IOWA DIRECT CARE ADVISORY COUNCIL

Interim Report to the Governor & General Assembly

FEBRUARY 2011

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Governor Branstad, Lt. Governor Reynolds, Members of the Iowa General Assembly, and Dr. Miller-Meeks,

Re: Interim report of the Iowa Direct Care Worker Advisory Council as required by HF 2526 (2010)

We in Iowa are fortunate to have state leadership that understands the critical role of direct care professionals in supporting the independence, daily living, and health of Iowans. We all have at some point, or will in the future, rely on the services and skills of direct care professionals for ourselves or someone we care about.

Much focus has been placed on job creation and sustainability to ensure economic recovery and long-term strength and prosperity of the state. Direct care professionals comprise the single largest profession in Iowa. Direct care jobs are here now, they are going unfilled, and they are also among the fastest growing and most in-demand jobs of the future. For all of these reasons, the Legislature, through changes in party leadership, administrations, and state agency administrators, have all recognized the need to address these issues and have charged diverse stakeholders represented on the Iowa Direct Care Worker Advisory Council with developing and implementing solutions.

The Advisory Council recognizes the challenge in committing state resources during difficult economic times. Members of the Council have dedicated considerable time deliberating and developing recommendations worthy of state investment and are pleased to submit this Interim Report. House File 2526, passed in 2010, outlines the charge for the Advisory Council, responsibilities to advise the Iowa Department of Public Health, and requests this report and a final report by March 2012.

The Council has addressed early legislative charges to identify issues, define the workforce, and determine training needs. This work has progressed to the point where the Council has developed career pathways, recommendations for curriculum content and competencies, and a strategic plan for implementation. Legislation has also directed the Advisory Council to pilot recommendations. The Advisory Council is pleased to report that the Iowa Department of Public Health was awarded a federal grant to conduct the pilot as a result of the Council's work, which is also a credit to the investment of the Iowa General Assembly. Iowa is one of just six states to be awarded such a grant to develop a national model for education and credentialing. The leadership and stakeholder expertise offered by the Council are more critical now than ever. We hope the state will see the value of continued investment based on both the need to address critical workforce issues, as well as the documented progress and success of the Council's work to date.

We hope this report will assist the Governor's Office, General Assembly, and the Iowa Department of Public Health in understanding workforce needs and implementing recommended solutions.

Sincerely,

Members of the Iowa Direct Care Worker Advisory Council

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The goal of the Advisory Council and recommendations are to ensure a stable, qualified, direct care workforce.

The Iowa Direct Care Worker Advisory Council has defined a direct care professional as an individual who provides supportive services and care to people experiencing illnesses or disabilities and receives compensation for such services. This definition excludes nurses, case managers, and social workers. Direct care workers are the front-line of Iowa's health, support, and long term care professionals, providing hands-on care and support to individuals of all ages and abilities in settings that range from services in home- and community-based settings to acute care in hospitals.

The Iowa Direct Care Worker Advisory Council is pleased to submit this interim report to the Governor and the Iowa General Assembly detailing progress to achieve their Legislative Charge and advise the Iowa Department of Public Health on implementation of education standards and credentialing for the direct care workforce in Iowa. This interim report represents documented progress and outcomes to address critical challenges that the state must address to ensure that all Iowans have access to qualified direct care professionals.

The Iowa Direct Care Worker Advisory Council, originally established as a Governor-appointed Task Force in 2006, has addressed numerous legislative charges over the years to identify issues, define the workforce, and determine training needs. This work has progressed to the point where the Council has developed career pathways, recommendations for curriculum content and competencies, and a strategic plan to pilot recommendations and complete an evaluation before statewide implementation.

THE NEED

The Advisory Council represents committed direct care professionals, educators, employers, and associations with diverse interests who find common ground in the need to address:

- **Critical projected workforce shortages.** Iowa is conservatively estimated to need 10,000 additional direct care professionals by 2016.
- **Dramatic job growth**. Direct care professionals represent two of Iowa's four fastest growing occupations. Over the period 2006 to 2016, home health aides are projected to grow by 43.2 percent, and personal and home care aides are projected to grow by 36.4 percent.
- **Increased demand for direct care services.** There was a 35.8 percent increase in Medicaid members receiving waiver services between 2005 and 2010. The state will experience ever-increasing demand as baby boomers age, placing critical stress on workforce capacity statewide and particularly in rural areas. Adequate capacity of this workforce to provide services in an individual's setting of choice is also essential to ensure that Iowa complies with the U.S. Supreme Court's Olmstead Decision.
- **Staggering turnover rates.** Employers report turnover in the range of 64 percent for certified nurse aides in Iowa, and, nationally, turnover for direct support professionals averages 52 percent. Employers are constantly trying to fill vacancies, which costs them millions of dollars statewide annually. Turnover impacts staff levels, continuity of services, and relationships with Iowans who utilize the essential services provided by direct care professionals.

PROGRESS

In 2010, House File 2526 provided a specific charge and planning activities for the Advisory Council through 2014. The General Assembly directed the Council to complete the following activities for which progress is summarized below and further detailed in the report.

- *Develop an estimate of the direct care workforce.* Based on data collection and analysis by the Advisory Council and Iowa Workforce Development, direct care professionals are the single largest workforce in the state. The Council conservatively estimates that there are 50,000 to 55,000 direct care professionals providing services in 2011. This number

significantly underestimates workforce size because there is no system in place to count and track the workforce, existing labor data may be missing a sizeable portion of workers providing services in home- and community-based settings, and because the estimate and projections are based on historical data, which do not account for anticipated increases in demand and shifts in service delivery from facility-based to home- and community-based models.

- *Report on the results of a pilot.* Legislation advised that recommendations be pilot-tested if resources were available, and the Council is pleased to report that the Iowa Department of Public Health secured a federal grant to conduct a three-year pilot. The grant was received as a result of state investment and stakeholder commitment of time and expertise to develop recommendations that place Iowa as one of just six states selected to develop a model for education and credentialing. Recruitment of participants and curriculum development for the pilot are already underway. Training of direct care professionals is set to begin in the fall of 2011. The Council hopes that this level of effort and outcomes are met with continued state support to advance implementation.
- *Report on activities for outreach and education.* The Council has successfully raised the visibility of the direct care profession and awareness of the critical workforce needs. The Council has actively undertaken outreach to stakeholders statewide by disseminating information, conducting focus groups, and delivering presentations. A long-term phased plan for outreach is in place to facilitate additional stakeholder input, participation, and support implementation of recommendations.
- *Recommend composition of the board of direct care workers and the elements of its work and credentials it will oversee.* The Council has developed career pathways to provide the opportunity for direct care professionals to grow, advance, and specialize. The pathways will: include unique credentials that reflect the services provided by direct care professionals and their role in the continuum of services delivered by the workforce; create a variety of opportunities for direct care professionals to access training and for employers to deliver training; and utilize existing state and national curriculum and best practices, as well as align with federal and state regulations.
- *Identify the information management system needs required to facilitate credentialing and estimate the cost for development and maintenance.* The Council has made recommendations regarding the capacity and functions of an information management system. Priorities include automating functions, streamlining workflows, and ease of use for initial and ongoing credentialing. Iowa Department of Public Health has selected a vendor whose system's capabilities meet the needs of the project and realizes efficiencies through sharing costs with other state boards and agencies.

NEXT STEPS

The Advisory Council has two areas of focus for upcoming work: fulfill the charge of HF 2526 by completing recommendations and providing the level of guidance and input necessary for Iowa Department of Public Health to establish the Board of Direct Care Professionals by 2014, culminating in a final report as directed in 2012; and provide critical stakeholder guidance and support to Iowa Department of Public Health as they pilot recommendations of the Council.

For more information about the Advisory Council and to access previous reports, please visit: www.idph.state.ia.us/hcr_committees/direct_care_workers.asp

WORKFORCE DATA

House File 2526 charges the Direct Care Worker Advisory Council to develop an estimate of the size of the direct care workforce. An estimate of the direct care workforce is presented alongside the rationale and narrative explanation of additional considerations to better understand and apply the estimate data to the work of the Direct Care Worker Advisory Council. Other related elements of the work to fulfill this requirement include identifying workforce data currently collected, entities collecting data, and gaps in existing data. Finally, since there are shortcomings in today's options for data gathering, recommendations to improve data collection methods are provided.

PRELIMINARY ESTIMATE OF THE DIRECT CARE WORKFORCE

The estimate of the number of direct care professionals (DCP) should be considered a preliminary estimate until such time that a method is developed and implemented that provides a comprehensive, unduplicated count of direct care professionals employed in the array of functions required to support people with a broad range of needs. No such method currently exists. However, there are known and verifiable data and qualitative sources that, when considered within the context of identified shortcomings, gaps, and impacts of expected trends, can help piece together an estimate of the number of direct care professionals.

There were an estimated 47,488 Iowa direct care professionals in 2009, the most recent year for which data are available. The remainder of this section provides additional information to fully understand the estimate, as well as the projected estimates through 2014 and the context in which data are gathered and direct care professionals work.

