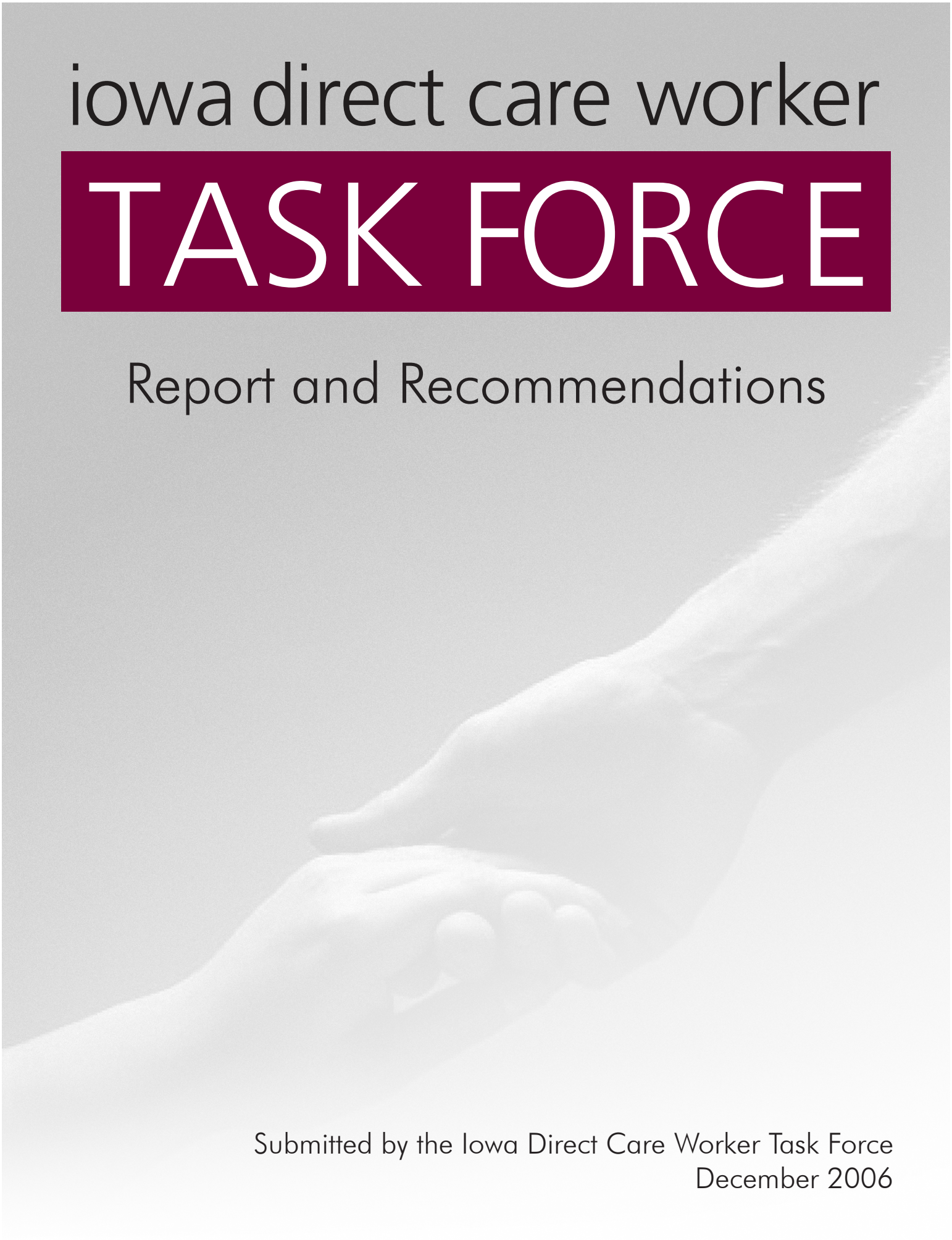
iowa direct care worker

TASK FORCE

Report and Recommendations



Submitted by the Iowa Direct Care Worker Task Force
December 2006

December 2006

Dear Governor Vilsack, Lt. Governor Pederson, and Members of the Iowa General Assembly,

We in Iowa are fortunate to have a Governor, Lt. Governor and State Legislature that understand the critical role direct care workers provide in our continuum of care. The 2005 Iowa General Assembly and Governor Vilsack took action to bring together a qualified Task Force in order to develop comprehensive recommendations to improve the quality of care Iowans receive by improving and streamlining education and training requirements for our direct care workforce.

The Task Force members were appointed by Governor Vilsack and included direct care worker, consumer, employer, and other health and long term care professional representatives. The Task Force's expertise and commitment to this issue have resulted in a consensus report focused on recommendations for improving and streamlining the education and training system for direct care workers.

Effective education and training of Iowa's direct care workers have never been more important. It has become commonplace to hear that health and long term care workers of all disciplines will face severe workforce shortages as well as increasing client and service demands. Recent initiatives to redesign long term care, including the IowaCare Act passed last year, the increase in our elderly population and an expansion in services available, demonstrate the need to recruit and retain a well-educated and trained direct care workforce. Also, an increasingly diverse population presents opportunities and challenges as we look at the future needs for both the direct care workforce and the consumer.

The Iowa Direct Care Worker Task Force has done a tremendous job of representing the interests of all Iowans as they have considered differing perspectives throughout this process. We hope this report will be used to guide the implementation of these comprehensive recommendations with leadership from the Governor's Office and General Assembly.

Sincerely,

Mary Mincer Hansen, R.N., Ph.D.
Director, Iowa Department of Public Health

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Acknowledgments

The Iowa Direct Care Worker Task Force developed a set of recommendations to address education and training, governance, infrastructure development, and policy-related issues that impact the direct care workforce system in Iowa. Many individuals and organizations invested an extraordinary amount of time and energy throughout the process in developing the contents of this report.

The Iowa Direct Care Worker Task Force wishes to express its great appreciation to Governor Vilsack, Lieutenant Governor Pedersen, and the Iowa General Assembly, for providing this opportunity as well as a commitment to improving the direct care worker education and training system in Iowa. This publication was made possible by grant number DIDHPO6382-01-01 from the Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services.

A number of individuals and organizations contributed their expertise in informing and supporting the work of the Task Force. The Task Force recognizes and thanks the following for their support and assistance:

- Key state agency staff from the Iowa Departments of Public Health, Inspections and Appeals, Human Services, and Elder Affairs for providing information about legislation, code, rules, and systems change efforts;
- Focus group participants for taking time to engage in a discussion about the importance of direct care worker education and training issues and for providing valuable first-hand expertise during June 2006;
- Everyone who promoted or completed the online survey during September 2006, which helped to further inform the Task Force about perceptions and issues;
- Anita Stineman, University of Iowa College of Nursing for her guidance on developing core competency statements for recommended education and training requirements; and,
- Becky Groff, Iowa State Office AARP for sharing survey findings related to education and training issues for direct care workers.

Appreciation is also extended to the State Public Policy Group (SPPG) team for providing facilitation, staffing, and report development services to the Iowa Direct Care Worker Task Force:

Ben Banowetz
Sarah Dixon
Erin Drinnin
Jennifer Furler
Brooke Findley
Mary Ann Lee
Rachel Lynch
Arlinda McKeen
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With gratitude,
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Preface

There is not a day that goes by when we do not hear about issues impacting our health and long term care delivery system. These issues range from access to health care coverage and health professional shortages to the quality and increasing cost of providing care. Every state, community, and citizen will be challenged on some level to address these issues. As the State of Iowa continues to engage in discussions and systems change efforts to ensure the health and well being of all Iowans, emerging issues and future needs must be considered.

Over the past decade there has been a systemic shift requiring direct care workers to take on increasing responsibilities for providing care. Exacerbating these increased demands is the direct care workforce shortage which in many cases is caused by low pay, lack of health care coverage, a lack of opportunity for professional advancement, and by a need and desire for more education and training. Given the current demographic, programmatic and policy changes in Iowa, the creation of a Direct Care Worker Task Force to address fundamental issues of education and training was essential. Direct care workers provide services to Iowans each day in long-term care settings, hospitals, assisted living agencies, community-based settings, and in the homes of residents. As the health and long term care delivery system adapts to changing needs, an infrastructure must be in place that is flexible and able to offer a continuum of care to those accessing services.

To further illustrate the impact direct care workers have on health services delivery, consider the following examples. According to a survey of long term care facilities designed and executed in 2005 on behalf of the Olmstead Real Choices Consumer Task Force, most long term care facilities in Iowa rely primarily on direct care staff to deliver services. In addition, a 2005 survey conducted by the Iowa Association of Local Public Health Agencies (IALPHA), found that a large number of home care aides are employed at local public health agencies and home care agencies throughout the state. As a result of these findings, IALPHA has discussed the need for education and training for this segment of the direct care workforce.

The stakeholder groups that include direct care workers, consumers, other health care professions, employers, and policymakers have been challenged to develop consensus recommendations regarding the pressing issues related to the direct care workforce and system. There is not a prevailing view from stakeholders across the state as to how to best ensure that direct care workers have access to and receive appropriate education and training needed to provide quality care to consumers.

The Iowa Direct Care Worker Task Force was formed to review current direct care worker classifications, education and training requirements and develop a set of recommendations to improve and streamline the current system. The Task Force consisted of key stakeholders including direct care workers, consumers, employers, other health care professionals, state agency representatives, and elected state officials. Specifically, the Task Force focused on education and training, governance, registry, and policy issues related to the direct care workforce system within the context of the larger issues. This report, including a set of integrated recommendations, is the outcome of the Task Force's extensive work.

Executive Summary

Health care and systems of service delivery continue to evolve and significant changes have occurred and will continue to require a broad range of skills and services in caring for Iowans in the spectrum of care settings. The Iowa Legislature, recognizing the importance of direct care workers to the health and well-being of Iowans, mandated the Iowa Direct Care Worker Task Force "review the education and training requirements applicable to and to make recommendations regarding direct care workers." With administrative support from the Iowa Department of Public Health, the Iowa Direct Care Worker Task Force undertook its charge to complete the following directives from the Legislature in House File 781:

- Identify the existing direct care worker classifications.
- Review and outline the corresponding educational and training requirements for each direct care worker classification identified.
- Determine the appropriate educational and training requirements for each direct care worker classification identified.
- Recommend a process for streamlining the educational and training system for direct care workers.
- Recommend a process for establishing a direct care worker registry by expanding the Iowa Nurse Aide Registry to integrate direct care workers, and consider moving administration of the registry to the Iowa Department of Public Health.

While the mandates of the Legislature were the focus of the work of the Task Force, members committed to ensuring a comprehensive review and an effort to thoroughly address related issues that will impact successful implementation of the set of recommendations. Paramount to the Task Force's deliberations was the health, safety, and well-being of Iowans as consumers of health care services. In this spirit, the Task Force completed its work and intentionally included additional information that underscores the central focus on the consumer and goes beyond the letter of the law to include more detail in the education and training requirements and required competencies.

