, including for-profit and non-profit facilities and agencies, and of varying sizes**

Education

Advisory Council discussions have long centered on ensuring that direct care worker training and education be accessible, low-cost, and require a reasonable time commitment. Pilot testing the curriculum will focus on these considerations, but more specifically on the accessibility of modalities, packaging of the competencies in specific modules, and feasibility of training. The Core curriculum and advanced training in the emphases will first be tested in the classroom, face-to-face between the worker and instructor. Online modules will be identified and developed for testing at a later pilot stage. To ensure greater access to the curriculum, instructors will be encouraged to provide the curriculum at community colleges, by employers, and by Iowa-based private and non-profit associations and providers.

Piloting Direct Care Worker Training and Education

- **Standard curriculum modules initially tested face-to-face**
- **Online modules identified and developed for testing in later stages**
- **Instructors from a diversity of settings provide curriculum**

Technology

Technology will be critical to the administration, reporting, tracking, and evaluation of pilot activities. An information management system will be identified early and utilized for grandfathering, administration, and evaluation of the pilot. Ideally, such an information management system would have the capacity to track modules completed by pilot participants, deliver online modules in later pilot stages, serve as a reporting tool for direct care workers, and interface with the Iowa Direct Care Worker Registry. The Advisory Council plans to work closely with the Iowa Department of Public Health to identify an information management system that will provide the functions needed for effective administration of the pilot and, in the future, a system for credentialing direct care workers in the state.

An information management system will:

- **Facilitate pilot administration, reporting, and tracking**
- **Deliver online modules of the direct care worker curriculum in later pilot or system stages**
- **Interface with the current Iowa Direct Care Worker Registry**

Grandfathering

Grandfathering during the pilot will follow the Advisory Council's 2008 recommendations. Using an information management system, direct care workers will report demographic information, criminal history, experience, education, employment history, and information related to their continuing education needs. This reporting will determine the competency level of direct care workers currently in the field and assign a credential reflecting their current level of competency. This will not test direct care workers for competency, but, rather, match identified skills with criteria for competency to determine competency levels for the purpose

of grandfathering in the pilot only. An optional survey will also be developed that collects additional data regarding their experience in the direct care workforce.

For the purposes of the pilot, grandfathered direct care workers will receive a recognition certificate from the state. Following analysis of results from the pilot, the Advisory Council will consider recommending that workers grandfathered as part of the pilot be recognized by the board of direct care workers as credentialed according to requirements set forth by that entity. For the purposes of the pilot, however, grandfathered workers cannot be given the assurance that they will automatically be grandfathered when the statewide direct care worker credentialing system is implemented in the future.

Pilot grandfathering will:

- **Report demographics, criminal history, experience, education, employment history, and information related to continuing education needs (per 2008 Advisory Council recommendations)**
- **Determine the competency level of the direct care worker currently in the field and assign a credential reflecting their current level of competency (for the pilot only)**
- **Provide direct care worker with a certificate of recognition from the state**

Incentives

Although significant outreach and education will occur prior to the pilot implementation phase to inform stakeholders of the goal and process of the pilot, participation in the pilot will require incentives for both workers and employers. The Advisory Council has discussed incentives for direct care workers and employers at length, and has developed a list of potential incentives for both groups. Potential incentives for direct care workers include state recognition, paid education, and increased job satisfaction. Potential incentives for employers include some of the same incentives plus having trained instructors on staff and deemed status if all employees participate. Additional incentives may be further developed as the pilot progresses.

Incentives for Direct Care Worker Participation

- **State recognition**
- **Education certificate**
- **Paid education**
- **Potential for increased wages and benefits**
- **Input on system development**
- **Job satisfaction**
- **DCW, employer, and supervisory training and supports**

Incentives for Employer Participation

- **Potential for increased reimbursement rates in the future**
- **Paid education**
- **State recognition**
- **Technical assistance**
- **Input on system development**
- **Trained instructors on staff**
- **Deemed status if all employees participate**
- **DCW, employer, and supervisory training and supports**

Evaluation

Comprehensive evaluation of the pilot will occur throughout the timeline of activities from planning through implementation. A number of strategies will be used to collect both quantitative and qualitative data to measure the impact of the pilot. Ongoing feedback will be elicited from the Advisory Council and local teams helping with implementation of the pilot. Data will be tracked throughout the pilot timeline, including the educational modules completed by workers, turnover and vacancy rates, and changes in perception of quality of care. Surveys and focus groups will be used to measure additional outcomes.