Occupational Title	Estimated Annual Employment Growth	2009 Estimate	2010 Estimate	2011 Estimate	2012 Estimate	2013 Estimate	2014 Estimate
Home Health Aides	4.3%	11,553	12,050	12,568	13,108	13,672	14,260
Nursing Aides, Orderlies, and Attendants	1.9%	23,566	24,014	24,470	24,935	25,409	25,892
Personal and Home Care Aides	4.0%	12,369	12,864	13,378	13,913	14,470	15,048
Total Estimated DCPs		**47,488**	**48,927**	**50,416**	**51,957**	**53,551**	**55,200**
Estimate - 10%		42,739	44,035	45,375	46,761	48,196	49,680
Estimate + 10%		52,237	53,820	55,458	57,152	58,906	60,720

Three occupations were identified as including the most comprehensive representation of direct care professionals in the workforce: Nursing Aides, Orderlies, and Attendants (NAOA), Home Health Aides (HHA), and Personal and Home Care Aides (PCA). These occupations are established by the United States Department of Labor Bureau of Labor Statistics (DOL BLS) 2000 Standard Occupational Classification (SOC) System and are used in workforce data collection in Iowa and nationwide. More detailed descriptions of these occupations are included in the *Methodology and Workforce Data Sources* section of this report.

The estimated annual employment growth rate is calculated by Iowa Workforce Development using 28 years of data to develop an industry growth model. This model is used to project the growth of each occupation within the industry. It is significant to note that the growth rates for home health aides and personal and home care aides are more than double that of nursing aides, orderlies, and attendants, which are primarily found in facility-based settings. This reflects the increasing attention to and demand for home- and community-based services. Later in this section, contextual information will show that these growth rates that are based on past experience may significantly underestimate the future demand.

Recognizing that these figures represent estimates, a margin of error of plus-or-minus 10 percent was also calculated to provide a reference point.

In 2010, direct care professionals are estimated to be 2.97 percent of the total workforce in Iowa, growing to an estimated 3.26 percent in 2014. This means that the growth in these occupations is greater than the rate of growth in the workforce as a whole.

CRITICAL CONTEXT

The estimated direct care workforce figures are taken from historical data and do not reflect the impact of demographic trends or accelerated demand for home- and community-based services. This section adds the critical context necessary to fully understand the estimates and their implications for training and credentialing direct care professionals. In short, there is a preponderance of evidence that, for a variety of reasons, shows the future years' growth rates of DCP occupations will increase significantly over the historical growth rates. These reasons include:

- Current DOL occupation lists have not evolved with the changing functions and job settings for DCPs, leaving some employees with no occupation that fits their type of job, and, therefore, unaccounted for as a DCP. Should those be updated to include additional occupations to reflect changes in the industry, the workforce numbers will show an increase.
- Demand for home- and community-based services is growing more rapidly than for facility-based services, and fewer systems exist for enumerating home- and community-based DCPs than for facility-based DCPs.
- Federally funded programs such as Money Follows the Person will add to this demand. Iowa's Money Follows the Person, funded through the Centers for Medicare and Medicaid and supporting the successful transition of individuals from institutional living to home- and community-based settings, is a major part of the state's long-term

systems transformation, dedicated to making a life in the community possible for everyone.

- U.S. Department of Justice-mandated implementation of the Olmstead Decision will also add to this demand. In the Olmstead Decision of 1999, the U.S. Supreme Court ruled it is unlawful to force individuals to live in institutions if they would be able to live in communities of their choice with the proper supports and services.
- Nationwide and in Iowa, direct care occupations are among the jobs in highest-demand for the future.
- The influx of aging baby boomers means an increase in the number of people needing services of DCPs for aging, disability, or health care supports.

The National Direct Service Workforce Resource Center reports that Occupational Employment Statistics (OES) program, which is part of the IWIN projections process in Iowa, produces useful workforce estimates for direct service occupations. The OES process is less useful for indirect service occupations, as the occupational definitions have not been updated to allow separation of DCPs providing direct and indirect services (*A Synthesis of Direct Service Workforce Demographics and Challenges across Intellectual/ Developmental Disabilities, Aging, Physical Disabilities, and Behavioral Health* Rep. National Direct Service Workforce Resource Center, Nov. 2008.). According to the Advisory Council, the outdated list of occupations excludes many DCPs because there are no appropriate occupations from which to select. The result may be that these preliminary workforce estimates are low.

Another factor indicating a higher actual number of DCPs is that there are no uniform requirements for reporting on the part of direct care professionals or their employers that would provide a consistent, long-term, reliable data source to enumerate DCPs. Home- and community-based services find DCPs employed directly by a person served or through a provider agency. In either instance, there are no systemic ways to track and count DCPs working independent from a reporting system. Likewise, there are no reporting requirements that would allow a count of DCPs working in home health and a variety of other settings.

Without a means of counting DCPs working outside facilities and directly for individuals, estimates and projections will lag behind the estimated numbers of DCPs. As an indication of the rapid growth in these services and workers, a recent evaluation of Iowa's Real Choices grant showed a 35.8 percent increase in Medicaid members receiving waiver services between 2005 and 2010, from 18,750 receiving one of seven waivers in 2005 to 25,478 in 2010. At the same time, Medicaid members receiving services in facilities declined 7 percent, from 27,546 in 2006 to 25,621 in 2010. (*CMS Real Choices Systems Transformation Grant: Final Evaluation Report*. Rep. Des Moines: State Public Policy Group, Inc., 2010. Print.) Shifts in where persons are served have a clear impact on where DCPs provide services, as well as whether DCPs are counted as part of the workforce.

According to the Paraprofessional Healthcare Institute (PHI), Iowa's direct care workforce was the second-largest occupational group, based on 2008 OES data and data on workers providing services directly to individuals. Advisory Council estimates for the workforce

using 2009 data from four sources, which are considered to be conservative but more comprehensive than other documented estimates, place direct care as the largest profession in Iowa. The table below illustrates the comparative size of Iowa's five largest occupational groups using PHI's data.

Iowa's Largest Occupational Groups in 2009

Occupation	Number
Retail Salespersons	48,550
Direct Care Workers	42,400
Teachers from Kindergarten to 12th Grade	40,410
Fast Food and Counter Workers	36,210
Registered Nurses	30,170

» Source: State Facts: *Iowa's Direct Care Workforce*. Issue brief. New York: Paraprofessional Healthcare Institute-PHI, 2009. Print.

PHI's research corroborates the observed shifts from the field in services for all populations in Iowa away from facility-based services to home- and community-based services. PHI further projects the increases in employment that will be brought about by these changes. Data provided are for the changes over the period 2006 to 2016.

Home- and Community-Based Jobs Growing the Fastest 2006–2016

Occupation	Percent change	Employment change
Home Health Aides	43.2%	4,300
Personal and Home Care Aides	36.4%	2,095
Nursing Aides, Orderlies, and Attendants	16.6%	3,610
All Direct Care Workers	26.7%	10,005

» Source: State Facts: *Iowa's Direct Care-Workforce*. Issue brief. New York: Paraprofessional Healthcare Institute-PHI, 2009. Print.

Finally, PHI notes Iowa's four fastest-growing occupations, two of which are direct care professional occupations. Over the period 2006 to 2016, home health aides are projected to grow by 43.2 percent, and personal and home care aides are projected to grow by 36.4 percent. These figures make a strong case for recognizing growth in DCPs that significantly exceed historical growth rates.

Fastest-Growing Occupations Generating the Most Jobs
2006–2016

Occupation	Percent change	Employment change
1. Home Health Aides	43.20%	4,300
2. Computer Software Engineers, Applications	42.90%	1,470
3. Personal & Home Care Aides	36.40%	2,095
4. Customer Service Reps	28.60%	6,860

» Source: State Facts: *Iowa's Direct Care-Workforce*. Issue brief. New York: Paraprofessional Healthcare Institute-PHI, 2009. Print.

The impact of the baby boomers reaching age 65 will also have an impact on the DCP workforce, creating an increased need for trained DCPs. The following chart reports the projected growth in the number of Iowans 65 and over between 2000 and 2030. While the number and percentages remain essentially static between 2000 and 2010, there is a projected 7.5 percent increase in Iowans 65 and over between 2010 and 2030.

Year	Number of Iowans 65+	Percent of Total Population of Iowans 65+
2000	436,213	14.9%
2010	449,887	14.9%
2030	663,186	22.4%

» Source: U.S. Census Bureau, Population Division, Population Projections Branch, April 2005.

A Woods & Pool Economics, Inc. study reports that at least 20 percent of the residents will be age 65 and over in 88 Iowa counties by 2030. In 2000, there were 30 counties. (*Older Iowans: 2010*. Issue brief. Des Moines: State Data Center of Iowa and Iowa Department on Aging, 2010. Print.)

145,277 Iowans age 65 and over (37.3 percent) have at least one type of disability, both physical and intellectual, according to 2008 data, and 37.3 percent of Iowa veterans age 65 and over have a disability. (*Older Iowans: 2010.* Issue brief. Des Moines: State Data Center of Iowa and Iowa Department on Aging, 2010. Print.)