The Iowa Direct Care Worker Task Force, in the course of its work, recognized the degree to which consumers, family members, and the general public do not know about nor understand the roles and functions of direct care workers. It is the expectation that implementation of the recommendations will serve to clarify and educate all stakeholders, including many within the health care system.

Upwards of 75,000 direct care workers in Iowa provide services to individuals in need, and family members nearby or in other states expect those providing care to their loved one are thoroughly educated and qualified to provide that care. As directed by the Iowa Legislature, the

recommendations of the Iowa Direct Care Worker Task Force will ensure that certified direct care workers are, indeed, knowledgeable and skilled in performing their assigned functions.

Direct Care Worker

For the purposes of the Iowa Direct Care Worker Task Force, a direct care worker was defined as an individual who provides services, care, supervision, and emotional support to people with chronic illnesses and disabilities. This definition does not include nurses, case managers, or social workers.

Iowa's Direct Care Workforce: Context for the Recommendations

Direct care workers in the system of health care are often those individuals who perform the broadest range of tasks and may be the most frequent points of contact with a consumer. As the health care system has changed over the decades, the role of direct care workers has also changed. There have never been consistent ways of describing direct care workers or the jobs they perform, and with a workforce more than 75,000-strong, the time has come, based on need, for Iowa to address consistency and education requirements for direct care workers.

The Iowa Direct Care Worker Task Force worked for one year in its efforts to carefully identify and examine the opportunities, issues, concerns, and the reality of direct care work in Iowa. The Task Force soon realized its work would be predicated on a thorough understanding of the impacts of these contextual issues.

The report does not directly address certain issues which were peripheral to the legislative charge, such as wages, benefits, and turnover, which fell beyond the scope of the Task Force's charge. It is the hope and expectation of the Task Force that implementation of recommendations contained in this report may result in the improvement of these related issues as an infrastructure is built and improved upon.

Five broad issues were discussed at length to inform and guide development of the comprehensive set of recommendations.

- **Current Structure** – Some direct care worker functions and training are closely regulated by Federal or state policy. Certified Nurse Aides (CNAs) and Home Health Aides are two examples. Tens of thousands of other direct care workers are not covered by any required education and training requirements, nor are there consistent descriptions of jobs. There are dozens of job titles with no functional description and no consistency from one employer to another.
- **Defining the Direct Care Workforce** – The very term "direct care worker" is unclear and confusing to people within and, certainly, outside the health care system. Many people, when asked, included nurses and case/service workers in their definition. These occupations have existing education and licensure/certification infrastructure in place. For these reasons, nursing, case management, and social workers were excluded from the definition of direct care worker.

Still, this left a significant scope of health care services around which the Task Force focused its efforts to identify classifications of direct care worker.

- **Scope of Services Provided by Direct Care Workers** – The services provided by direct care workers in Iowa vary depending on the setting where the services are being provided and who is being served. People familiar with direct care services generally categorize them into three broad categories: environmental/chore, instrumental activities of daily living, and personal care.
- **Education and Training as it Currently Exists** – In the current system, there is little standardization or consistency in training provided to direct care workers. There is no indication of quality of training an individual may have received. A standard curriculum is lacking and employers offer training that is applicable only to a single institution, limiting the portability of education an individual does receive. Consumers and family members are concerned about the quality and content of direct care worker training. There is currently no assurance that the training an individual worker receives is correlated to the services the direct care worker is performing.
- **Image and Understanding of the Direct Care Workforce** – Direct care workers, while often fulfilling a wide array of service needs, are largely invisible to the public and to some parts of the health care system. Consumers and family members are most likely to be unable to explain the role of a direct care worker or describe education and training requirements. The Iowa Direct Care Worker Task Force supports and believes that direct care workers, employers, and policymakers are committed to improvements in the education and training system for direct care workers in Iowa.
- **Remaining Issues and Concerns** – The Iowa Direct Care Worker Task Force agreed to not resolve two issues that recurred throughout discussions of the dozens of topics and issues faced through the year-long process.
    - **Consumer Choice and Other Waiver Options** – There was consensus among Task Force members that the implementation of the home and community based waivers initiative created a gray area where the recommendations of the Task Force were concerned. While the group emphasized their concern about the quality of care individuals can provide without adequate education and training and the seeming "exemption" of those choosing to enroll in one of the waiver options, the fundamental charge of the Task Force did not allow for the revision of how individuals select employees to provide their supports. The Task Force reached consensus that its recommendations could only extend into encouraging involvement of income maintenance workers, case managers, and other system professionals in educating and advising consumers about the importance of hiring appropriately-trained direct care workers. In this approach, consumers will still exercise consumer choice, but there would be information provided about the importance of that person receiving appropriate education and training to the classification of service needed. This was included as a recommendation.

- **Preferred Term for "Direct Care Worker"** – The term "direct care worker" is not descriptive of the role and responsibility of this health care service provider. However, it is the common lexicon and most people understand its meaning. With the ultimate impacts of implementation of the recommendations contained in this report will come an overall increase in status, so to speak, of the direct care workforce. In this spirit, there was recurring discussion of the advisability of changing the lexicon to include the word "professional, provider, or paraprofessional." There was agreement by the Task Force members that this issue could not be resolved through protracted Task Force discussion. Further, the terminology was not a critical element in moving forward with the fundamental premises of functional classifications, standard education and training requirements, and other recommended actions.

Recommendations

In the judgment of the members of the Iowa Direct Care Worker Task Force, the following set of recommendations fulfills the requirements of the Legislative mandate. In addition, the recommendations set forth a means through which the recommendations can be moved forward through the legislative and administrative processes.

The Iowa Direct Care Worker Task Force emphasizes that to fully meet the requirements of the Legislature and, more important, to protect the health and safety of Iowans, these recommendations must be adopted and implemented as integrated initiatives. Without attention to the complete set of issues, a solution will be less than comprehensive and will fall short of Legislative expectations.

The recommendations fall into four categories.

- Category One: Education and Training
- Category Two: Implementation
- Category Three: Establishment and Responsibilities of a Governing Body
- Category Four: Directory of Certified Direct Care Workers

Category One: Education and Training Recommendations

1. Establish Direct Care Worker Classifications Based on Function

Recommendation – Establish the following six direct care worker classifications based on functions and services provided by direct care workers.

- Environmental / Chore
- Instrumental Activities of Daily Living
- Personal Care Support
- Personal Care Activities of Daily Living

- Health Monitoring and Maintenance
- Specialty Skills

2. Establish Functions for Each Direct Care Worker Classification

Recommendation – Implement the following functions for each of the six direct care workers classifications based on the categories of core competencies. Below are the general functions and core competencies. Detailed core competency statements can be found in the Appendix of this report. Additionally, each of the six classifications will also be required to receive an overarching education and training orientation, which is also detailed below.

Education and Training Orientation Components

This orientation is an agency-specific training, but should address the following components.

- Confidentiality
- Ethics and Legal
- Consumers' and Workers' Rights
- Person Directed/Consumer Centered Care
- Cultural Competency
- Growth, Development, and Disability Specific Competency
- Observation, Referral, and Reporting
- Communication and Interpersonal Skills
- Problem Solving
- Safety and Emergency Procedures
- Infection Control and OSHA Guidelines
- Professional Education and Training

Environmental / Chore Functions

Defined as functions that are necessary for an individual to live independently that encompasses heavier cleaning tasks, including outside maintenance and chores. There is no physical contact between workers and clients.

- While the functions may include heavy household cleaning, garbage removal, shoveling snow, changing light bulbs, putting screens on windows, cover/uncover air conditioners, or lawn care/mowing, among others, there are no education and training requirements beyond the required agency-specific orientation.

Instrumental Activities of Daily Living Functions

Defined as care to assist an individual to function independently. This care goes beyond basic needs and transcends into care necessary for an individual to be able to live independently. There is no physical contact between workers and clients.

- Prevention of disease and injury (infection control)
- Home management (using the phone, laundry, shopping, cooking, washing dishes, bed making, and light housekeeping)
- Financial management (managing money, but not serving as a payee)
- Food preparation and nutrition (food safety, shopping, awareness of special diets, but not cooking skills)

Personal Care Support Functions

Defined as providing support to individuals as they perform personal and instrumental activities of daily living (support role for activities of daily living – personal and instrumental). There is no physical contact between workers and clients.

- Testing / Training
- Observation / Recording / Documenting
- Coaching / Supporting / Supervising

Personal Care Activities of Daily Living Functions

Defined as care to assist an individual in meeting their basic needs, acknowledging personal choices and encouraging independence. In most cases, physical contact would be involved between workers and clients.

- Eating and feeding (swallowing, choking)
- Bathing, back rubs, skin care, grooming (hair care, nail care, oral care, shaving), dressing and undressing, toileting (includes urinal, commode, bedpan)
- Mobility assistance (transfers to chair/bed, walking, turning in bed, etc.)

Health Monitoring and Maintenance Functions

Defined as medically-oriented care that assists an individual in maintaining their health on a daily basis. In most cases, physical contact would be involved between workers and clients.

- Checking vitals (temperature, pulse, respiration, blood pressure, pain assessment), measuring height and weight, handling/gathering specimens

- Measuring intake and output, catheter care, ostomy care, urinary care, collecting urine and fecal samples
- Application of TED hose, heat and cold packs, range of motion exercises

Specialty Skills Functions

Defined as functions that require additional education and training in order to provide specialty services to individuals. In most cases, physical contact would be involved between workers and clients. It is important to note that certain specialty skills must be delegated by licensed nurses in specific settings.

- Dementia/Alzheimer's Care
- Psychiatric Care (including all mental health issues), plan activities and exercises for social, physical, and emotional/mental health
- Monitoring/Administration of Medications
- Simple dressing changes, drawing blood, sputum, and cultures, giving shots, giving enemas, and respiratory management
- Hospice and Palliative Care
- Protective Services
- Restorative and Strengthening Exercises – Ambulation
- Mentoring

3. Implement Consistent and Appropriate Education and Training Requirements for Direct Care Worker Classifications

Recommendation – Implement the appropriate education and training requirements identified by the Direct Care Worker Task Force for each of the six direct care worker classifications: environmental / chore, instrumental activities of daily living, personal care support, personal care activities of daily living, health monitoring and maintenance, and specialty skills. The following matrix illustrates this in a systemic manner. Additionally, it is recommended that employers provide an Overarching Education and Training Orientation to all direct care workers. The matrix indicates which education and training should be completed by each of the six types of direct care workers. The core competencies for education and training for each of the classifications is found in the Appendix of this report.

Recommended Education and Training Content for Each Direct Care Worker Classification

Below is a matrix that outlines what education and training should be completed by direct care workers based on their classification. This matrix should be read horizontally. For additional details, read Recommendations 1 and 2 above.