Criteria for Evaluation

- **Tracking of modules completed by workers**
- **Reduction in average turnover, number of vacancies**
- **Qualitative feedback from Advisory Council and partners**
- **Survey feedback from direct care workers, employers, instructors, and consumers**
- **Changes in perceived quality of care and services**

Outreach Activities

The pilot provides a significant opportunity for the Advisory Council to develop stakeholder awareness of direct care workers and the critical roles they fill in Iowa's health, long-term, and support fields. It will be necessary to conduct an outreach effort that establishes an infrastructure for communication and support for all entities involved in the pilot. Because the current system is fragmented, the pilot will need to provide information for those that are used to working in their fragmented areas and streamline understanding. Much like the wide diversity of functions that direct care workers perform, key targets for outreach will also span many segments of target communities. This infrastructure is vital to the success of the pilot and will also serve the direct care community statewide when the formal credentialing system is implemented.

The outreach effort will have three primary goals: 1) direct care worker, employer, and partner recruitment through generation of interest; 2) informing stakeholders about details of the pilot and how it relates to broader efforts to increase the profile of the direct care profession; and 3) provision of information to the public about direct care. The project will utilize a comprehensive outreach strategy adapted to the pilot. The recruitment strategy will include the development of a unique website that will serve as a one-stop resource for information about the pilot; printed and electronic materials specifically for use by community college partners, workers for peer outreach, and employers to recruit workers and advance the skills of incumbent workers; and general materials for distribution through the networks represented by members of the Advisory Council.

Primary Goals of Pilot Outreach

1. Direct care worker, employer, and partner recruitment
2. Informing stakeholders about details of the pilot and how it relates to broader efforts to increase the profile of the direct care profession
3. Provision of information to the public about direct care

Local leadership teams comprised of direct care workers, employers, educators, and workforce staff will be engaged for purposes of outreach and recruitment in the pilot regions. Information about the pilots will also be shared through stakeholder newsletters, websites, and at events and conferences to meet goals for participation and recruitment, as well as to inform the broader stakeholder community about the pilot and the larger initiative to enhance the Iowa direct care profession. Partner organizations will receive materials related to the goals of the pilot and opportunities for individuals enrolled in WIA or PROMISE JOBS programs for training and job placement. Inactive CNAs will also be targeted through outreach.

The infrastructure will initially be developed to facilitate recruitment for and administration of the pilot, but will also be developed with the intention for long-term impact. A plan for concurrent outreach activities will include strategies for sharing information about the new credentialing system with workers, employers, associations, educators, policymakers, and other stakeholders. A number of products will be created to establish and maintain this critical infrastructure. Most importantly will be to develop a pilot identity, or brand, early in the pilot process and indicate to the public and critical stakeholders that this initiative is a shared vision, designed to create a lasting, systems-wide approach to enhancement of the direct care workforce through training and education. This identity will include a logo and standard language to describe the pilot and the overall importance of direct care workers, increasing awareness for and credibility of the pilot. Messaging to diverse stakeholders will be developed that communicates the need for and value of improved training for all direct care workers. A unique website that serves as a one-stop resource for information on the new direct care worker career pathway will be designed to provide information to a wide audience and regularly updated with current information.

Products will also be designed that appeal and serve specific partners that relate to their interests. Initial partners include direct care workers, employers, educators and trainers, policymakers, workforce professionals, and other related professional organizations. These products will be developed based upon suggestions and identified needs of these partners, and will likely include summary materials, a frequently asked questions (FAQ) guide, and news updates sent out periodically to pilot partners and stakeholders. Regularly providing such current information will require the development of a large database of stakeholders that request to receive regular updates about the pilot. This will be an ever-evolving list as the outreach effort progresses.