Disability in Iowans 65 and Over	Number of Iowans
Hearing difficulty	60,957
Vision difficulty	24,940
Cognitive difficulty	28,200
Ambulatory difficulty	86,096
Self-care difficulty	27,977
Independent living difficulty	52,243

» Source: *Older Iowans: 2010*. Issue brief. Des Moines: State Data Center of Iowa and Iowa Department on Aging, 2010. Print.

The estimated number of direct care professionals established from the four data sources, described in detail in the *Methodology and Workforce Data Sources* section of the report, provides an important foundation for development of systems to support training, credentialing, and enumerating DCPs. The additional considerations described here underscore the recognition that these estimates may be low. Development and evolution of the functions and responsibilities of DCPs mean the occupational tracking systems have not kept pace with changes, resulting in undercounts of DCPs. The demand for expanded home- and community-based services both increases the number of DCPs providing specialized services individually or through an agency and makes them harder to count under the current systems. Other data show that DCPs are among the fastest-growing occupations, which will generate additional jobs. Finally, a significant increase in the numbers of Iowans over 65 creates additional opportunities for DCPs and creation of new jobs. These factors combine to add credence to the expectation that the rate of growth of DCP occupations will continue to accelerate significantly beyond the historical rates.

RECOMMENDATIONS TO IMPROVE WORKFORCE DATA COLLECTION

The most important improvement to DCP workforce data collection would be to establish a single, comprehensive, DCP-focused system that is easy to access and user-friendly. The Advisory Council recommends that an information management system, described in the *Information Management System* section of the report, would best serve the need if it includes the following characteristics:

- Is accessible via the Internet.
- Includes data on the array of DCPs in all functions and settings.
- Is managed by the Iowa Department of Public Health.
- Functions within Health Insurance Portability and Accountability Act (HIPAA) requirements.
- Links to other state data sources, such as the Certified Nurse Aide (CNA) Registry and Iowa Workforce Development data resources.
- Allows simple entry of data by DCPs.
- Allows employer access to certain data.
- Allows public access to certain data.
- Generates aggregate data on the DCP workforce.
- Aligns with other criteria and systems in other states and nationally for broader value.

A level of specificity can be added to this general overview of an Iowa data collection and management system by considering the long-term value and application of the information available to support informed policy decisions and planning. A useful source of additional insight into the value and implementation of an information management system is the 2009 white paper developed by the National Direct Service Workforce Resource Center, entitled *The Need for Monitoring the Long-Term Care Direct Service Workforce and Recommendations for Data Collection* (http://www.dswresourcecenter.org/tiki-download_file.

php?fileId=393). Of special interest to the Iowa direct care professional data collection, training, and credentialing initiative is information on the type of data to be gathered, the array of settings from which data would be available, and guidance on a minimum data set to provide decision-making value to stakeholders.

The National Direct Service Workforce Resource Center (NDSWRC) recommends that three data components are gathered:

- Workforce volume
  - Number of full-time workers
  - Number of part-time workers
- Workforce stability
  - Turnover rate
  - Vacancy rate
- Workforce compensation
  - Average hourly wage
  - Benefits (health insurance and paid time off)

The NDSWRC white paper also outlines the continuum of settings that should be included in a data gathering initiative. While the continuum closely resembles the types of settings discussed in the estimate of Iowa's DCP workforce, the array suggested provides a concise summary and organizational clarity as Iowa considers its next steps.

- Institutional Settings
  - Nursing facility and residential rehabilita¬tion
  - State operated institutions and large private institutions
- Home- and Community-Based Settings
  - Community Residential
    - 24-hour residential supports and services
  - Supports to Individuals and Families
    - Less than 24-hour residential supports and services
    - Home health care services
    - Personal care services (agency-directed)
  - Non-Residential Community Supports
    - Personal care services (consumer-directed)
    - Day programs and reha¬bilitative or medical supports
    - Job or vocational services

Advisory Council recommendations call for a information management system to be developed by IDPH and the Iowa Department of Administrative Services as an effective and efficient system of managing the eventual credentialing of the state's largest workforce. Incorporating necessary data collection into this system makes the greatest practical sense. The outcome will be comprehensive and accurate data about the number and

qualifications of direct care professionals that is necessary to meet Iowans' needs for a well-trained workforce in the rapidly expanding field.

METHODOLOGY AND WORKFORCE DATA SOURCES

Methodology to Calculate the Estimated DCP Workforce

Estimation planning began with two primary goals. The first goal was to define the direct care professional occupational group to be inclusive enough to include all stakeholder occupations but exclusive enough not to dilute the definition. The more difficult task was to exclude those occupations in which a preponderance of skills was not used for the direct care or support of persons served. Many occupations, i.e. housekeeper and life coach, could be included in a more loosely-defined direct care professional occupational group, but would also include skills not used in providing direct care services and supports. Other occupations were excluded from the grouping if they were already regulated and granted licensure or other credentials from another governing body. The list of occupations established by the U.S. Department of Labor (DOL), Bureau of Labor Statistics (BLS) was used as a base for determining which occupations would provide the most accurate occupational group. This list of occupations is commonly used in many surveys and data analyses. After careful review, three occupations were selected for estimation of the direct care professional workforce: Nursing Aides, Orderlies, and Attendants, Home Health Aides (HHA), and Personal and Home Care Aides (PCA).

The three occupations selected are defined as follows in the U.S. DOL BLS 2000 Standard Occupational Classification (SOC) System.

- Nursing Aides, Orderlies, and Attendants (NAOA) – Provide basic patient care under direction of nursing staff. Perform duties, such as feed, bathe, dress, groom, or move patients, or change linens.
- Home Health Aide (HHA) – Provide routine, personal health care, such as bathing, dressing, or grooming, to elderly, convalescent, or persons with disabilities in the home of individuals served or in a residential facility.
- Personal and Home Care Aides (PHCA) – Assist elderly or persons with disabilities with daily living activities at the person's home or in a daytime non-residential facility. Duties performed may include keeping house (making beds, doing laundry, washing dishes), preparing meals, implementing behavior plans, providing employment supports, and personal assistance, and advising on nutrition, cleanliness, and household needs.

The second goal in the planning phase was to find the most reliable source from which to estimate each of the occupations within the group. Known sources of direct care professional data were researched and evaluated as to their usefulness, completeness, availability, and other factors specific to the source. There were several sources available to estimate each of the three occupations. It was ultimately decided that four available sources would be used to arrive at an average of estimates. While the estimations from each source were statistically close to one another, there were several weaknesses inherent to each source that will be described later in this section.

Estimated Number of DCPs in Each Occupation by Data Source and Average of All Sources

Occupational Title	Projected 2009 Iowa Workforce Information Network	2009 Iowa Laborshed Survey	Extrapolated 2009 Bureau Labor Statistics with NAICS 62311	Extrapolated 2009 Bureau Labor Statistics with NAICS 622	2009 CDAC & CCO	Average 2009 Estimate
Home Health Aides	10,868	7,540	17,025	10,779	-	11,553
Nursing Aides, Orderlies, and Attendants	23,829	25,781	27,178	17,478	-	23,566
Personal and Home Care Aides	9,599	7,297	18,969	13,610	3,671	12,369

Total Estimated DCPs	47,488
Estimate - 10%	42,739
Estimate + 10%	52,237

Four Selected Estimation Sources

The Iowa Workforce Information Network (IWIN) at Iowa Workforce Development (IWD) produces the Iowa Occupational Projections data set every two years. Occupational projections are available for Iowa statewide and for each of the 15 workforce development regions separately. The projections provide detailed information on estimated employment, employment growth, and wages. The estimations are made from a large sample and are compiled from a sound methodology. Employment growth is projected out to 10 years. The disadvantage of the IWIN data is that the information may have a lag of up to two years, and the data for many occupations, especially at the regional level, are suppressed for reasons of confidentiality. The most recent employment estimates from IWIN (2008) show statewide employment of 10,420 Home Health Aides (HHA); 23,385 Nursing Aides, Orderlies, and Attendants (NAOA); and 5,700 Personal and Home Care Aides (PHCA). The estimated yearly employment growth rates of 4.3 percent, 1.9 percent, and 4.0 percent for HHAs, NAOAs, and PHCAs, respectively, are used to estimate 2010 employment of 11,335 HHAs, 24,282 NAOAs, and 6,165 PHCAs. These growth rates will also be used to estimate total employment out to the year 2014.

The Iowa Laborshed Study is a product of the Regional Research and Analysis Bureau within Iowa Workforce Development. The analysis is composed of 6,000 responses of individuals in the State of Iowa through a phone survey. The responses are extracted from the statewide Laborshed database of 35,100 surveys conducted in each zip code based on a random sample of the population ages 18 through 64. The survey is conducted yearly and has a significantly shorter time lag than other resources. The study shows a range of information including worker demographics, education levels, wages, occupation and occupational experience, commuting patterns, worker perceptions, and underemployment statistics. The disadvantage of the Laborshed Study is that it is a self-reporting survey.