Classifications	Education & Training Requirements						
	Overarching Education and Training Orientation	Environmental / Chore	Instrumental Activities of Daily Living (IADLs)	Personal Care Support	Personal Care Activities of Daily Living	Health Monitoring and Maintenance	Specialty Skills
Environmental / Chore	X	No additional requirements					
Instrumental Activities of Daily Living	X		X				
Personal Care Support	X		X	X	Required components: only classroom, not clinical		
Personal Care Activities of Daily Living	X		Required components: prevention of disease/injury + food prep. & nutrition		X		
Health Monitoring and Maintenance	X		Required components: prevention of disease/injury + food prep. & nutrition		X	X	
Specialty Skills	X		Required components: prevention of disease/injury + food prep. & nutrition		X	X	X

4. **Require Standard Curriculum for Direct Care Worker Education and Training**

   Recommendation – Use of an approved, standard curriculum will be required in training of direct care workers in each classification. The content of the curriculum will be different for each classification of direct care worker and will be based on the training requirements included as part of this set of recommendations for each classification and the related core competencies.

5. **Combine the Specialty Requirements for Medication Manager and Medication Aide**

   Recommendation – Any direct care worker who will be assisting an individual with prescribed medications will be required to complete the Medication Aide course, thus eliminating the need for the Medication Manager course. The Task Force recognizes that federal rules may not allow all direct care workers to assist individuals with prescribed medications regardless of education and training.

Category Two: Implementation Recommendations

6. **Designate the Iowa Department of Public Health with Responsibilities for Implementation**

   Recommendation – The Governor and Legislature shall pass legislation directing the Iowa Department of Public Health (IDPH) to be designated with the responsibilities for implementation of the Iowa Direct Care Worker Task Force's recommendations. IDPH will create an implementation task force to assist with this effort consisting of direct care workers, consumers, educators, other health professionals, employers, and involved state agencies and including a minimum of 25% of the Iowa Direct Care Worker Task Force membership.

7. **Qualify and Adopt Curriculum Meeting Required Standards**

   Recommendation – IDPH and the implementation task force will ensure that standard curriculum be used for each direct care worker classification whether the course is offered within an agency or at an institution for higher learning. The curriculum will meet or exceed any Federal or state requirements.

8. **Establish Educational Equivalency Standards for Other Health Care Professions**

   Recommendation – IDPH and the implementation task force will establish an equivalency of prior education and training for individuals who have completed higher education in a health care profession. Equivalency will be based on core competencies established for each direct care worker classification as correlated to

specific institutional curriculum in health care professions as approved by IDPH. Those with the above-stated equivalency will be allowed to take the state exam for the appropriate direct care worker classification.

9. Ensure Competence of Existing Direct Care Workforce

Recommendation – IDPH and the implementation task force will provide guidelines and establish standards to incorporate the existing direct care workforce into the new system based on their education, training, current certifications, and/or demonstration of core competencies. The system will allow each direct care worker to demonstrate competence and be certified in the classification in which she/he wants to work.

10. Qualify Educators and Trainers

Recommendation – IDPH and the implementation task force will develop a means to determine the competence level of educators and will qualify direct care worker educators and trainers, training organizations, and institutions of higher education. These educators and trainers will then be qualified and approved to use the required curricula in delivering required courses.

11. Establish Continuing Education Requirements

Direct Care Workers

Recommendation – IDPH and the implementation task force will set continuing education requirements and standards to ensure that direct care workers remain competent and adapt to the changing needs of the direct care workforce, employers, and consumers. Standards will meet or exceed existing Federal or state continuing education requirements for applicable classifications.

Educators and Trainers

Recommendation – IDPH and the implementation task force will set standards to ensure that direct care worker educators and trainers retain their level of competency and adapt to the changing needs of the direct care workforce, employers, and consumers. Standards will meet or exceed existing Federal or state continuing education requirements.

12. Develop Certificate Program Criteria for Direct Care Worker Classifications

Recommendation – IDPH and the implementation task force will determine criteria for successful completion of the program of education. Individuals who successfully meet the criteria will be issued a certificate for each appropriate direct care worker classification.

13. Ensure Title Protection for Certified Direct Care Workers

Recommendation – IDPH and the implementation task force will work to establish title protection for the term Certified Direct Care Worker.

14. Standardize Supervision of Direct Care Workers

Recommendation – IDPH and the implementation task force will establish a standardized condition for supervision based on the functions being performed within each classification regardless of setting. Requirements for supervision will differ between classifications. The roles and responsibilities of direct care worker supervisors (nurses and other supervisory positions) shall also be established and meet or exceed existing Federal or state requirements for supervision.

15. Shift Responsibility for Credentials to Individual Direct Care Workers

Recommendation – IDPH and the implementation task force will change current policy to assign responsibility of maintaining credentials and continuing education and training to the individual direct care worker and shift that responsibility from the employer.

16. Require Income Maintenance Workers and Case Managers to Provide Information to Home and Community Based Waiver Participants

Recommendation – IDPH and the implementation task force will work with the Iowa Department of Human Services to require income maintenance workers and case managers to provide information about the education and training direct care workers should receive to provide care and services according to the consumers needs under the home and community based waiver options.

Category Three: Establishment and Responsibilities of a Governing Body

17. Establish a Governing Body for Direct Care Workers

Recommendation – The Legislature will establish a direct care worker governing body within the Iowa Department of Public Health to provide accountability and oversight of certification and impose professional standards. The governing body will monitor classifications, competency, education, and training requirements to respond to an ever-changing direct care industry. It will also be responsible for disciplinary review and action and will ensure compliance with existing regulation, such as the nurse delegation act. Responsibilities of the governing body should include:

- Protecting the public
- Ensuring consistency and equity among and between classifications of direct care workers
- Investigation of credentialing issues
- Imposing disciplinary actions, including decertification
- Conducting ongoing review and authority to change requirements
- Providing guidance and direction to the Directory of Certified Direct Care Workers administration

18. Include Representation of Primary Stakeholders in Governance

Recommendation – The Legislature, IDPH and the implementation task force will ensure the governing body includes adequate representation of the six classifications of direct care workers, supervisor occupations, educators, and citizen consumers of direct care services. Policy should ensure the governing body is established in the most appropriate environment with adequate resources and reasonable regulatory support.

Category Four: Directory of Certified Direct Care Workers

19. Expand the Iowa Direct Care Worker Registry

Recommendation – The Iowa Direct Care Worker Registry shall be called the Directory of Certified Direct Care Workers and will include all classifications of certified direct care workers as well as their completed education and training. The Task Force recognizes that resources are needed to expand the Iowa Direct Care Worker Registry.

Change Management

Implementation of the full set of recommendations contained in this report will, over time, significantly impact the quality of care provided to Iowans by the certified direct care workers. The Task Force and the Iowa's direct care workers can aid in the transitions and in assisting stakeholders and the public understand the implications of the classifications, training requirements, competencies, and certification. Iowa Department of Public Health, Iowa Department of Inspections and Appeals, other state agencies, stakeholder associations, and interested groups and individuals can and should all play a part in ensuring consistent progress toward the goals of a well-educated and skilled workforce.

Change will not occur without guidance and encouragement from interested parties. The Iowa Direct Care Worker Task Force strongly encourages ongoing communication among stakeholders, consistent messages to policymakers and others, and a unified voice in support of

these proposals. Iowa's direct care workforce benefits; Iowa's health care system benefits. Most of all, Iowans benefit from improved health care services provided by certified direct care workers.

Task Force Legislation and Charge

House File 781

An Act Relating to the Establishment of a Direct Care Worker Task Force

Be it enacted by the General Assembly of the State of Iowa:

Section 1. Direct Care Worker Task Force Recommendations Report

1. The Iowa department of public health shall convene a direct care worker task force to review the education and training requirements applicable to and to make recommendations regarding direct care workers. The Iowa department of public health shall provide administrative support for the task force.
2. The task force shall consist of twelve members including representatives of the direct care workforce, healthcare providers, consumer and disability advocates, and individuals involved in the education and training of direct care workers selected by the governor.
3. The task force shall also include the director or the director's designee of the Iowa department of public health, the department of human services, the department of elder affairs, and the department of inspections and appeals, and members of the general assembly as ex officio, nonvoting members.
4. The legislative members of the task force shall be appointed by the president of the senate, after consultation with the majority leader and the minority leader of the senate, and by the speaker of the house, after consultation with the majority leader and the minority leader of the house of representatives.
5. The task force shall select a chairperson from its membership. A majority of the members of the task force shall constitute a quorum.
6. The direct care worker task force shall do all of the following:
    a. Identify the existing direct care worker classifications.
    b. Review and outline the corresponding educational and training requirements for each direct care worker classification identified.
    c. Determine the appropriate educational and training requirements for each direct care worker classification identified.
    d. Recommend a process for streamlining the educational and training system for direct care workers.
    e. Recommend a process for establishing a direct care worker registry by expanding the Iowa nurse aide registry to integrate direct care workers, and consider moving administration of the registry to the Iowa department of public health.
7. The task force shall submit a report of its recommendations regarding the issues specified in subsection 6 to the governor and the general assembly no later than December 15, 2006.

Iowa's Direct Care Workforce: Issues, Concerns and the Current Reality

No system involving people and problems is perfect. Even if it is near-perfect, gradual shifts in priorities, methods, and communities will occur with time so that the old system no longer is as appropriate as it was in the past. The direct care worker and larger health and long term care delivery systems are examples of system that are being challenged to change at an increasingly rapid pace.

Direct care workers have existed as long as people needed assistance with daily activities or with certain health needs. Over the years the recognition of direct care workers has grown, and it is estimated there are now over 75,000 direct care workers in Iowa fulfilling a broad array of needs in many settings. Currently, however, there is not a way to ensure that direct care workers have had appropriate education and training, making it more difficult to ensure the safety of consumers.

Issues related to the direct care workforce and system can be considered in two broad categories. Issues of the role, relationships, and emerging prominence of direct care workers within the larger health care system are one category. These are global, systemic issues that have implications for the larger health and long term care system, costs, quality of care, and workforce shortages. Clearly, these issues go far beyond the direct care workforce, but cannot be ignored in the longer term.

The second category includes those issues that the Iowa Direct Care Worker Task Force was designed to address. These issues are no less complex than the former, but they are more narrowly focused on solutions to education and training elements of direct care workers. Because no element of the health and long term care system is independent of others, the recommendations of the Task Force in its assigned areas will also have a positive impact on the issues in the first category.

The Iowa Direct Care Worker Task Force was given a charge by the Legislature and Governor's Office to identify existing direct care worker classifications, current education and training requirements, and to make recommendations focused on streamlining the direct care worker education and training system. The charge included how best to expand the Direct Care Registry, which is administered and managed by the Iowa Department of Inspections and Appeals. Currently the Direct Care Registry only contains information about Certified Nurse Aides (CNAs), which is a federal requirement.

The charge itself is straightforward; however the issues and concerns that surround it are complicated and demanding. During the first meeting of the Task Force, members were asked

to identify their top issues related to the charge. Many of the issues highlighted by Task Force members proved to be the most challenging throughout the course of their work. Following is a summary of the issues and challenges that permeate the broader discussion of how Iowa ensures the direct care workforce has access to and completes the education and training needed to provide quality care to its residents, who are often the most vulnerable in our communities.