Pilot Outreach Activities

- Development of a branding identity and communication materials for the pilot
- Establish a communication and outreach infrastructure
- Generate interest and credibility
- Communicate specific information about pilot and how it relates to larger effort to increase profile of direct care profession
- Inform stakeholders of opportunity, responsibilities, and timeframe for participation in pilot
- Recruit participants in pilot
- Utilize the constituencies of the Advisory Council and partner organizations for dissemination

Pilot Timeline

Planning, implementation, and evaluation of the pilot will be completed in three years. The following timeline is an estimation of timeframes for the activities and tasks that can preliminarily be identified. The Advisory Council would like to emphasize that the timeframes presented in this section may not accurately reflect the urgency felt by the Council to undertake the proposed activities. While the timeframes do not provide specific dates of completion for pilot activities and tasks, the Advisory Council expects to begin work immediately upon receipt of funds to undertake the initial stages of the pilot.

Pilot Phase: Planning		
Activity/Tasks	**Timeframe**	**Products/Outcomes**
EDUCATION: Curriculum Development and Instructor Training **Tasks** • Develop curriculum • Gather input from DCWs, consumers, and providers to finalize curriculum content • Develop competency test • Develop trainer guide for curriculum • Conduct train-the-trainer session for pilot regions • Disseminate curriculum through trained direct care worker instructors	Year 1; 15 months	Curriculum; Train-the-Trainer Guide; Trained Instructors

TECHNOLOGY: Information Management System Development **Tasks** • Identify criteria for information management system • Based on criteria, determine feasibility of enhancing current systems that have received state investment • Obtain complete quote for upgrade or development of system • Develop and test information management system	Year 1; 12 months	Operational information management system available for testing prior to pilot Implementation Phase
TECHNOLOGY: Direct Care Worker Registry Update **Tasks** • Identify capacity needs and components to enhance current Registry at the Iowa Department of Inspections and Appeals (DIA) • Establish interface to link Registry with Information Management System • Complete technology enhancements to Registry	Year 1; 12 months	Enhanced Registry operational and interfaced with information management system prior to Implementation Phase
OUTREACH: Outreach Plan and Materials Development **Tasks** • Finalize outreach plan • Develop web resource that serves as a one stop for information • Develop printed and electronic materials specifically for WIA/ IWD offices, direct care workers, instructors, and employers for recruitment • Create general materials for distribution through the networks represented by members of the Advisory Council and others • Identify and train local leadership teams including DCWs, employers, and instructors • Place recruitment information in stakeholder newsletters and present at conferences/events. • Develop simple application for participation in pilot for community colleges and employers	Year 1; 4-6 months	Outreach plan and materials for awareness and recruitment developed Outreach conducted for recruitment

INCENTIVES **Tasks** • Develop recognition plan for employer and workers including certificate, media, website • Develop state recognition certificate • Explore opportunities to offer deemed status to employers	Year 1; 6 to 12 months	
Pilot Phase: Implementation		
Activity/Tasks	**Timeframe**	**Products/Outcomes**
OUTREACH: Distribute Materials and Promote Pilot **Tasks** • Disseminate materials for recruitment and information • Promote website for recruitment and information • Identify primary pilot participants: community colleges and employers. • Continue promotion to DCWs for participation. • Provide regular pilot progress updates to stakeholders	Year 2; 12 months	Outreach activities; defined pilot participants
EDUCATION: Pilot Direct Care Worker Training and Offer Incentives **Tasks** • Offer Direct Care Worker Training to new and incumbent workers both online and through trained instructors. • DCWs will complete training in the new career pathway and will receive certificate of completion and state recognition.	Year 2; 12 months	Number of trained DCWs; Evaluation results

GRANDFATHERING: Pilot System for Grandfathering and Offer **Incentives Tasks** • Encourage system testing for grandfathering of incumbent workers and former DCWs in target regions and through other Assoc./interest groups as necessary • Provide recognition and incentives to participants • Develop mechanism that will save participant data in system, so only updates are required when official grandfathering begins	Year 2; 12 months	Data from grandfathering reporting and optional survey