Workers are asked to voluntarily give their job title and other information. These job titles must then be codified into standard occupational classifications for analysis. Some workers, otherwise classified as direct care professionals, may see themselves primarily engaged in another occupation and would thus report themselves as the unrelated job title. It is believed, however, that the extremely high survey response data diminishes this problem. Using 2009 data, multiplied by relevant projected growth rates, the Iowa Laborshed Study estimates 7,864 HHAs, 26,271 NAOAs, and 7,589 PHCAs.

The Bureau of Labor Statistics (BLS) provides estimates of employment distributions across industry and occupations through the National Employment Matrix. The source can be searched by one of 260 industries or 700 occupations and estimates the percentage of each occupation employed within each industry. These percentages are then combined with employment data by industry, also provided by the BLS, to estimate total employment within an occupation. For example, the matrix estimates that Nursing Aides, Orderlies, and Attendants make up 7.6 percent of the workforce in the hospitals sub-industry and that 29.4 percent of all NAOAs work within the sub-industry. If total employment within Hospitals is 67,368, then estimated NAOA employment is found by: (67,368*7.6%)/29.4% or 17,478. Using the relevant percentages yields an estimate of 10,779 HHAs, 17,478 NAOA s, and 9,940 PHCAs. The estimation was also done for the Nursing Facilities sub-industry resulting in 17,025 HHAs, 27,178 NAOAs, and 15,298 PHCAs. The disadvantage of this methodology is that the percentage estimates within the matrix can be very small, only 0.1 percent of the employment within hospitals is estimated to be PHCAs. This can result in less reliable estimates when trying to extrapolate total occupational employment.

Iowa Medicaid Enterprise (IME) gathered data in 2009 on the number of DCPs providing services under the Consumer Directed Attendant Care (CDAC) and the Consumer Choice Option (CCO) available to persons with disabilities and older Iowans receiving Medicaid support. The actual count by IME of these workers in 2009 was 3,671. It can be shown that these workers typically serve one person and are not included in the personal and home care aides occupational title. Thus, 3,671 was added to each of the estimated PHCA totals in the IWIN, the Iowa Laborshed Study, and the two BLS sub-industries data.

Estimates for each of the three occupations from each source, with the IME count added to the PHCA figures, were then averaged to find a final occupational estimate for 2009. The relevant historical employment growth rates were then used to find estimated employment out to 2014. The final estimation for 2010 employment within the direct care professional occupational group was 12,050 Home Health Aides, 24,014 Nursing Aides, Orderlies, and Attendants, and 12,864 Personal and Home Care Aides. These estimates yield a total occupational group of 48,927 workers in Iowa growing to about 55,200 by the year 2014. It should be noted that the employment growth projections do not account for changes in overall population demographics and higher demand for services; thus, estimated projected employment should be considered as a range instead of only a point estimate.

Other Current Workforce Data Sources

It is generally recognized that there are significant gaps in data about the direct care workforce in Iowa and nationally. This initiative found no available, comprehensive, unduplicated source of data for the number of direct support professionals in the workforce serving people with disabilities, those providing home health services in any setting, or practicing Certified Nurse Aides (CNA).

The four sources used to develop the DCP estimate for 2009 and projections for 2010 through 2014 described above were determined to be the most comprehensive and unduplicated, yet have also certain elements creating a degree of inaccuracy. With the exception of the Iowa Medicaid information on CDAC and CCO providers, they do not provide an individual count of direct care professionals in all types of jobs or settings.

Other data sources were considered and evaluated in this process. Each was found to be valuable in some way, but did not meet the criteria of an available, comprehensive, source for unduplicated data on the number of DCPs. Data sources that were explored included:

- Department of Inspections and Appeals: Certified Nurse Aide Registry
  As part of the responsibilities of the Iowa Department of Inspections and Appeals (DIA) to provide oversight and compliance with federal and state regulations for nursing homes and skilled nursing facilities, the Certified Nurse Aide Registry is part of ensuring that facilities are employing DCPs trained in accordance with federal regulations. The term "Certified Nurse Aide" or CNA is not the same as the BLS occupation title used to determine the DCP workforce estimate. CNA refers to the training required for an individual to pass a test in Iowa to receive the CNA designation making her/him eligible to work in a federally regulated facility. The CNA Registry maintained by DIA exists as a record of "eligible CNAs" working in the regulated facilities; this leaves a large gap in data collection for those individuals with the CNA training who do not work in those regulated facilities. The Registry is not a fully inclusive or exclusive set of data and could not be used alone to identify the number of CNAs working in Iowa. The Registry includes not only eligible CNAS who are working, but those who are not employed, who have not taken the test, as well as more than 13,000 in-state and out-of-state abusers. CNAs who have completed their coursework and the test frequently continue their education to become a registered nurse, meaning that the Registry includes individuals who are both CNAs and RNs. In October 2010, DIA and the Board of Nursing collaboratively cross-checked the two databases and identified 4,408 individuals carrying both credentials. The Registry, while valuable for many purposes, was not a good fit for purposes of generating the best estimates of the DCP workforce.
- Iowa Medicaid Enterprise: Waiver Provider Self-Assessment
  On an annual basis, Iowa Medicaid Enterprise (IME) requires all agency providers of Medicaid waiver services, under any of the seven waivers, to complete a self-assessment. In its current form, the self-assessment does not ask providers to include information about the number of full- and part-time DCPs employed or in what occupational category they fall. In discussions with IME, they are willing and interested in adding this request to their annual self-assessment. While it was not

possible to finalize and include in the 2010 assessment, which was distributed in September and due in November, the decision has been made to include these questions in future years. This would provide an important step in filling the data void for DCPs who provide services in home- and community-based settings, one of the major gaps in current data collected.

- Iowa Association of Community Providers: Member Employee Count
  The state association of disability services providers, the Iowa Association of Community Providers (IACP), gathers employment data from its members. However, two issues make these data incomplete. First, IACP only gathers data on total employment and does not break down the data according to job function to be able to identify how many of the total are DCPs. In the most recent survey, IACP found that the member disability providers reported a total of about 25,000 individuals employed in their agencies; a majority of those are believed to be DCPs, but a count was not available. The second issue with the IACP provider data is that not all providers are members of the association, meaning that the data is not inclusive of all providers employing DCPs in those functions. A related shortcoming of this data source is that it is unknown how many of these employees are represented in the BLS occupations because of the lag in updating the list of BLS occupations to reflect changes in the DCP workforce. While this is valuable information, the IACP Member Employee Count data is not comprehensive or unduplicated for DCPs providing supports and services for people with disabilities in the array of home- and community-based settings.

Other sources of data included national organizations and studies. Again, while some of those were helpful, such as the PHI data cited earlier, none provided the current and unduplicated, comprehensive focus on Iowa's DCP workforce necessary to meet the requirements of HF 2526.

INFORMATION MANAGEMENT SYSTEM

HF 2526 charged the Direct Care Worker Advisory Council with identifying the information management system required to facilitate credentialing of direct care workers and estimating the costs of development and maintenance of the system. The Advisory Council's work related to grandfathering and recommendations for career pathways and credentialing have set the expectations for the functions of the IT system. The system is expected to interface with multiple internal and external stakeholders and credential and track a workforce by 2014. Therefore, the information management system must be capable of automating many functions and streamlining workflows. IDPH has worked closely with the Iowa Department of Administrative Services (DAS) to identify the best contractor for development of a system that can manage complex business decisions and provide a user-friendly web presence for the various stakeholders that will use the system.

CSDC, a vendor with an existing state contract through DAS, presented their customizable credentialing software to the Council. CSDC has established service agreements with several other professional boards in Iowa, including the Dental Board, Board of Nursing, Pharmacy Board, the 19 boards operated by IDPH's Bureau of Professional Licensure and 8 boards operated by Commerce's Professional Licensing Bureau. In addition, Iowa Workforce Development and Iowa Department of Commerce have selected CSDC's software, with more state agencies expected to migrate to the system. IDPH intends to develop a service agreement with CSDC because the system's capabilities meet the needs of the project and because of the efficiencies realized through sharing costs with other Boards and agencies.

SYSTEM FUNCTIONS AND CAPABILITIES

IDPH, DAS, and CSDC have completed a scoping analysis for the software and identified initial primary software functions. The customizable software provided by CSDC is known as AMANDA (Automated Management and Data Analysis). As part of the service agreement with CSDC, IDPH will purchase AMANDA licenses and CSDC will create a unique public access portal and workflow for direct care workforce credentialing. CSDC and DAS will provide analysis, design, configuration, testing, and training of the software, and DAS will provide ongoing maintenance and hosting for the system.

Recommendations of the Advisory Council are the basis for expectations for IT system components and functions. The Advisory Council will support IDPH throughout IT system development to ensure the system is consistent with recommendations and address stakeholder needs and other considerations.