It is no surprise to those working in or with the direct care worker system that concerns and unaddressed issues have, over time, emerged and become more pronounced. It is important at this juncture to reiterate why the Iowa Direct Care Worker Task Force was created. Among all of the stakeholder groups, there is not a prevailing viewpoint about how best to structure the education and training system for direct care workers. The disparate opinions about these issues vary between stakeholder groups and among them. General areas of concern related to the central issue of ensuring that direct care workers receive appropriate education and training were identified by the Iowa Direct Care Worker Task Force, and affirmed in the outreach conducted in the form of six focus groups and a statewide online survey. They include the following issues:

- Which health care occupations and roles are included in the direct care worker category?
- How do we ensure direct care workers receive education and training that supports the services they are providing to individuals with varying needs?
- What are the roles and responsibilities of a governing body?
- How do we design an education and training system that adapts to the changing needs of direct care workers, consumers and providers?

Five broad issues emerged as the heart of concern with the current direct care worker system. These issues are described in the following sections which address the current structure, the challenge of defining the direct care workforce, the broad scope of services provided by direct care workers, education and training for direct care workers as it currently exists, and the image and understanding of direct care workers by the broader public. The report does not directly address certain issues which were peripheral to the legislative charge, such as wages, benefits, and turnover. These issues fell beyond the scope of the Task Force's charge, but it is the hope and expectation of the Task Force that implementation of recommendations contained in this report may result in the improvement of these related issues as an infrastructure is built and improved upon.

Current Structure

Education and training requirements for some direct care workers and employers are described in Federal or state code or rules. A listing of the code and rules that impact the direct care workforce system in Iowa can be found in the Appendix of this report. The code and rules are specific to types of employers (i.e., skilled nursing facility, home health agency) and much of the Federal policy is dependent on whether or not the employer is qualified to provide Medicaid or Medicare reimbursable

services. Additionally, code and rules exist that address education and training requirements for specific types of direct care workers (i.e., Certified Nurse Aide (CNA), supported community living specialist). Existing code and rules vary among work settings and types of direct care workers as well as require different levels of oversight. Moreover, the work settings and direct care workers that are governed by state or Federal code and rules contain differences in requirements for education and training based on the setting and type of worker. Lastly, the responsibility for ensuring that the code or rules in place are being met falls almost completely upon the employers of direct care workers.

At the state and Federal level, different government agencies are responsible for ensuring that employers meet the requirements of the code and rules. In Iowa, four state agencies play a role in providing oversight to different areas of the direct care workforce system: Iowa Department of Public Health, Iowa Department of Inspections and Appeals, Iowa Department of Human Services, and the Iowa Department of Elder Affairs. The oversight structure is guided by funding streams at the Federal and state levels, by the charge of each Department, and the populations they are mandated to serve. Depending on the services provided by the employer, they may be required to report to multiple state and Federal agencies.

Like other large systems, the current education and training system for the direct care workforce is full of inconsistencies and is fragmented. Direct care workers have limited portability among different types of work settings. Education and training requirements are not consistent based on which services a direct care worker provides and instead are dependent on the work setting. It is difficult for consumers and their family members to find out what level of training a particular worker should have, given the services being provided. Additionally, employers are responsible for reporting varying levels of information to Federal and state agencies that do not have the same governing and reporting rules in place. Most importantly, there is no statewide governing body that is charged with ensuring and overseeing an adequately trained direct care workforce.

Defining the Direct Care Workforce

Defining the direct care workforce is a difficult task. In the outreach conducted by the Iowa Direct Care Worker Task Force the term direct care was defined broadly and many participants included nursing, case managers, and social workers into their definition of direct care providers. The Task Force decided early on that for the purposes of this report, that the nursing workforce would not be included in their definition of the direct care workforce. The nursing workforce already has a comprehensive education and training system and an established governing body in place. Likewise, case managers and social workers were not considered direct care workers for purposes of this legislative charge.

Removing nursing, case management, and social workers from the definition of direct care workers still leaves a number of job classifications and job titles. During their first two meetings the Task Force was able to identify more than 40 job titles for direct care workers. While the

Task Force was able to identify numerous job titles, the Certified Nurse Aide (CNA) is the job title that was most familiar to the general public. Education and training requirements for CNAs are more likely to be known as they are stipulated in Federal code and certain agencies must employ CNAs. Because the CNA is most known and understood, the other types of direct care workers are often forgotten.

There is also a market force that contributes to the large number of job titles that exist for direct care workers. Like others, employers of direct care workers want to attract qualified applicants when they have job openings to fill. Employers may develop new job titles to try to entice workers to apply for their open positions, though these titles carry no standard education or training requirements. It is also difficult to find out how all of the job titles held by direct care workers correspond with education and training they should have received. While this is not a unique issue among most categories of workers, it is unique in the direct care worker category. The majority of the general population has some sense of the education and training health care professionals such as doctors and nurses receive, but this is not as often the case for direct care workers.

Additionally, direct care workers provide services in a variety of work settings: long term care facilities (which includes nursing homes), residential care facilities, intermediate care facilities; hospitals; assisted living agencies; home care agencies; supported community living agencies; other community-based settings; and individual homes. As one can see, the difficult task of defining who is included in the direct care worker category is exacerbated by the number of work settings and job titles that exist for the workforce. Considering the number of job titles with inconsistent definitions depending on the employer, the variety of settings in which an individual can work, the lack of clear definition of a direct care worker, and the tens of thousands of individuals filling these positions, it is easy to see how and why the definition of “direct care worker” is evasive.

Scope of Services Provided by Direct Care Workers

The services provided by direct care workers in Iowa vary depending on the setting where the services are being provided and who is being served. Since the consumers that are served by direct care workers all have individual needs, defining the scope of services provided by all direct care workers is difficult. However, people who are familiar with direct care services generally categorize them into three broad categories: environmental / chore, instrumental activities of daily living, and personal care.

Environmental / chore services can take place both outside and inside of an individual’s home. These services are designed to assist an individual in living independently in their community.

Instrumental activities of daily living is a medical term that encapsulates services ranging from regular home cleaning to the preparation of food and assistance in financial management activities.

Personal care services are the broadest category and include hygiene needs, bathing, feeding, mobility assistance, checking blood pressure and other vital signs, and range of motion exercise.

A distinction must also be made between direct care workers who provide support to consumers as they care for themselves and direct care workers who actually assist with or directly provide the care. Moreover, certain services provided by direct care workers require oversight by a supervisor such as a nurse or other supervisory personnel, which varies by work setting. There are also services that a nurse can delegate to a direct care worker if they are deemed competent by the supervising nurse.

Education and Training as it Currently Exists

From the other issues described above, it is not surprising that the current education and training fails to meet the needs of consumer and family members, direct care workers, and employers. There is little formalized assurance regarding the quality and consistency of training providers. Nor is there standardized curriculum for all of the training courses that are offered. This makes it difficult for direct care workers to have portability among different work settings, for consumers to feel assured that direct care workers providing services to them have had quality education and training, and for employers to easily hire trained staff.

Currently, many employers have assumed responsibility for the costs of education and training for their direct care worker staff. Employers typically include training costs into their agency budget, rather than paying those costs to direct care staff in increased wages or in an educational allowance. They also are responsible for tracking and reporting credentials of direct care workers as well as for providing and maintaining the records for any required continuing education. This leaves direct care workers without ownership of or responsibility for their own education and training or continuing education requirements.

The quality of training courses and continuing education varies by training provider and, in many cases, by work setting. Some agencies have employed their own trainers while others rely on outside training providers, such as the community colleges, to provide training to their direct care worker employees. Training is not only delivered in various settings, but the providers of training also greatly vary based on the Federal or state rules that govern a particular work setting or direct care worker type.

Many consumers and family members are concerned that there is not enough emphasis placed on meeting the specific needs of an individual in the training courses that are offered. Additionally, all stakeholder groups want to ensure that the education and training direct care workers receive fit the services the direct care workers are performing. A critical education and training issue is how best to track the certifications and training completed for the entire direct care workforce. Currently, the Iowa Department of Inspections and Appeals (DIA) houses and maintains the Iowa Direct Care Worker Registry, which in the past only included information about CNAs (a Federal mandate). Recently, the DIA worked with the Iowa Department of Public Health and the Iowa CareGivers Association through the Better Jobs, Better Care Project to expand the Registry to include other types of direct care workers. The remaining challenge is to ensure that the appropriate information is collected about all direct care workers and that it is usable to employers, direct care workers, and consumers and family members.

Image and Understanding of the Direct Care Workforce

Few, if any, health and long term care workforce classifications are as poorly understood and undervalued as the direct care workforce. The public remains almost oblivious to the direct care worker until they or a family member needs care. If asked about the role and responsibility of direct care workers or the education and training they receive, surprisingly few people, including some working within the health and long term care delivery system, could provide a correct response without guessing, and most have likely not given it much thought at all.

Consumers and family members are most likely to misunderstand the education and training requirements of direct care workers. Perceptions may range from believing direct care workers receive the same education and training across the board, to believing that direct care workers receive no formal education and training. Elected officials likely do not fully understand the role and responsibility of direct care workers or the education and training they receive. The lack of a public image and misunderstandings about education and training requirements are challenging when stakeholder groups are seeking support to move the system forward.

The Iowa Direct Care Worker Task Force recognizes and believes that direct care workers, employers, and policymakers are committed to improvements in the education and training system for direct care workers in Iowa. In addressing each of the issues highlighted in this section of the report, the Task Force, with advice and support from various stakeholder groups, carefully examined and discussed their integrated nature and how public policy change might improve the system. While each issue was also discussed independently of the others, solutions were seldom single solutions. The interdependent nature and impacts of the issues ultimately led the Task Force to develop a set of interdependent solutions.

Remaining Issues and Concerns

The Iowa Direct Care Worker Task Force, over its one-year process, addressed dozens of issues and aired frank differences of perspective in order to achieve the consensus in the content of this report, and particularly in the integrated set of recommendations. Two issues were discussed at length at various points in the process, and the Task Force agreed to let these issues remain unresolved. It is important to provide a brief narrative regarding the issues and the points of discussion.

1. Consumer Choice and Other Waiver Options

The Iowa Direct Care Worker Task Force understands that the environment in direct care is evolving, and that a new type of direct care "employee" is emerging from the emphasis on consumer choice and the US Supreme Court Olmstead Decision. Consumer choice is part of a new system currently in the implementation phase where individuals who need support services are able to hire, direct and pay someone of their choosing to provide those services. The service provider hired may be a traditional direct care worker or a friend, neighbor or relative the individual trusts or who may have been providing direct care services on a voluntary basis.

The Task Force heard presentations from those involved in the development of the home and community based waiver system and discussed, at length, the implications of this evolution to the charge to the Iowa Direct Care Worker Task Force.

There was consensus among Task Force members that the implementation of the home and community based waivers initiative created a gray area where the recommendations of the Task Force were concerned. While the group emphasized their concern about the quality of care individuals can provide without adequate education and training and the seeming "exemption" of those choosing to enroll in one of the waiver options, the fundamental charge of the Task Force did not allow for the revision of how individuals select employees to provide their supports.