Pilot Phase: Evaluation		
Activity/Tasks	**Timeframe**	**Products/Outcomes**
Employer participant providing baseline data	Years 1 and 2	Surveys
Instructors and training participants will complete an evaluation of the curriculum to inform adjustments. Participants will be tracked for follow-up evaluation on effectiveness of training in preparing them for job duties.	Years 2 and 3	Curriculum evaluation results
DCWs will be tracked for the length of the pilot to evaluate retention and job satisfaction	Years 1-3	Reduction in average turnover
Track vacancies for participating employers	Years 1-3	Reduction in number of vacancies
Gather feedback from implementation teams and Advisory Council	Years 1-3	Qualitative data from local and state leadership
Conduct focus groups with employers, instructors, and DCWs	Year 3	Qualitative data from pilot participants; will inform survey development
Conduct surveys with employers, instructors, and DCWs	Year 3	Quantitative data from pilot participants
Analyze participant and grandfathering data captured in information management system for analysis of demographics, workforce skills, potential continuing education needs, etc	Years 2 and 3	Participant and workforce data from reporting, optional survey, and pilot activity

The Advisory Council believes strongly in the need for the pilot prior to the establishment of a board of direct care workers by July 1, 2014. The Advisory Council is currently seeking funding opportunities to fully plan for, implement, and evaluate the pilot to test their recommendations. The Advisory Council has discussed the pilot in depth, taking the initiative to plan for the activities of the pilot to best lay the groundwork for immediate action upon receipt of funds. The Advisory Council recognizes that significant resources must be allocated to ensure success of the pilot, but is ready to take up activities when the opportunity comes to fruition.

Concurrent Advisory Council Activities

Curriculum Development

Curriculum development has been conducted by a small committee of dedicated Advisory Council members. The committee members represent both the health and disability fields, as well as direct care workers and instructors of the Certified Nursing Assistant curriculum. Under the leadership of this committee, the Iowa Direct Care Worker Core Curriculum (the "Core") is nearly complete. This Core will be used to train all direct care workers across all settings and will serve as a minimum training to expose workers to the field, the different settings in which they may work, and basic competency to successfully perform the essential functions of a direct care worker. Competencies covered in the Core currently include:

- **Communication**
- **Documentation**
- **Infection control and universal precautions**
- **Person-centered/direct care**
- **Body mechanics**

Committee members agree that the Core is sufficient, yet accessible, training for all direct care workers, and will serve the critical function of introducing the worker to the direct care worker credentialing system. This introduction not only provides information regarding responsibilities of the worker in a system of credentialing, but also the professional obligations and ethical standards assigned to workers in a profession. The Core is expected to be finished this summer and will be a primary consideration for testing in the pilot detailed earlier in this plan.

The Curriculum Committee has identified next steps for continuing its progress. Based on the current model for credentialing developed by the Advisory Council, the Committee will work next on identifying competencies that are essential for direct care workers providing care and services to individuals with disabilities. The Committee recognizes that national portability is a priority for the Iowa model, and will look to national competencies to identify those for Iowa's disability emphasis training. Once competencies have been identified, the Committee will discuss how best to package the competencies in modules to allow for more accessible training for direct care workers. While the health emphasis will be standardized in alignment with the Iowa Certified Nursing Assistant curriculum, the Committee must discuss expanding the health emphasis with a national, 120-hour CNA model to ensure national portability of the health emphasis, as well.

The Curriculum Committee and Advisory Council recognize that much work is still ahead of them. While great progress has been made toward finalizing the Core, the Iowa Direct Care Worker Advisory Council expressed interest in stepping back and collecting stakeholder feedback regarding its recommendations and work during this year. The Advisory Council recognized that significant strides had been made since its work began in 2005. However, members felt that they would like additional input from stakeholders regarding current work, including the Core, the current model for credentialing direct care workers, and the potential impact of such a system.

The Advisory Council has recommended that focus groups be conducted with different stakeholder groups to get a diversity of perspectives on their work and recommendations. The following stakeholder groups will be engaged in focus groups in the specified locations:

- **Direct care workers – Spencer, Iowa**
- **Employers of direct care workers – Iowa City, Iowa**
- **Consumers – Council Bluffs, Iowa**
- **Family members of consumers – Ottumwa, Iowa**

The Advisory Council charged the Curriculum Committee with identifying questions for developing a script for the focus groups. Additional discussion was brought to the full Advisory Council in April 2010. Advisory Council members recommended that the focus groups elicit specific feedback regarding access to training, competencies for basic direct care worker functions and more advanced functions, and the impact direct care worker credentialing might have on quality of care and services. Based on findings from the focus groups, the Advisory Council will provide appropriate direction to the Curriculum Committee for future work related to curriculum development.