Main system components will include:

- Multiple users – including direct care professionals, employers, instructors, IDPH, and the Board of DCPs.
- Interface with other systems – The system will explore opportunities to interface with the federally-required Direct Care Worker Registry operated by the Department of Inspections and Appeals to eliminate duplication and ensure seamless public

information exchange. The system will also seek to interface with learning management systems offering approved curriculum.

- Credentialing – DCPs will input required information (under data collection below) and the system will generate certificates. Credentials will include:
  - Certified Direct Care Associate
  - Advanced Certified Community Living Professional
  - Advanced Certified Personal Support Professional
  - Advanced Certified Health Support Professional
  - Specialty Endorsements
- Data collection – the IT system will provide data about the direct care workforce that is not currently available. The data will assist the IDPH, Iowa Workforce Development, and other state agencies in making projections about workforce trends and demand. The Council, through its work and that of the workforce data committee, has recommended data collection that aligns with what is collected by other professional boards. Data will include:
  - Demographics
  - Criminal history
  - Education
  - Employment
  - Additional information, including formal education, race/ethnicity, languages spoken, employment status, practice setting, type of position, wage/salary, and career plans
- Grandfathering – existing DCPs who are currently working or have worked in the field within the previous five years will be eligible to report their experience and employment to receive a credential. Grandfathering will be conducted online and will include:
  - General information, including demographics, criminal history, experience, education, and employment history
  - Reporting of functions performed – upon selecting checkboxes of functions, the system will automatically determine eligibility for a credential (and type of credential)
  - Additional data collection, including formal education, race/ethnicity, employment status, and wage/salary information
  - System-generated recommendations for continuing education based on responses
- Maintenance of Certification
  - DCPs will renew their certificate(s) every two years
  - Random auditing will ensure compliance with continuing education requirements; the IT system will conduct the random sorting and assign staff responsibilities for the audits

TIMELINE

CSDC estimates that it will take approximately 10 months from initial start of the project until the IT system "goes live." Services during the 10-month project period include project

management; software installation; business rules analysis and design; business rules configuration; development of forms, documents, and reports; public portal analysis and configuration; data conversation analysis; system testing; and staff training.

COSTS

Total costs for software, implementation, and training for the new information management system are estimated to be $280,000. This estimate was provided by CDSC based on a scoping meeting with IDPH and other stakeholders, where Advisory Council recommendations for system capacity and functions were presented and discussed. The table below provides a breakdown of system costs.

Product/Service	Cost
AMANDA Software	$40,000
Implementation Services	$230,000
Training Services	$10,000
Total	**$280,000**

CSDC will provide new software and utilize the existing software already purchased by the State for other licensing and regulatory functions. CSDC will provide implementation services consisting of project management, software installation, analysis, design, configuration, testing, training and “go live” support. CSDC will also provide training services, utilizing a train-the-trainer model, to enable DAS Information Technology Enterprise (ITE) staff to support the system once it is implemented. In addition to the costs estimated above, the system will require ongoing annual hosting and maintenance conducted by DAS ITE at a cost of approximately $19,000 per year.

Financing for the information management system will be provided by a combination of federal grant funding and, upon successful application, by the State of Iowa IOWAccess Revolving Fund. This IOWAccess Revolving Fund provides start-up support for applications that provide citizens with ready online access to State data and services.

PILOT PROJECT

As a result of state investment and Advisory Council member commitment of time and expertise to develop recommendations, the Iowa Department of Public Health was awarded a $2,244,000 federal grant from the Health Resources and Services Administration (HRSA) – the Personal and Home Care Aide State Training Grant – to conduct a three-year pilot of the recommendations developed by the Advisory Council. This grant places Iowa as one of just six states selected to develop a model for education and credentialing. The pilot will allow IDPH to test recommendations and make necessary changes before implementing any training or credentialing activities statewide. This project is providing the funding needed for Iowa to realize the goal of developing a direct care training and credentialing system that is nationally recognized, provides responsive and flexible training, promotes the highest quality of care, and develops career pathways to professionalize the direct care workforce in Iowa.

Specifically, the grant will pilot the recommendations for a portion of the direct care workforce, home health aides and personal and home care aides. Iowa's project will target two geographic regions in the state, one urban and one rural. The sample of direct care professionals participating in the pilot project will work in a variety of settings, including homes, intermediate care facilities, residential care facilities, supported employment, assisted living programs, and adult day programs. Direct care professionals participating in the project will provide services and supports to individuals with disabilities, individuals who are aging, and individuals with health conditions. To best measure the impact of the proposed training and credentialing process, the project will seek full-time, part-time, new, and incumbent workers to participate. Project participants will receive an interim credential to be fully recognized by the state when the credentialing system is implemented statewide. The information management system needed for credentialing and tracking the workforce will be developed with partial funding from the grant.

PILOT ACTIVITIES

The major activities of the pilot project include curriculum development, training of direct care professionals, retention and mentoring supports for direct care professionals, pilot credentialing, and evaluation. Further detail about pilot project activities is provided below. Individuals and agencies participating in the pilot project will promote and participate in the training modules and seek associated credentials; collect data and participate in evaluation activities; and engage in direct care professional retention activities, leadership training, and a mentoring program. Pilot training is expected to begin in October 2011, testing two types of training: face to face and web-based.

- Curriculum Development – a Curriculum Work Group will develop standard and competency-based modules of curriculum. Standard curriculum modules are defined as a single approved curriculum. Only that standard curriculum is approved for receiving applicable credentials. Competency-based curriculum refers to knowledge, skills, and attitudes each worker will achieve with identified goals, objectives, and outcomes. These components will be used to evaluate curriculum submitted for approval and establish their eligibility for associated credentials. (Refer to description

of curriculum in the Governance section of this report.) Four modules will be developed by the Curriculum Work Group:

- Instrumental Activities of Daily Living (competency-based curriculum)
- Personal Support (competency-based curriculum)
- Home and Community Living (competency-based curriculum)
- Personal Care Activities of Daily Living (standard curriculum)

Note: the Health Monitoring and Maintenance module outlined in the career pathways is not being developed or piloted as part of this project. However, direct care professionals that currently provide Health Monitoring and Maintenance services and support may be eligible to take other modules or continuing education through the pilot.

- Training of Direct Care Professionals (DCPs) – Core Training (a standard curriculum consisting of approximately six hours of initial training) and the four modules outlined above will be offered to participating direct care professionals. DCPs will be encouraged to select modules to enable them to receive one or both of the credentials being piloted: the Personal Support Professional and Community Living Professional (described in more detail below under "Pilot Credentialing"). Instructors of standard and competency-based modules will be located within participating provider agencies or educational institutions. The project aims to train at least 800 DCPs by the end of the pilot.
- Retention and Mentoring Support of Direct Care Professionals – The direct care profession is plagued by high turnover rates, particularly within the first 30 to 90 days of employment. This project will target initially-employed DCPs to identify and respond to issues that arise early in employment with the goal of improving retention of existing workers in the field. A mentor training will be available to employers and direct care professionals to assist in developing mentor programs within employment settings and to train DCP mentors. Additional leadership training opportunities will be offered to participating DCPs. Supervisors may also utilize mentoring available through the web-based training system called the College of Direct Support.
- Pilot Credentialing – Since the Board of Direct Care Professionals has not yet been established, the Department will issue interim credentials during the pilot project. The Department will also pilot the Council recommendations regarding a process for granting current DCPs credentials that recognize their education and experience, also known as "grandfathering." This process will take place during the third year of the project, and current DCPs in the pilot regions will be encouraged to submit their experience and education/training online through the information management system being developed and be issued applicable interim credentials.
- Evaluation – Measuring the impact of the training and credentialing on service delivery, quality of care, customer satisfaction, and turnover rates is essential for determining success and identifying changes that might be necessary before implementing a statewide system. Pilot project individuals and organizations will participate in evaluation activities, including but not limited to quantitative data collection, interviews, surveys, and focus groups. Comparison group regions will be identified, and participating sites will collect and report specific data elements for purposes of the evaluation.

PILOT TIMELINE

Estimated timeline of key activities that implement and build on the work of the Advisory Council:

January 24, 2011	Issue Request for Proposal (RFP) in the two regions selected for the pilot
April 1, 2011	Finalize contracts with participating pilot sites
June 1, 2011	Establish baseline data collection
October 1, 2011	Finalize curriculum and begin training
June 2012	Begin pilot grandfathering
October 2013	Completion of grant; sustainability plan in place
July 1, 2014	Establish Board of Direct Care Professionals

ONGOING ROLE OF THE DIRECT CARE WORKER ADVISORY COUNCIL

The Advisory Council's ongoing work and activities will be instrumental to IDPH's ability to implement the pilot project. The Council will also provide guidance regarding Board composition and responsibilities and authority, as well as the credentialing process for new and existing workers. Direct care professionals who are members of the Council will review applications from direct care professionals to participate in the Educational Review Committee. In addition, the Council will play a critical role providing ongoing feedback as outcomes from the evaluation better inform previous recommendations.