The Task Force reached consensus that its recommendations could only extend into encouraging involvement of income maintenance workers, case managers, and other system professionals in educating and advising consumers about the importance of hiring appropriately-trained direct care workers. In this approach, consumers will still exercise consumer choice, but there would be information provided about the importance of that person receiving appropriate education and training to the classification of service needed.

2. Preferred Term for "Direct Care Worker"

The term "direct care worker" is not descriptive of the role and responsibility of this health care service provider. However, it is the common lexicon and most people understand its meaning. With the ultimate impacts of implementation of the recommendations contained in this report will come an overall increase in status, so to speak, of the direct care workforce. In this spirit, there was recurring discussion of the advisability of changing the lexicon to include the word "professional, provider, or paraprofessional."

There was agreement by the Task Force members that this issue could not be resolved through protracted Task Force discussion. Further, the terminology was not a critical element in moving forward with the fundamental premises of functional classifications, standard education and training requirements, and other recommended actions.

Recommendations

This set of recommendations represents a comprehensive review of the education and training needs of Iowa's direct care workforce balanced with the judgment of the Task Force regarding feasible approaches to change. The Task Force considers these recommendations as a unit, and by implementing them in an integrated manner, believes the direct care worker education and training system in Iowa can become more integrated and responsive to the needs of consumers, direct care workers, and employers. A consensus of Task Force members was reached on the content of this report and, specifically, on these recommendations.

Following each recommendation, a rationale is provided that demonstrates how the recommendation addresses issues and concerns related to existing requirements, delivery, and oversight of education and training for direct care workers. An impact statement indicates how the implementation of the recommendation is anticipated to affect the system and how it is integrated with other recommendations. The recommendations fall into four categories, which are listed below.

- Category One: Education and Training
- Category Two: Implementation
- Category Three: Establishment and Responsibilities of a Governing Body
- Category Four: Directory of Certified Direct Care Workers

While the ultimate establishment of a governing body is a recommendation that permeates nearly all of the other recommendations, the first part of the recommendations section will focus on the Task Force's charge to determine the appropriate education and training requirements for each direct care worker classification they identified.

For the purposes of the Iowa Direct Care Worker Task Force, a direct care worker was defined as an individual who provides services, care, supervision, and emotional support to people with chronic illnesses and disabilities. This definition does not include nurses, case managers, or social workers.

The Iowa Direct Care Worker Task Force was given specific tasks in House File 781 which focused its work and the recommendations contained in this report. Within the legislation, the Task Force was asked to:

1. Identify the existing direct care worker classifications.
2. Review and outline the corresponding educational and training requirements for each direct care worker classification identified.
3. Determine the appropriate educational and training requirements for each direct care worker classification identified.

4. Recommend a process for streamlining the educational and training system for direct care workers.
5. Recommend a process for establishing a direct care worker registry by expanding the Iowa Nurse Aide Registry to integrate direct care workers.

Category One: Education and Training Recommendations

In consideration of the issues and concerns identified in Task Force and outreach discussions (see the Summary of the Outreach section), it was evident that meeting the charge to the Task Force would require a clear vision and logical steps toward an improved education and training system for all direct care workers. The Task Force's intent was also to create a system based on the needs of consumers. These education and training recommendations approached the issues from a fundamental level, building to address the complexity of the issues and the charge.

1. Establish Direct Care Worker Classifications Based on Function

Recommendation – Establish the following six direct care worker classifications based on functions and services provided by direct care workers.

- Environmental / Chore
- Instrumental Activities of Daily Living
- Personal Care Support
- Personal Care Activities of Daily Living
- Health Monitoring and Maintenance
- Specialty Skills

Rationale – To devise a system where education of direct care workers is related to the work they do and to ensure the system is responsive to the needs of consumers, it is critical to adopt a common language and definitions of that work. The six proposed classifications are based on function and can be understood no matter which setting or job title is involved. Currently, job setting and job title drives how direct care workers are trained, not the functions or services they provide. This makes it difficult to understand what services direct care workers are qualified to provide based on the education and training they have completed. Detailed information about the functions that fall within each of the six classifications can be found in the next recommendation and in the Appendix of this report. A brief summary of each classification is below.

- Environmental / Chore – Defined as functions that are necessary for an individual to live independently that encompasses heavier cleaning tasks, including outside maintenance and chores. There is no physical contact between workers and clients.

- Instrumental Activities of Daily Living – Defined as care to assist an individual to function independently. This care goes beyond basic needs and transcends into care necessary for an individual to be able to live independently. There is no physical contact between workers and clients.
- Personal Care Support – Defined as providing support to individuals as they perform personal and instrumental activities of daily living (support role for activities of daily living – personal and instrumental). There is no physical contact between workers and clients.
- Personal Care Activities of Daily Living – Defined as care to assist an individual in meeting their basic needs, acknowledging personal choices and encouraging independence. In most cases, physical contact would be involved between workers and clients.
- Health Monitoring and Maintenance – Defined as medically-oriented care that assists an individual in maintaining their health on a daily basis. In most cases, physical contact would be involved between workers and clients.
- Specialty Skills – Defined as functions that require additional education and training in order to provide specialty services to individuals. In most cases, physical contact would be involved between workers and clients. It is important to note that certain specialty skills must be delegated by licensed nurses in specific settings.

Impact – Since the six classifications are not mutually exclusive, their implementation will result in a streamlined system which distinguishes direct care workers by function rather than by setting or job title. It allows for portability of direct care workers among various job settings and ensures consistency and quality among the entire workforce. Consumers, employers, and other health care professionals will understand what level of care a direct care worker is qualified to provide. Classifications, and education and training based on classification, will ultimately improve the accountability of direct care workers in the field.

2. Establish Functions for Each Direct Care Worker Classification

Recommendation – Implement the following functions for each of the six direct care workers classifications based on the categories of core competencies. Below are the general functions and core competencies. Detailed core competency statements can be found in the Appendix of this report. Additionally, each of the six classifications will also be required to receive an overarching education and training orientation, which is also detailed below.

<u>Education and Training Orientation Components</u>

This orientation is an agency-specific training, but should address the following components.

- Confidentiality
- Ethics and Legal
- Consumers' and Workers' Rights
- Person Directed/Consumer Centered Care
- Cultural Competency
- Growth, Development, and Disability Specific Competency
- Observation, Referral, and Reporting
- Communication and Interpersonal Skills
- Problem Solving
- Safety and Emergency Procedures
- Infection Control and OSHA Guidelines
- Professional Education and Training

Environmental / Chore Functions

Defined as functions that are necessary for an individual to live independently that encompasses heavier cleaning tasks, including outside maintenance and chores. There is no physical contact between workers and clients.

- While the functions may include heavy household cleaning, garbage removal, shoveling snow, changing light bulbs, putting screens on windows, cover/uncover air conditioners, or lawn care/mowing, among others, there are no education and training requirements beyond the required agency-specific orientation.

Instrumental Activities of Daily Living Functions

Defined as care to assist an individual to function independently. This care goes beyond basic needs and transcends into care necessary for an individual to be able to live independently. There is no physical contact between workers and clients.

- Prevention of disease and injury (infection control)
- Home management (using the phone, laundry, shopping, cooking, washing dishes, bed making, and light housekeeping)
- Financial management (managing money, but not serving as a payee)
- Food preparation and nutrition (food safety, shopping, awareness of special diets, but not cooking skills)

Personal Care Support Functions

Defined as providing support to individuals as they perform personal and instrumental activities of daily living (support role for activities of daily

living – personal and instrumental). There is no physical contact between workers and clients.

- Testing / Training
- Observation / Recording / Documenting
- Coaching / Supporting / Supervising

Personal Care Activities of Daily Living Functions

Defined as care to assist an individual in meeting their basic needs, acknowledging personal choices and encouraging independence. In most cases, physical contact would be involved between workers and clients.

- Eating and feeding (swallowing, choking)
- Bathing, back rubs, skin care, grooming (hair care, nail care, oral care, shaving), dressing and undressing, toileting (includes urinal, commode, bedpan)
- Mobility assistance (transfers to chair/bed, walking, turning in bed, etc.)

Health Monitoring and Maintenance Functions

Defined as medically-oriented care that assists an individual in maintaining their health on a daily basis. In most cases, physical contact would be involved between workers and clients.

- Checking vitals (temperature, pulse, respiration, blood pressure, pain assessment), measuring height and weight, handling/gathering specimens
- Measuring intake and output, catheter care, ostomy care, urinary care, collecting urine and fecal samples
- Application of TED hose, heat and cold packs, range of motion exercises

Specialty Skills Functions

Defined as functions that require additional education and training in order to provide specialty services to individuals. In most cases, physical contact would be involved between workers and clients. It is important to note that certain specialty skills must be delegated by licensed nurses in specific settings.

- Dementia/Alzheimer's Care
- Psychiatric Care (including all mental health issues), plan activities and exercises for social, physical, and emotional/mental health
- Monitoring/Administration of Medications
- Simple dressing changes, drawing blood, sputum, and cultures, giving shots, giving enemas, and respiratory management

- Hospice and Palliative Care
- Protective Services
- Restorative and Strengthening Exercises – Ambulation
- Mentoring

Rationale – Without establishing and implementing core functions and competencies for each of the six direct care worker classification, it is difficult for consumers, employers, and other health care providers to understand what education and training a direct care worker has completed.

Impact – By establishing functions and core competencies for each of the six direct care work classifications, consumers, employers, and other health care professionals will understand what education and training a direct care worker has completed. Because the functions are competency-based, it also allows for consistent information to be provided to direct care workers through the education and training they complete.

3. Implement Consistent and Appropriate Education and Training Requirements for Direct Care Worker Classifications

Recommendation – Implement the appropriate education and training requirements identified by the Direct Care Worker Task Force for each of the six direct care worker classifications: environmental / chore, instrumental activities of daily living, personal care support, personal care activities of daily living, health monitoring and maintenance, and specialty skills. The following matrix illustrates this in a systemic manner. Additionally, it is recommended that employers provide an Overarching Education and Training Orientation to all direct care workers. The matrix indicates which education and training should be completed by each of the six types of direct care workers. The core competencies for education and training for each of the classifications is found in the Appendix of this report.

Recommended Education and Training Content for Each Direct Care Worker Classification

Below is a matrix that outlines what education and training should be completed by direct care workers based on their classification. This matrix should be read horizontally. For additional details, read Recommendations 1 and 2 above.