Identification of an Information Management System

The Iowa Direct Care Worker Advisory Council recognizes the importance of identifying and securing an information management system with the capacity to maintain and track direct care worker credentialing. Such a system must also interface in some manner with the Iowa Direct Care Worker Registry currently managed by the Iowa Department of Inspections and Appeals. While the Advisory Council has discussed the criteria of the ideal information management system, the Iowa Department of Public Health will take the lead in identifying the necessary system. The Advisory Council will provide guidance and feedback to the Department as it takes on this task.

Estimating the Direct Care Workforce in Iowa

Estimating the Iowa direct care workforce has remained a challenge for the Advisory Council since its inception. The nature of the direct care profession has made the workforce hard to quantify. Currently, the actual size of the direct care workforce in Iowa is unknown; multiple job classifications and titles have been identified, but no common tool exists to determine who direct care workers are, where they work, or what training they receive.

The fact that there currently is no comprehensive, reliable data on the workforce indicates the difficulty of the assignment. The scope of this task is significant and will likely require the hard work and diligence of Advisory Council members and issue experts to estimate the workforce as closely as possible. The legislature has set forth the expectation in House File 2526 that the Advisory Council estimate the number of direct care workers in Iowa prior to the establishment of a board in 2014. The Advisory Council will take up this task in the coming year.

House File 2526 provides clear guidance on the process by which the Advisory Council will undertake estimating the Iowa direct care workforce. HF 2526 advises the Advisory Council to

identify what workforce data is currently being collected and by whom, the gaps in existing data, and strategies to collect data necessary to fill those gaps. Estimating the workforce has been a significant priority of the Advisory Council since its beginning as the Iowa Direct Care Worker Task Force. With this guidance the membership will enthusiastically take on this task and lay a foundation for the successful implementation of further activities of the Advisory Council.