OUTREACH AND EDUCATION ACTIVITIES

House File 2526 charges the Direct Care Worker Advisory Council with conducting an education and outreach campaign with direct care professionals and other stakeholders regarding strategies to increase the professionalism and stability, and meet the training needs of the workforce. In completing this charge, the Direct Care Worker Advisory Council benefits from its committed, diverse membership who provide broad perspectives on issues and offer direct links to professional organizations and peer groups as diverse as the members themselves, including employers, direct care professionals, and advocates. The commitment of Advisory Council members is reflected in their continued diligence to seek and use stakeholder input throughout the process of developing and implementing recommendations. For the purpose of outreach and ease of stakeholder understanding, activities related to Advisory Council recommendations and the pilot are known as the Iowa Direct Care Workforce Initiative.

Over the past year, the outreach and education activities of the Advisory Council have expanded in scope and delivery. In 2010, the Advisory Council undertook a series of focus groups with four unique but equally important stakeholder groups: direct care professionals, employers of direct care professionals, consumers of direct care services and support, and families of consumers. The goal of the focus groups was to gather information from stakeholders regarding the essential qualities and skills of DCPs, training needs, preferences for training delivery, and perspectives on credentialing the workforce. The information is actively being used to support curriculum development, planning for the pilot, and development of recommendations. The following themes are reflective of the valuable information collected from the focus groups.

- Participants cited the need for direct care professionals to possess the qualities and skills of compassion, competence, effective communication, integrity, and flexibility. One employer mentioned her organization “looks for honesty and those who care.”
- Participants believed a system for training and credentialing direct care professionals will be beneficial – as long as it is done in the right way. One participant noted, “The opportunity [presented by a credentialing system for direct care professionals] outweighs the threats.”
- The issue of public safety related to work history, experience, references, background checks, and credentials was important to all participants. It was noted by one participant that, “There is a need for consistency in trusting workers in homes; they must be dependable and honest workers.”
- Direct care professionals and employers stated that mentoring and realistic exposure to work environments best enable workers to be successful. A participant noted that, currently, “There is not enough in-home training.”
- Participants identified quality of care as “emotional well-being [of the person served], dignity, and respect, and recognizing that you are caring for an individual and not just another client;” and “giving the person what they want where they want, while anticipating their needs.”

The information provided by the focus groups encouraged Advisory Council members that their recommendations effectively reflected the opinions and needs of a wide variety of stakeholders likely to be impacted by the credentialing system, but that it was still critical to continue to engage external stakeholders in their discussions.

The Advisory Council's plan for outreach and education activities is organized in three phases. The first phase of foundational outreach would be ongoing throughout the timeline of activities; the second phase represents pilot recruitment, implementation, and evaluation activities; and the third, final phase would occur upon implementation of the new credentialing system following the establishment of the Board of Direct Care Professionals by July 2014.

The Advisory Council is undertaking significant stakeholder outreach and public education. It has evolved from a Task Force to Advisory Council that is developing, guiding, and testing a future credentialing system, working toward a Board of Direct Care Professionals in 2014. Outreach supports this work through creating products and plans for broad statewide dissemination. This section provides timelines, goals, strategies, and activities for each phase identified by the Advisory Council to guide their work.

PHASED PLAN FOR STAKEHOLDER OUTREACH AND PUBLIC EDUCATION

Phase 1: Foundational Outreach

Timeline: Ongoing

Goal: Improve stakeholder knowledge of direct care and build support for systems change.

Strategies:

1) Define the workforce
2) Improve awareness of direct care and growing demand
3) Communicate the need for a consistent system of direct care professional education and training

Activities: Outreach has always been a priority of the Advisory Council and a very important element of all Advisory Council discussions and recommendations. Each Advisory Council member is expected to collect input from and share information with their respective organizations and peer groups so the discussions of the group incorporate diverse perspectives and information is widely disseminated. When especially difficult and high-impact decisions are discussed, Council Members take the initiative to go back to their organizations and peer groups to collect input that may influence later discussions.

An important discussion of the Advisory Council was establishing an umbrella name for the workforce. Taking comments from the focus groups and the perspectives voiced in the committee, the title of "direct care professional" or DCP has been established with the following rationale.

- The word Direct is used because the workforce is the front line of service delivery for consumer support and health services. The workforce is characterized by its direct delivery of services and the depth of the relationships with persons served.
- The word Care is used to describe some of the most important attributes of the workforce – compassion and a sense of commitment and caring about the job they are performing, and the importance of their role in the lives of persons served.

- The word Professional is used to demonstrate the value of the workforce in the continuum of support and health services, to unify a fragmented workforce, and to articulate direct care as a profession with career pathways. The word Professional also signifies that an individual has demonstrated the educational standards, ethics, and competencies recognized by their peers and persons served.

The recommended career pathways described in the Governance section of this report outline unique titles for credentialed workers according the services they provide and their specific skills.

The work in Phase 1 is ongoing. Many of the activities developed for purposes of pilot recruitment and information sharing have also been utilized to meet foundational goals such as defining the workforce and increasing awareness of direct care services and supports. For instance, the Direct Care Workforce Initiative's Facebook page offers a venue to share statistics and other information on the workforce, not just the pilot. Additionally, currently the pilot shares a website with the Direct Care Advisory Council, reflecting their interrelationship and also their unique goals and audiences.

Phase 2: Iowa Direct Care Workforce Initiative (PHCAST Pilot) Implementation

Timeline: October 2010 – July 2014

Goal: Pilot recruitment, implementation, and evaluation

Strategies:

1) Communicate the purpose and activities of the pilot and how to participate
2) Portray Iowa as a national leader in direct care professional education and training
3) Encourage direct care professional leadership
4) Communicate successful components of tested system
5) Communicate lessons learned with stakeholders and corresponding response

Activities: The Advisory Council plays a critical role in pilot outreach. In close consultation with the Iowa Department of Public Health, the Direct Care Worker Advisory Council has developed branding for the pilot, the "Iowa Direct Care Workforce Initiative," that would portray the effort as a national model and align the initiative with the DCP, direct care professional, branding.

Outreach was started quickly upon receiving confirmation of the HRSA award to the Iowa Department of Public Health. As mentioned previously, all activities undertaken to meet Phase 2 goals are also viewed by the Advisory Council as an opportunity to share foundational information such as defining the workforce and increasing awareness of direct care services and supports. The Advisory Council began disseminating a bi-weekly e-update to interested individuals. The e-updates encourage recipients to forward the information and for others to sign up to receive updates. This database of individuals has grown exponentially since the first e-update in November 2010.

Two webinars hosted by the Iowa Department of Public Health provided interested individuals information on participating in the pilot and an overview of Advisory Council recommendations. Direct care professionals are being encouraged to apply for participation

on the Direct Care Educational Review Committee. Committee membership will mirror the Council's recommendation for composition of the board and members will assist with curriculum development and review. Outreach has also been targeted to potential training providers in all regions of the state to submit information regarding their interest in participating in pilot activities. Advisory Council members have been committed to disseminating the Request for Information release by IDPH and continue to reach out to potential applicants.

Additional activities will continue to evolve as the pilot moves forward in implementation. It will be important for the Advisory Council, in partnership with the Iowa Department of Public Health, to share successes with stakeholders, as well as recognize areas for improvement and adjustment of recommendations on the part of the Advisory Council. It is also expected that as technological capabilities are enhanced through the information management system, more information regarding credentialing recommendations will be accessible online.

One important goal of the pilot is to develop leadership and engage strong participation among direct care professionals through a regional team structure. Still in the development phase, these leadership teams would, ideally, be resources for other professionals and providers in their area. The strengthening of this structure would be valuable as the Board of Direct Care Professionals is institutionalized, grandfathering occurs, and the new system is in full implementation. These leadership teams will be key in disseminating information across the state and ensuring that DCPs are leaders in establishing and ultimately overseeing credentialing.

Phase 3: Establish the Board of Direct Care Professionals and System Grandfathering

Timeline: July 2014 – completion of grandfathering

Goal: Implementation of statewide system for credentialing of direct care professionals

Strategies:

1) Publicize the establishment of the Board of Direct Care Professionals to provide leadership and oversight of newly established credentialing system
2) Utilize the leadership council structure to disseminate information directly to direct care professionals about expectations under new credentialing system (peer-to-peer outreach)
3) Inform all pertinent stakeholders of regional opportunities for training, continuing education, and specialty endorsements
4) Broadly inform the public of new expectations for direct care professionals

Activities: Activities for this phase are currently being planned, but the Advisory Council recognizes that upon implementation of the new system of credentialing, capacity must exist to answer the inevitable questions, undertake the process of grandfathering, and implement the new credentialing system.

GOVERNANCE

House File 2526 called for the establishment of a Board of Direct Care Workers within the Iowa Department of Public Health by July 1, 2014, and charged the Direct Care Worker Advisory Council with making recommendations regarding credentialing of the workforce. The Advisory Council has completed recommendations for several major components addressed in the legislation. Specifically, recommendations are included related to the following elements of governance for this Interim Report.

- The role and composition of the Board of Direct Care Workers
- The definitions of and categories for credentialing direct care workers
- The form of credentialing to be used

The Advisory Council recommendations are meant to achieve two core principles: Credentialing will be led by direct care professionals through a professional board; and direct care professionals will have access to career pathways within the profession to allow them to grow, advance, and specialize.