Classifications	Education & Training Requirements						
	Overarching Education and Training Orientation	Environmental / Chore	Instrumental Activities of Daily Living (IADLs)	Personal Care Support	Personal Care Activities of Daily Living	Health Monitoring and Maintenance	Specialty Skills
Environmental / Chore	X	No additional requirements					
Instrumental Activities of Daily Living	X		X				
Personal Care Support	X		X	X	Required components: only classroom, not clinical		
Personal Care Activities of Daily Living	X		Required components: prevention of disease/injury + food prep. & nutrition		X		
Health Monitoring and Maintenance	X		Required components: prevention of disease/injury + food prep. & nutrition		X	X	
Specialty Skills	X		Required components: prevention of disease/injury + food prep. & nutrition		X	X	X

Rationale – Training and education requirements vary by job setting and are not consistent among direct care workers performing the same functions. Direct care workers, no matter where they work or the title they carry, need to be able to provide services in a safe and consistent manner. To further support the matrix, a subcommittee of the Task Force developed general core competency statements to accompany each classification. The core competencies can be found in the Appendix of this report. It should be noted that the specific education and training recommendations in the matrix are directly linked to and hinge on the successful implementation of the Task Force's recommendations regarding the requirements for education and training for the six direct care worker classifications.

Impact – The implementation of this recommendation will result in a gradual improvement in the quality of services provided to consumers by direct care workers no matter where the services are being provided or the job title of the person performing them. It will be easier for employers to hire qualified direct care workers because employers will be able to access information detailing what education and training a direct care worker has completed or needs to complete. It will also be easier for direct care workers to access and measure any additional education and training they receive.

4. Require Standard Curriculum for Direct Care Worker Education and Training

Recommendation – Use of an approved, standard curriculum will be required in training of direct care workers in each classification. The content of the curriculum will be different for each classification of direct care worker and will be based on the training requirements included as part of this set of recommendations for each classification and the related core competencies.

Rationale – The success of this initiative is predicated on educated and well-trained direct care staff performing at a high level of competence in various functions in various settings. A standard curriculum serves as the next building block of this system; without standard curricula for the classifications, the system cannot be effective.

Impact – Use of standard curricula will provide a more versatile direct care workforce and will ensure that consumers receive quality care. In addition, educators and trainers will be assured of quality materials and guidance in consistent delivery of the content. With a decline of very targeted skill or facility-specific training in favor of a standard knowledge base, the general capacity and skills of the greater direct care workforce will increase.

5. Combine the Specialty Requirements for Medication Manager and Medication Aide.

Recommendation – Any direct care worker who will be assisting an individual with prescribed medications will be required to complete the Medication Aide course, thus eliminating the need for the Medication Manager course. The Task Force recognizes that federal rules may not allow all direct care workers to assist individuals with prescribed medications regardless of education and training.

Rationale – The Medication Manager course is a shortened version of the Medication Aide course, which allows direct care workers to perform the same services as individuals who have completed the Medication Aide course. A direct care workers ability to assist an individual with prescribed medications is considered a Specialty Skill as denoted in the education and training matrix above.

Impact – Eliminating the Medication Manager course and requiring all direct care workers who are going to assist an individual with prescribed medications to take the Medication Aide course will result in a workforce that has received consistent and appropriate education and training. It will also ensure that consumers receive appropriate assistance with their medications.

Category Two: Implementation Recommendations

The Iowa Direct Care Worker Task Force was charged with determining the classifications and appropriate education and training requirements for direct care workers. Through thorough examination of the issues, the Task Force also developed a set of related recommendations which would support the implementation and creation of a comprehensive system. This requires the development of a multi-year timeline and process for implementation of the recommendations and systems change effort.

6. Designate the Iowa Department of Public Health with Responsibilities for Implementation

Recommendation – The Governor and Legislature shall pass legislation directing the Iowa Department of Public Health (IDPH) to be designated with the responsibilities for implementation of the Iowa Direct Care Worker Task Force's recommendations. IDPH will create an implementation task force to assist with this effort consisting of direct care workers, consumers, educators, other health professionals, employers, and involved state agencies and including a minimum of 25% of the Iowa Direct Care Worker Task Force membership.

Rationale – IDPH is best suited to lead the implementation of these recommendations given its current responsibilities for 19 boards under the Bureau of Professional

Licensure and given the Department's responsibility for tracking health care workforce professions. IDPH has in the past and must continue to work with the other state agencies that have oversight responsibilities for parts of the direct care work force, such as the Iowa Department of Inspections and Appeals, the Iowa Department of Human Services, and the Iowa Department of Elder Affairs. Also, all Federal requirements in effect for certain types of direct care workers are regulated and set by the United States Department of Health and Human Services.

Impact – Without a planned implementation of the previous recommendations, the system cannot be established to meet the needs of consumers. With a focused and resourced implementation, Iowa's direct care workers can participate in and avail themselves of a system to strengthen individual expertise and workforce enhancement.

7. Qualify and Adopt Curriculum Meeting Required Standards

Recommendation – IDPH and the implementation task force will ensure that standard curriculum be used for each direct care worker classification whether the course is offered within an agency or at an institution for higher learning. The curriculum will meet or exceed any Federal or state requirements.

Rationale – There is no consistent educational curriculum for direct care workers, often leading to training only for a specific set of tasks in a specific setting. This reduces the portability of the direct care worker, does not address function, and does ensure quality. The Task Force developed general core competency statements to accompany each classification around which a standard curriculum should be developed. Some existing curricula may meet the established standards with little adaptation. In come cases, new curricula may be developed to best meet the requirements for use in teaching direct care workers. See the Appendix of this report for additional detail.

Impact – Immediate improvement of individual direct care worker knowledge and skills will be seen with use of a standard curriculum based on function within classification. The longer term impact is the development of formal education and training for direct care workers and the development of a more highly competent and capable direct care workforce, which will result in higher quality care to consumers.

8. Establish Educational Equivalency Standards for Other Health Care Professions

Recommendation – IDPH and the implementation task force will establish an equivalency of prior education and training for individuals who have completed higher education in a health care profession. Equivalency will be based on core competencies established for each direct care worker classification as correlated to specific

institutional curriculum in health care professions as approved by IDPH. Those with the above-stated equivalency will be allowed to take the state exam for the appropriate direct care worker classification.

Rationale – Some trained health care workers, e.g. nurses or technicians, may opt to enter the direct care workforce. There are no current equivalency standards and those individuals are often required to take courses in which they already have been trained. Currently, the challenge test rules allow people that have not had appropriate education and training to become direct care workers.

Impact – This recommendation ensures that individuals who have had education and training in a health care profession are able to become direct care workers without having to take a duplicate course. This recommendation will also serve to safeguard consumers as individuals transition from one health care profession to another.

9. Ensure Competence of Existing Direct Care Workforce

Recommendation – IDPH and the implementation task force will provide guidelines and establish standards to incorporate the existing direct care workforce into the new system based on their education, training, current certifications, and/or demonstration of core competencies. The system will allow each direct care worker to demonstrate competence and be certified in the classification in which she/he wants to work.

Rationale – There are thousands of direct care workers currently working providing quality care to many Iowans. The new system has to provide an opportunity for this workforce to seamlessly continue to provide care, with qualifying education to be based on functional classification. The guidelines and standards will recognize current education and training while aligning it with the new system requirements.

Impact – The state will now, for the first time, have a system by which to gather demographics, data, and quantify the number and capacities of the direct care workforce. It will also be able to determine the needs of the health and long term care workforce and ensure quality services to its residents. Individuals in the existing workforce will be allowed to seek and receive the certifications they have earned according to these transitional equivalencies.

10. Qualify Educators and Trainers

Recommendation – IDPH and the implementation task force will develop a means to determine the competence level of educators and will qualify direct care worker educators and trainers, training organizations, and institutions of higher education.

These educators and trainers will then be qualified and approved to use the required curricula in delivering required courses.

Rationale – By qualifying educators and trainers, the state will ensure educators and trainers are committed to the new system and process for ensuring direct care workers receive appropriate and consistent education and training. It also encourages potential educators and trainers to become a conduit for ongoing success of the system. Educators involved in this system will have an avenue for gauging engagement and successes of direct care workers in this new system. Conversely, approved curriculum providers will also have an opportunity to hear from educators and the direct care workers that will augment communication and information exchange.

Impact – Implementation of this recommendation will ensure consistency, standardization, and quality of direct care worker educators and trainers, which will serve to safeguard consumers as they access care.

11. Establish Continuing Education Requirements

Direct Care Workers

Recommendation – IDPH and the implementation task force will set continuing education requirements and standards to ensure that direct care workers remain competent and adapt to the changing needs of the direct care workforce, employers, and consumers. Standards will meet or exceed existing Federal or state continuing education requirements for applicable classifications.

Rationale – State level involvement in continually reviewing and monitoring continuing education requirements for direct care workers is essential so that all direct care workers are provided the same quality continuing education opportunities in their classification as they received in their initial education.

Impact – The direct care workforce will maintain and improve its capacity and knowledge base and remain responsive to the changing needs of the residents it serves.

Educators and Trainers

Recommendation – IDPH and the implementation task force will set standards to ensure that direct care worker educators and trainers retain their level of competency and adapt to the changing needs of the direct care workforce, employers, and consumers. Standards will meet or exceed existing Federal or state continuing education requirements.

Rationale – State level involvement in continually reviewing and monitoring continuing education requirements for direct care worker educator and trainers is essential so that all direct care workers in every classification are provided quality continuing education opportunities.

Impact – The direct care workforce and its educators and trainers will remain responsive to the changing needs of the residents it serves.

12. Develop Certificate Program Criteria for Direct Care Worker Classifications

Recommendation – IDPH and the implementation task force will determine criteria for successful completion of the program of education. Individuals who successfully meet the criteria will be issued a certificate for each appropriate direct care worker classification.

Rationale – The certificate allows portability for the direct care worker and serves to formalize and standardize the educational requirements and achievements of each member of the workforce. There currently is no means by which an individual worker can demonstrate competency in their chosen classifications.

Impact – This recommendation will allow employers and consumers to access information and ensure direct care workers have the required education and training. Additionally, the certification program will increase the profile and standing of the direct care workforce.

13. Ensure Title Protection for Certified Direct Care Workers

Recommendation – IDPH and the implementation task force will work to establish title protection for the term Certified Direct Care Worker.

Rationale – Title protection would provide legal protection of the term Certified Direct Care Worker based on standard education and training requirements. Title protection is commonly used by groups of workers to establish a professional title that distinguishes individuals completing the recommended education and training from individuals that did not.

Practice protection provides legal protection of functions and services provided by a group of workers based on standard education and training requirements. While the Task Force does not recommend practice protection for Certified Direct Care Workers at this time, this may be a future consideration for the established governing body. Practice protection in this case would mean that only individuals completing the

recommended education and training be allowed to provide the functions and services addressed by the education and training.

Impact – Implementation of this recommendation would mean only direct care workers completing the recommended education and training could use the term Certified Direct Care Worker. Title protection for Certified Direct Care Worker would allow consumers and employers to more easily hire individuals that have completed the recommended education and training, resulting in better safeguards for consumers.

14. Standardize Supervision of Direct Care Workers

Recommendation – IDPH and the implementation task force will establish a standardized condition for supervision based on the functions being performed within each classification regardless of setting. Requirements for supervision will differ between classifications. The roles and responsibilities of direct care worker supervisors (nurses and other supervisory positions) shall also be established and meet or exceed existing Federal or state requirements for supervision.