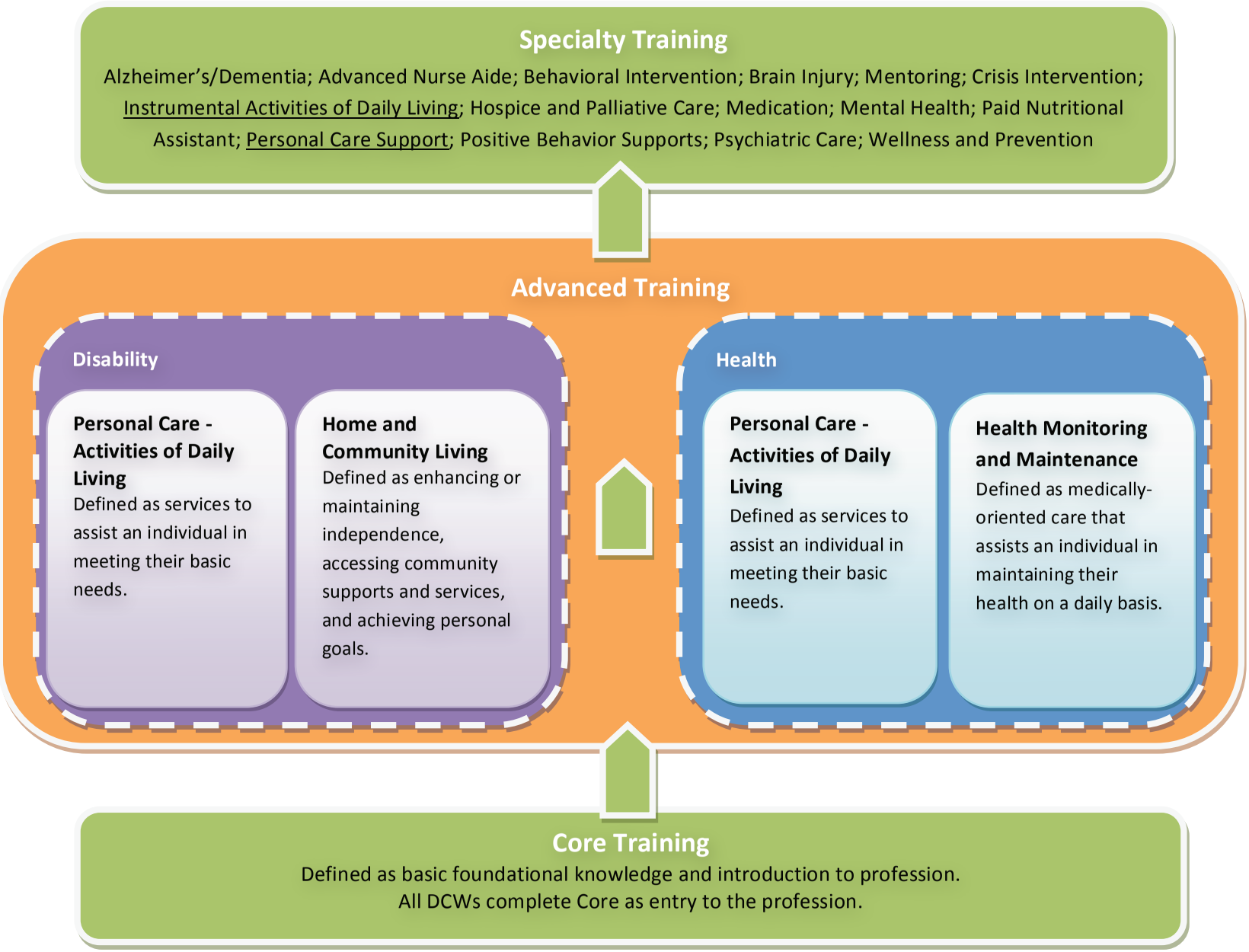
Conclusion

The Iowa Direct Care Worker Advisory Council is committed to improved direct care worker education and training because the Council recognizes the return on investment enhanced direct care worker education and training provides our health, support, and long-term care systems. Enhanced, more comprehensive training for direct care workers has been shown to improve job satisfaction and increase workers' sense of value, in turn increasing quality of care, retention, and recruitment of workers into the profession. These gains have far-reaching implications; direct care workers serve a wide range of consumers across all settings, including nursing homes, hospitals, intermediate care facilities, group homes, homes, and assisted living facilities. Enhancing training and education for this workforce would mean greater quality of care and services in all areas of health, support, and long-term care provision.

With the passage of House File 2526, the Iowa General Assembly has also recognized the important role of direct care workers and has set forth clear guidance on activities through 2014 to establish a board of direct care workers. Much work is necessary to meet this goal, including activities relating to a pilot, curriculum, an information management system, and stakeholder education and outreach. The Advisory Council has many challenges ahead as it builds the foundation for direct care worker credentialing in Iowa. A board of direct care workers is a goal long sought by the Advisory Council. Now a path has been cleared for realization of this goal and the hard work continues.

Appendix

Appendix 1: Current Direct Care Worker Credentialing Model


Specialty Training
Alzheimer's/Dementia; Advanced Nurse Aide; Behavioral Intervention; Brain Injury; Mentoring; Crisis Intervention; Instrumental Activities of Daily Living; Hospice and Palliative Care; Medication; Mental Health; Paid Nutritional Assistant; Personal Care Support; Positive Behavior Supports; Psychiatric Care; Wellness and Prevention
Advanced Training
Disability
Personal Care - Activities of Daily Living
Defined as services to assist an individual in meeting their basic needs.
Home and Community Living
Defined as enhancing or maintaining independence, accessing community supports and services, and achieving personal goals.
Health
Personal Care - Activities of Daily Living
Defined as services to assist an individual in meeting their basic needs.
Health Monitoring and Maintenance
Defined as medically-oriented care that assists an individual in maintaining their health on a daily basis.
Core Training
Defined as basic foundational knowledge and introduction to profession.
All DCWs complete Core as entry to the profession.

IOWA DIRECT CARE

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