BOARD COMPOSITION AND AUTHORITY

The General Assembly has determined that the board of direct care workers be established within the Iowa Department of Public Health. This is consistent with previous recommendations of the Advisory Council and will create efficiencies in both operations and credentialing expertise as IDPH currently operates a majority of state licensing and certification boards. IDPH is also responsible for coordinating public and private efforts to develop and maintain an appropriate health care delivery infrastructure and a stable, well-qualified, and diverse health care workforce. Direct care professionals are the largest component of this workforce and provide an estimated 70 to 80 percent of hands-on services to individuals who are aging or experiencing disabilities. The Direct Care Worker Advisory Council represents a true partnership among public, private, and nonprofit organizations and has brought together direct care professionals, employers/providers, educators, and advocates to develop solutions for critical, shared, workforce needs. This stakeholder partnership will provide a foundation for establishing and transitioning to a credentialing board.

The Advisory Council recommends that the board be known as the Iowa Board of Direct Care Professionals, and be composed of 9 members consisting of 5 direct care professionals—3 representing different categories of credentials and 2 to provide additional balance among settings and populations served — 2 members of the public, 1 registered nurse who serves as a direct care professional instructor, and 1 human services professional. The 9-member board will be appointed by the Governor and will be given the authority, in legislation, to credential direct care professionals in Iowa. The Board will work closely with IDPH and other partners, including the Department of Inspections and Appeals, to accomplish its role. Among the early responsibilities of the Board will be administrative rulemaking to guide credentialing, adoption of competencies/curriculum, and adoption of recommended standards and qualifications for instructors.

CAREER PATHWAYS

The Direct Care Worker Advisory Council recommends the development of career pathways for direct care professionals. Career pathways consist of a series of educational and training options that would enable direct care professionals to grow and advance over time to more specialized education and employment in the profession. Direct care has historically been considered an entry level position in health, support, and long-term care services; therefore, career pathways have been developed to move individuals out of direct care to what are considered more advanced positions in areas such as nursing or social work. Because direct care is the largest single profession in the state and consistently ranks among the fastest-growing and high-demand occupations, it is essential that the profession attract new workers and retain current direct care professionals. Career pathways will provide direct care professionals the opportunity to direct their career according to their interests, growth areas, advancement, and specialization according to the needs of the individual(s) served.

Career pathways will consist of Core, Advanced, and Specialty Training. The Iowa Board of Direct Care Professionals will issue credentials to individuals who have completed training and have demonstrated competency in those areas. Iowa direct care professionals will have the opportunity to obtain three types of credentials – Certification, Advanced Certification, and Specialty Endorsements, which are described in detail in the *Career Pathways Chart*.

Key considerations of the Advisory Council in developing the career pathways included:

- Developing unique credentials that accurately reflect the services provided by the DCP to individuals served and their role in the continuum of services delivered by the workforce.
- Creating a variety of opportunities for DCPs to access training and for employers to deliver training. The Council anticipates that training will be delivered directly by employers, accessed by DCPs outside of employment, and offered by educational providers including community colleges.
- Utilizing existing state and national curriculum and best practices, as well as aligning with federal and state regulations to ensure diverse requirements are met.

How Credentialing will be Applied

The Direct Care Worker Advisory Council recommends that credentialing be applied in much the same manner as current practice to ensure that recommendations do not result in unintended outcomes. Completion of the Core Training, which is foundational and introductory to the profession, will be a new component for the entire workforce. Additional training requirements will be applied according to existing state and federal regulation established by setting of service delivery.

- The Core Training and resulting certification will be required for all direct care professionals according to established definitions. Individuals providing services considered direct care only to family or one individual would be exempt from requirements.

- Requirements for Advanced Training and associated credentials will be determined based on existing provider/facility regulations.
- Advanced Training will be optional for all other workers in provider settings/facilities where training regulations do not exist.
- Worker credentials will be tracked through an information management system that will provide worker, employer, and public interfaces. Details regarding this system are outlined in detail in the *Information Management System* section of this report.
- Education and training completed by direct care professionals will be based on state-recognized competences and will be portable, avoiding duplication when DCPs change employment.
- Current direct care professionals will be grandfathered into the credentialing system based on experience and skills. The Council is currently working on detailed recommendations for grandfathering, which will be provided to the Governor and General Assembly in their final report per requirements of HF 2526. Grandfathering will be a component of the pilot, which is described in detail in the Pilot Project section of this report.
- Direct care professionals may hold multiple credentials. For example, a DCP may have multiple certifications in advanced training areas and may have one or more specialty endorsements.

DIRECT CARE
WORKFORCE INITIATIVE

DIRECT CARE PROFESSIONAL CAREER PATHWAYS

SPECIALTY ENDORSEMENTS

Autism, Alzheimer's/Dementia, Advanced Nurse Aide, Brain Injury, Crisis Intervention, Hospice & Palliative Care, Medication Aide, Medication Manager, Mental Health, Mentoring, Positive Behavior Supports, Paid Nutritional Assistant, Psychiatric Care, Rehab Aide, Wellness & Prevention

Specialty Endorsements will be developed by experts in those subject or professional areas and approved by the Iowa Board of Direct Care Professionals. Specialty Endorsements currently have or may have unique regulatory requirements.

Optional education open to all Certified Direct Care Associates. Some Endorsements may be required for workers based on regulations for those specialties.

Requirements: Active Certification status.

Credential Received: Endorsement

Continuing Education: Determined separately for each Endorsement. Continuing education completed for a specialty will count toward hours to maintain Certification or Advanced Certifications.

Title: Determined separately for each Endorsement.

CORE TRAINING CORE

Direct Care Associate

Basic foundational knowledge and introduction to profession.

Required for all direct care workers, except individuals providing services only to family or one individual.

Requirements: Must meet minimum age for employment and pass a background check to be employed.

Credential Received: Certification; must be renewed every two years

Continuing Education: 6 hours every two years

Title: Direct Care Associate

ADVANCED TRAINING MODULES

HCL — Home & Community Living

Services to enhance or maintain independence, access community supports and services, and achieve personal goals.

IADL — Instrumental Activities of Daily Living

Services to assist an individual with daily living tasks to function independently in a home or community setting.

PS — Personal Support

Services to support individuals as they perform personal activities of daily living.

PADL — Personal Activities of Daily Living

Services to assist an individual in meeting their basic needs.

HMM — Health Monitoring & Maintenance

Medically-oriented services to address health needs and maintaining health.

ADVANCED TRAINING CREDENTIALS

Community Living Professional

Optional education open to all Certified Direct Care Associates.

Requirements: CORE + HCL + IADL + PS + active Certification status
Credential Received: Advanced Certification; must be renewed every two years
Continuing Education: 20 hours every two years
Title: Community Living Professional (CLP)

Personal Support Professional

Optional education open to all Certified Direct Care Associates.

Requirements: CORE + PS + PADL + active Certification status
Credential Received: Advanced Certification; must be renewed every two years
Continuing Education: 20 hours every two years
Title: Personal Support Professional (PSP)

Health Support Professional

Optional education open to all Certified Direct Care Associates . Certification is required for individuals performing health support functions in nursing facilities and home health/care agencies.

Requirements: CORE + HMM + PADL + active Certification status
Credential Received: Advanced Certification; must be renewed every two years
Continuing Education: 20 hours every two years
Title: Health Support Professional (HSP)

Core Training

- Who Completes: Required for all direct care professionals, except individuals providing services only to family or one individual.
- Requirements: Individuals will be informed of minimum age requirements for employment in different settings of service delivery and will also be made aware of requirements for background checks to be eligible for employment.
- Credential Received: Certification; must be renewed every two years.
- Continuing Education: 6 hours every two years.
- Title: Direct Care Associate.

All direct care professionals must complete the Core before the start of work. Some elements of the Core will be recommended for use by employers during the pilot as a job preview based on national best practices related to recruitment and retention. The Core is estimated to be approximately six hours of training. The Core will be a standard curriculum. Units of the Core Training will be available in multiple formats, including online.

Advanced Training Career Pathways

Advanced Training will be delivered through five training modules that reflect the major functions and continuum of services delivered by direct care professionals. Modules will be grouped into three credentials: Community Living, Personal Support, and Health Support.

Advanced Training modules will consist of two types: competency-based modules, where multiple curricula are approved by the Board of Direct Care Professionals, and standard modules, where only one curriculum will be approved by the Board. Health Monitoring and Maintenance and Personal Activities of Daily Living training modules will be standard for consistency with current practice and to meet federal requirements associated with training for Certified Nurse Aides. Home and Community Living, Instrumental Activities of Daily Living, and Personal Support training modules will be approved based on criteria outlined in the *Criteria for Curriculum Approval* section below. The approach will be tested and evaluated in the pilot.