Rationale – Consistent supervision should be provided to direct care workers performing certain functions no matter what setting they are providing care in. This includes the specialty areas such as administration and management of medications by a direct care worker.

Impact – Implementation of this recommendation will guarantee the appropriate support, oversight and accountability is provided for direct care workers requiring supervision regardless of where they are providing care. This will improve the quality of services and care provided to consumers.

15. Shift Responsibility for Credentials to Individual Direct Care Workers

Recommendation – IDPH and the implementation task force will change current policy to assign responsibility of maintaining credentials and continuing education and training to the individual direct care worker and shift that responsibility from the employer.

Rationale – Direct care workers, through this classification and standardized education system, will seek to improve their skills, knowledge, and marketability and will need to have access to and be accountable for their own development. Currently employers are responsible for managing the credentials of direct care workers, making it difficult for direct care workers to establish control of their professional lives and requiring additional administrative time of employers.

Impact – This recommendation will result in a direct care workforce that has greater autonomy and responsibility for its professional development, and ultimately, quality of care provided.

16. Require Income Maintenance Workers and Case Managers to Provide Information to Home and Community Based Waiver Participants

Recommendation – IDPH and the implementation task force will work with the Iowa Department of Human Services to require income maintenance workers and case managers to provide information about the education and training direct care workers should receive to provide care and services according to the consumers needs under the home and community based waiver options.

Rationale – There is concern that individuals participating in home and community based waivers system will not have information about the education and training a potential direct care worker should have received to provide high quality services. Income maintenance workers and case managers are in a unique position to be able to provide education and training-related information to participants based on the coordinating role assigned to those individuals.

Impact – Participants in the home and community based waivers system will be provided information about the education and training direct care workers should receive in order to provide services and care according to the consumers needs. This will allow for participants to make a more informed decision before hiring a direct care worker.

Category Three: Establishment and Responsibilities of a Governing Body

Following the implementation of the recommendations discussed above, a governing body should be created. The governing body will be responsible for providing oversight and monitoring of the system. It will also be responsible for ensuring the health and safety of the public, including disciplinary review and action. The following recommendations address governance issues for direct care worker education and practice.

17. Establish a Governing Body for Direct Care Workers

Recommendation – The Legislature will establish a direct care worker governing body within the Iowa Department of Public Health to provide accountability and oversight of certification and impose professional standards. The governing body will monitor classifications, competency, education, and training requirements to respond to an ever-changing direct care industry. It will also be responsible for disciplinary review and action and will ensure compliance with existing regulation, such as the nurse delegation act. Responsibilities of the governing body should include:

- Protecting the public
- Ensuring consistency and equity among and between classifications of direct care workers
- Investigation of credentialing issues
- Imposing disciplinary actions, including decertification
- Conducting ongoing review and authority to change requirements
- Providing guidance and direction to the Directory of Certified Direct Care Workers administration

Rationale – Without the establishment of a governing body, no entity will be responsible for ensuring the above recommendations are maintained.

Impact – The establishment of a governing body will guarantee consistent and responsive education and training standards resulting in a direct care workforce that provides quality services to all Iowans.

18. Include Representation of Primary Stakeholders in Governance

Recommendation – The Legislature, IDPH and the implementation task force will ensure the governing body includes adequate representation of the six classifications of direct care workers, supervisor occupations, educators, and citizen consumers of direct care services. Policy should ensure the governing body is established in the most appropriate environment with adequate resources and reasonable regulatory support.

Rationale – As the policymaking process moves forward, it is sometimes easiest to use an existing model or structure to shortcut new policy. Because there is estimated to be upward of 75,000 direct care workers in Iowa, the initial and ongoing governance of these occupations is critical and is best served by careful structuring of the governing body and accompanying rules. The Task Force is convinced that current funding cannot support the implementation of this new system, including the creation of a governing body.

Impact – Governance of this critical workforce establishes direct care workers in the mainstream of the health and long term care system with high standards and the right level of oversight to protect the public. As with other health and long term care occupations ranging from massage therapists to physicians, accountability and standards are led and maintained by boards inclusive of the primary stakeholders. Over time, the Board of Direct Care Workers will be instrumental in enhancing the role and performance of the workforce.

Category Four: Directory of Certified Direct Care Workers

As part of the legislative charge, the Iowa Direct Care Worker Task Force was asked to recommend a process for establishing a direct care worker registry by expanding the Iowa Nurse Aide Registry to integrate all direct care workers. The successful implementation of the above education and training related recommendations rest firmly on the expansion of Iowa Direct Care Worker Registry. The Task Force is recommending that the Iowa Direct Care Worker Registry be called the Directory of Certified Direct Care Workers.

19. Expand the Iowa Direct Care Worker Registry

Recommendation – The Iowa Direct Care Worker Registry shall be called the Directory of Certified Direct Care Workers and will include all classifications of certified direct care workers as well as their completed education and training. The Task Force recognizes that resources are needed to expand the Iowa Direct Care Worker Registry.

Rationale – The change in nomenclature is important for two reasons. First, the new Directory of Certified Direct Care Workers communicates that individuals listed in the directory were issued certificates verifying their educational status. Second, the term "registry" has a negative connotation (i.e. the Sex Offender Registry or the Abuse Registry).

If an individual successfully completes the required education and training requirements and is issued a certificate of program completion (see above), that individual will be listed on the Directory as certified in one or more of the six classifications. The Directory will be housed within the Iowa Department of Inspections and Appeals. The Iowa Department of Inspections and Appeals will establish appropriate communication and information sharing practices with the Iowa Department of Public Health and the direct care worker governing body once it is established. The specific information that should be tracked in the Directory is detailed below.

Impact – The expansion and renaming of the Iowa Direct Care Worker Registry will ensure that appropriate information about Iowa's direct care workforce is tracked, maintained, and accessible. The Directory of Certified Direct Care Workers will be a vital information management tool for direct care workers, consumers, and employers.

The following table contains ideas regarding what information should be included in the Directory and who should have access to that information. It should be noted that the governing body may determine additional information needs to be tracked within the Directory. The governing body shall also determine who should have access to the information.

Information Included in the Directory	Direct Care Worker	Current Employer	Training Institutions	Public
1. Name	X	X	X	X
2. Address	X	X		
3. County of Residence	X	X	X	X
4. Social Security Number	X	X		
5. Date of Birth	X	X	X	X
6. Active / Inactive Status	X	X		
7. Employability Status	X	X	X	X
8. Classification(s)	X	X	X	X
9. Certification(s)	X	X	X	X
10. Date of Certification(s)	X	X		
11. Work History	X	X		
12. Continuing Education Status	X	X		
13. Scores of Skills Tests and Written Tests	X	X	X	
14. Dependent Adult Child Abuse Training	X	X	X	

The Challenge of Change

Hundreds of Iowans invested their time and effort into the work that resulted in this report. In order to ensure their feedback is taken into full consideration, stakeholders in the direct care workforce must assume a concentrated advocacy effort. Producing a report with recommendations is meaningless unless policymakers are made aware of and fully understand the issues. Additionally, it will take the sustained efforts of many individuals to ensure that policymakers are informed and encouraged to make progress on the issues and that individual efforts are coordinated with those of the Iowa Departments of Public Health, Inspections and Appeals, Human Services, and Elder Affairs. This process is expected to require, at a minimum, a two-year effort. Direct care workers across the state should be contacting their individual legislators to educate them about the report recommendations and encourage their support. Other organizations of consumers and related health issues or occupations may also wish to voice their support of this effort to improve the education and training of the estimated 75,000 direct care workers in the state. Sustained efforts will also be needed to promote the role of direct care workers in Iowa's health and long term care delivery system and to educate families, individuals, and public officials on the scope and value of the direct care workforce.

Summary of the Outreach

Outreach was conducted in June of 2006 through a series of six focus groups, two with each of the primary stakeholder groups (consumers/family members, direct care workers, and employers) and through an online survey. The outreach was designed to gather input on education and training requirements for each direct care worker classification from the perspectives of direct care workers, employers, and consumers/family members. State Public Policy Group provided assistance to the Task Force in the outreach process through which initial recommendations could be made regarding education and training requirements for direct care workers. It should be noted that the findings from the focus groups and survey are not generalizable across the broader population of consumers/family members, direct care workers, and employers.

Following is a summary of responses to major issues, beginning with quotes from participants in the focus groups. For more information on how meetings were structured, please see the outreach methodology in the Appendix of this report.

Focus Group Findings

In general, focus group participants supported the Task Force's approach to tackling the challenging questions related to education and training for Iowa's direct care workforce. There was some confusion about how to define a direct care worker. Some participants considered positions like nurses or maintenance personnel to be direct care workers. They considered anyone providing direct care or direct contact with the individual receiving the service to fall into this category. Consumers and family members, in particular, expressed that they felt this way.

Additionally, participants' responses varied somewhat when they were asked what first came to mind when they heard the term direct care worker. Some listed titles of direct care workers, others referenced the hands-on work completed by direct care workers, and some used terms like "underpaid" and "turnover." Overall, the focus groups demonstrated a lack of understanding and consensus regarding existing and appropriate education and training for direct care workers, thus demonstrating the need for the Iowa Direct Care Worker Task Force to thoroughly examine these issues and provide answers and guidance. When there is no prevailing view, as in this case, it becomes necessary for a representative group of stakeholders to convene, deliberate, and ultimately come to consensus as the Iowa Direct Care Worker Task Force has done.

1. **Direct Care Worker Titles and Familiarity with Education and Training**

   "When I hear direct care worker, I think immediately, what kind of training has that person had? When you hear CNA, you know what training they have had."

   Similar to earlier discussions by Task Force members, focus group participants could list many different titles for direct care workers, which did not necessarily describe the services provided by that direct care worker.

There were some differences of opinion regarding whether or not a direct care worker's title made it easy to determine what education and training an individual had received. The Certified Nurse Aide (CNA) was the easiest job title for participants to link to education and training, while other job titles were not as easily linked. Consumers and family members were least familiar with the education and training required by direct care workers.

2. Classifications of Direct Care Worker

"The training should be the same regardless of setting. This is especially important for a home health aide because they are out working on their own. I believe they need the same training no matter whether they are working in a hospital or as a home health aide. The oversight is different."

The Task Force categorized existing direct care workers by the types of services they perform, regardless of setting or job title. This process resulted in the creation of six classifications: environmental/chore; instrumental activities of daily living; personal care support; personal care activities of daily living; health monitoring and maintenance; and specialty skills. These classifications were presented to the focus group participants for feedback. For the majority of participants, the classifications identified by the Task Force made sense. Participants commented on the distinction between the classifications and recognized that the classifications were primarily divided by the amount of care or assistance needed.

3. Education and Training for Direct Care Workers

"The CNA position is becoming a career. We do many of the things that RNs used to do. There is a lifetime commitment to this profession just like nursing was years back. It is a necessity with our aging population, too."

The focus group participants who were currently serving as direct care workers all considered themselves to be "career direct care workers." All of them felt strongly that every direct care worker should have the same amount of education and training, stating that, perhaps, the CNA certification should be the minimum level of training required for direct care workers.