Available Advanced Training Modules:

- Home and Community Living (multiple approved curricula based on established competencies and criteria)
- Instrumental Activities of Daily Living (multiple approved curricula based on established competencies and criteria)
- Personal Activities of Daily Living (standard curriculum)
- Personal Support (multiple approved curricula based on established competencies and criteria)
- Health Monitoring and Maintenance (standard curriculum)

Community Living

- Who Completes: Optional education open to all Certified Direct Care Associates.
- Requirements: Successful completion of Core, Home and Community Living Module, Instrumental Activities of Daily Living Module, Personal Support Module, and active Certification status.
- Credential Received: Advanced Certification; must be renewed every two years.
- Continuing Education: 20 hours every two years to maintain active Certification status.
- Title: Community Living Professional (CLP)

Personal Support

- Who Completes: Optional education open to all Certified Direct Care Associates.
- Requirements: Successful completion of Core, Personal Activities of Daily Living Module, Personal Support Module, and active Certification status.
- Credential Received: Advanced Certification; must be renewed every two years.
- Continuing Education: 20 hours every two years to maintain active Certification status.
- Title: Personal Support Professional (PSP)

Health Support

- Who Completes: Optional education open to all Certified Direct Care Associates. Certification is required for individuals performing health support functions in nursing facilities and home health/care agencies. (Regulated by Iowa Department of Inspections and Appeals, IAC Chapter 58 for certified nursing facilities and Iowa Department of Human Services IAC Chapter 81 for nursing homes. Regulated by Iowa Department of Public Health, IAC Chapter 80 for Medicare-certified home health agencies.)
- Requirements: Successful completion of Core, Personal Activities of Daily Living Module, Health Monitoring and Maintenance Module, and active Certification status.
- Credential Received: Advanced Certification; must be renewed every two years.
- Continuing Education: 20 hours every two years to maintain active Certification status.
- Title: Health Support Professional (HSP)

Criteria for Curriculum Approval

Curriculum will be eligible for approval relating to the following DCP Advanced Training Modules:

- Home and Community Living
- Personal Support
- Instrumental Activities of Daily Living

Health Monitoring and Maintenance Module and Personal Activities of Daily Living Module will utilize one standard curriculum approved by the Iowa Board of Direct Care Professionals and Iowa Department of Inspections and Appeals.

Curricula must meet the following criteria for consideration for approval in Iowa:

- Addresses Board-approved competencies. (To be established and approved by the Board for each module.)
- Demonstrates best practices within the field.
- Has specified learning objectives.
- Was developed utilizing a peer review process. Peers are defined as direct care professionals actively working in the profession in the content area covered in the curriculum.
- Requires a competency assessment upon course completion.
- Meets requirements for theory and experiential learning. (To be established and approved by the Board for each module.)
- Demonstrates that curriculum is reviewed and updated as needed, but at a minimum of every two years.
- Utilizes a variety of adult learning techniques.
- Is delivered by instructors who meet specified qualifications.
- Submitted curriculum must be approved for all delivery methods.

Specialty Endorsements

Specialty Endorsements will not be created by the Iowa Board of Direct Care Professionals. Specialty Endorsements will be developed by various disciplines and experts in those subject or professional areas. Subject areas defined as possible Specialty Endorsements currently have or may have unique regulatory requirements. However, Specialty Endorsements will be recognized and approved by the Iowa Board of Direct Care Professionals, and the Board will issue credentials for approved Endorsements. Specialty endorsements will be included in the grandfathering process.

Anticipated Specialty Endorsements: Autism, Alzheimer's/Dementia, Advanced Nurse Aide, Brain Injury, Crisis Intervention, Hospice and Palliative Care, Medication Aide, Medication Manager, Mental Health, Mentoring, Positive Behavior Supports, Paid Nutritional Assistant, Psychiatric Care, Rehabilitation Aide, Wellness and Prevention.

- Who Completes: Optional education open to all Certified Direct Care Associates. Some Endorsements may be required for workers based on regulations for those specialties.
- Requirements: Active Certification status.
- Credential Received: Endorsement
- Continuing Education: Determined separately for each Endorsement. Continuing education completed for a specialty will count toward hours to maintain Certification or Advanced Certifications.
- Title: Determined separately for each Endorsement.

Criteria for Approval of Curriculum Submitted for Specialty Endorsements

Curriculum will be eligible for approval relating to specialty content areas that advance the knowledge, skills, and capacity of the DCP workforce and the quality of DCP services and supports needed by Iowans. Curriculum must meet the following criteria for consideration for approval in Iowa:

- Demonstrates best practices within the field.
- Has specified learning objectives.
- Was developed utilizing a peer review process. Peers are defined as direct care professionals actively working in the profession in the content area covered in the curriculum.
- Requires a competency assessment upon course completion.
- Consists of theory and experiential learning.
- Demonstrates that curriculum is reviewed and updated as needed, but at a minimum of every two years.
- Utilizes a variety of adult learning techniques.
- Has established qualifications for instructors.
- Submitted curriculum must be approved for all delivery methods.

Continuing Education Requirements for Direct Care Professionals

The Direct Care Worker Advisory Council recommends the Iowa Board of Direct Care Professionals establish continuing education requirements for credentialed direct care professionals and standards to ensure that continuing education activities are appropriate for credit, advance the knowledge and skills of direct care professionals, and meet or exceed existing state and federal requirements. Continuing education will be required to maintain credentials. The Advisory Council makes the following recommendations for continuing education with the goals of ensuring quality professional development opportunities for DCPs and ease of access and flexibility for completing continuing education.

- Continuing education compliance period – Credentialed direct care professionals will be required to complete specified continuing education units every two years.
- Minimum hourly continuing education requirements for credentialed direct care professionals –
  - Direct Care Associate – 6 hours
  - Community Living Professional – 20 hours
  - Personal Support Professional – 20 hours
  - Health Support Professional – 20 hours
  - Specialty Endorsements – Hours will be determined for each specialty. Continuing education hours obtained for Endorsements will count toward overall hours needed for Certification and Advanced Certification.
- Responsibility – The credentialed direct care professionals will be responsible for completing continuing education hours every two years.

- Organizations or individuals providing continuing education will not be approved by the Iowa Board of Direct Care Professionals, which is consistent with the practice of other professional boards within the Iowa Department of Public Health.
- All credentialed direct care professionals will be required to report that continuing education has been completed each time their credential is renewed (every two years). A percentage of credentialed DCPs will be audited on a biennial basis to ensure compliance with requirements and standards. Direct care professionals will be informed of their individual responsibilities for record keeping.
- A continuing education activity is appropriate for continuing education credit if the continuing education activity:
  - Constitutes an organized program of learning which contributes directly to the professional competency of the credentialed direct care professional.
  - Pertains to subject matters which integrally relate to the practice of the profession.
  - Is conducted by individuals who have specialized education, training, and experience concerning the subject matter of the program.
  - Fulfills stated program goals, objectives, or both.
  - Provides an individual certificate of completion or evidence of successful completion of the course by the course sponsor. This documentation must contain the course title, date, contact hours, sponsor, and name of the credentialed direct care professional.
- Source of continuing education:
  - A minimum of 1/3 of continuing education hours shall be obtained in a group learning setting, which may include a work site.
  - Continuing education can be met through the employer; however, no more than 1/3 of the total continuing education hours can be issued directly from an employer. Current in-service hours required by state and federal law will not qualify for continuing education hours, with the exception of in-service related to child or dependent adult abuse.
  - Continuing education can be obtained online. Only online programs that issue a post test will qualify for continuing education hours.
  - Hours of education and training completed to obtain another DCP credential or to obtain a specialty endorsement will qualify as continuing education.
  - The Iowa Board of Direct Care Professionals will adopt provisions consistent with other professional boards within the Iowa Department of Public Health that allow for exemption for special circumstances and outline grounds for disciplinary action.

UPCOMING WORK AND RECOMMENDATIONS

The Advisory Council has two areas of focus for upcoming work: fulfill the charge of HF 2526 by completing recommendations and providing the level of guidance and input necessary for IDPH to establish the Board of Direct Care Professionals by 2014, culminating in a final report as directed in 2012; and provide critical stakeholder guidance and support to IDPH as it pilots recommendations of the Council. Specifically, the Council will:

- Complete recommendations and timeframe for grandfathering and transitioning the current workforce into the new credentialing system.
- Establish a timeframe for system implementation.
- Estimate cost needed for establishing and maintaining board operations. (Federal grant funds will support some costs associated with establishing the board, namely the information management system.)
- Continue and expand statewide outreach to support timelines for grandfathering and system implementation.
- Provide stakeholder leadership and guidance to IDPH for pilot implementation and planning.
- Provide multi-disciplinary review and facilitate diverse stakeholder input on curriculum and competencies developed by work groups associated with the pilot.
- Review pilot activities and evaluation outcomes regularly throughout grant, and as needed adjust or improve Council recommendations.
- Assist IDPH with problem solving and technical assistance to ensure success of the pilot.
- Assist IDPH with developing and testing of the information management system.

For more information about the Advisory Council and to access previous reports, please visit: *www.idph.state.ia.us/hcr_committees/direct_care_workers.asp*