Many focus group participants referred to the need for more hands-on training, stating that many of the courses now taught to direct care workers focus on how to perform a particular service, but not necessarily how to care for an individual. Many employers responded that while they would like to see the education and training requirements improved for the direct care workforce, this is difficult given the high turnover and low

wages for many workers. There was also recognition among all focus group participants that several barriers to training exist, including cost, availability, and access. Some participants referred to the increase in regulation as a barrier as well. As a whole, the employers conducted their own orientation and training with new workers regardless of whether or not they had received training in the past.

When asked what level of care participants wanted for themselves or their family members, all responded that they wanted the highest level of care. Participants as a whole also agreed philosophically, that all individuals performing the same services should be required to take the same training.

4. Direct Care Worker Registry

"All direct care workers of any type should eventually be found on this registry."
"I think you should list different levels of skill and training for direct care workers on the registry. This will help to expand consumer choice."

The group of questions focusing on the Iowa Direct Care Worker Registry varied the most by the type of focus group participants. Not surprisingly, the consumer and family members knew the least about the Registry. There is certainly an opportunity for additional information to be made available to the general public about the Registry.

There were also differences of opinion regarding use of the Registry between employers and direct care workers. Direct care workers, in general, supported the expansion of the Registry, while only some employers supported its expansion, fearing administrative burden.

5. Implementation and Systems Change

Regarding grandfathering direct care workers, "You would have to have at least a certain number of years on-the-job. They would need to have some accumulated experience. There needs to be a certain line drawn in the sand."

Focus group participants had mixed responses regarding the grandfathering of workers given a change in education and training requirements. Some participants felt all workers should be required to meet the new education and training standards, whether they took courses or demonstrated their knowledge through testing. The other participants thought that workers who had a certain number of years experience should be exempt from any changes in requirements; there was no agreement on the number of years of experience a direct care worker should have.

"I think if a governing body were appointed … it would ensure a more standardized ongoing training program and assist with setting a standard of care."

The notion of a governing board also caused focus group participants to share various opinions. Some participants thought an efficient way to create a governing board for the Direct Care Worker Registry would be to create one that would be managed by the Iowa Board of Nursing. Rationale for this idea was based on not having to create a totally new entity and also to build off the successes of another governing body. Others, primarily the direct care workers, thought a governing board was needed, but they thought the direct care workforce would benefit from a structure outside of any existing entity.

Online Survey Findings

A non-probability survey was conducted to provide an additional opportunity for stakeholders to provide input to the Task Force. The survey accommodated input on a scale that could not be achieved through focus groups alone. The survey was distributed electronically to stakeholder agencies, providers and direct care worker associations, among others. There were 383 respondents from 84 counties. Respondents included direct care workers, employers, consumers and family members, and other stakeholders.

In general, survey findings demonstrated the need for the Iowa Direct Care Worker Task Force. Survey responses illustrated a lack of understanding regarding current education and training requirements for direct care workers, which is necessary to provide recommendations for changes or enhancements. Survey responses very clearly indicated that there is no prevailing view regarding the adequacy of existing education and training or changes that might enhance the quality of direct care services. Such findings underscore the need for the Task Force to gather information, participate in thorough discussion and deliberation on very complex issues, and ultimately reach consensus on recommendations. By creating the Iowa Direct Care Worker Task Force and clearly outlining their charge, the Iowa General Assembly took a strong step forward in ensuring the safety of Iowans and responding to the needs of the direct care workforce.

Process and Methodology

The process to improve and streamline education and training requirements for Iowa's direct care workforce was designed and implemented by State Public Policy Group (SPPG) under contract with Iowa Department of Public Health. The use of a non-government, outside facilitator with previous experience working with Iowa's health care providers and other stakeholders was important to ensure a deliberative process, a comprehensive review of the current situation and challenges facing the direct care workforce, and consensus on recommendations.

Beginning in December 2005, the process was implemented over a 12-month period. The time frame allowed the necessary time for a thorough review of existing direct care worker classifications and corresponding education and training, as well as stakeholder input to ensure that consumers receive the supports and services they need.

Task Force members were appointed by the Governor's office from a pool of interested applicants. The Task Force was composed of individuals from across the state representing certified nurse aides, home health aides, nurses, physician assistants, consumers, hospitals, community colleges, and the Iowa CareGivers Association. SPPG conducted early interviews with Task Force members and other stakeholders to gain an understanding of their unique perspectives and goals for the work of Task Force. These interviews also allowed SPPG to collect information that revealed the complexity of the issues facing the Task Force, possible model state systems for research, and an early outline of current education and training requirements for direct care workers.

The charge of the Task Force and scope of work were clearly outlined by the Legislature. The first task involved defining the direct care workforce by determining the professions that should be considered direct care workers and, therefore directly impacted by the recommendations of the Task Force. The Task Force proceeded by reviewing and outlining the corresponding education and training requirements for each direct care worker classification identified. This required a thorough review and understanding of state and Federal laws pertaining to direct care workers.

Through facilitated discussion, the Task Force reached consensus on initial recommendations regarding the appropriate education and training requirements for each direct care worker classification. Concurrently, a workgroup outlined competencies for each direct care worker classification which will support education and training providers in the development of curriculum.

SPPG conducted six focus groups to obtain input from stakeholders regarding initial recommendations and remaining issues for the Task Force to address. Focus groups were held with consumers and family members, direct care workers, and employers. Two sessions each were held with each stakeholder category. A key element of the methodology was to separate the three participant groups to isolate each group's input from the other groups to ensure open discussion.

Sites were selected on the basis of geographic location and size, including a balance of urban and rural sites.

To supplement the feedback from the focus groups, an online survey was developed and distributed to a broad audience of stakeholders. Upon completion of the six focus groups and survey, SPPG summarized the feedback and input from the meetings and provided a report to the Task Force to inform their recommendations. For more information regarding the focus groups and survey, please see the outreach summary contained in this report.

SPPG also conducted a review of practices in other states related to a governing body that would be charged with oversight of training, education, and continuing education for direct care workers. The information gathered from other states provided a foundation for discussion and finalization of recommendations regarding the composition and responsibilities of a governing body.

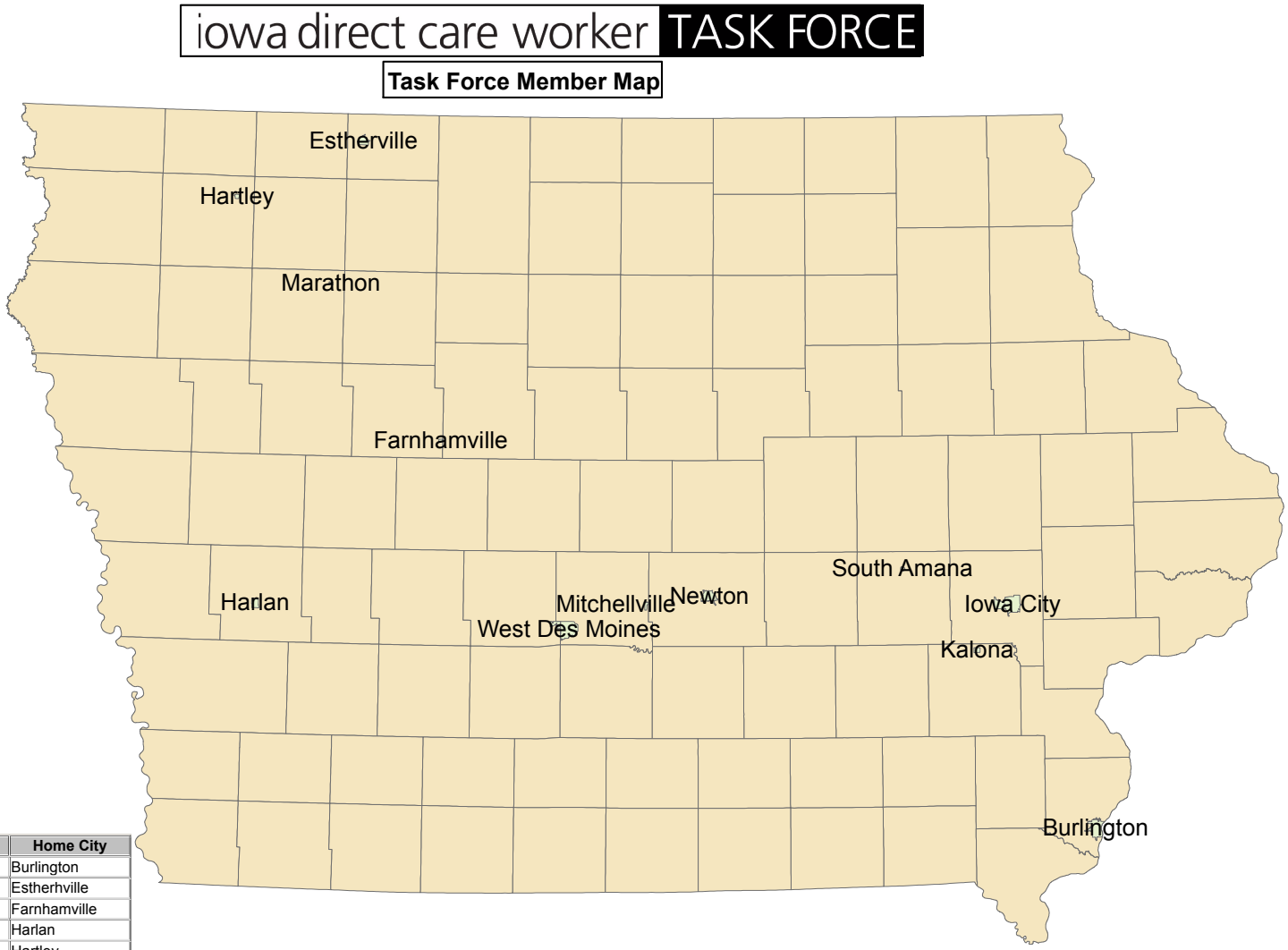
SPPG, at the request of the Task Force, coordinated presentations and information sharing from stakeholder groups to support and inform decision making. This included information and/or presentations about consumer choice, the Better Jobs Better Care Coalition, an AARP consumer survey, the Bureau of Professional Licensure, and the Iowa Board of Nursing.

The final report and recommendations encompass information and consensus recommendations developed during 11 full-day Task Force meetings throughout the 13-month process.

Appendix

Iowa Direct Care Worker Task Force Map
Federal and State Code and Rules
Core Competencies / Learning Objectives
State Review
Focus Group Report
About State Public Policy Group

Iowa Direct Care Worker Task Force Map



Name		Home City
Suzanne	Russell	Burlington
Diane	Frerichs	Estherhville
Cindy	Kail	Farnhamville
Bill	Miller	Harlan
Tony	Wells	Hartley
Ginny	Kirschling	Iowa City
Tony	Brenneman	Kalona
Judy	Haberman	Marathon
Di	Findley	Mitchellville
Bob	Campbell	Newton
Larry	Hertel	South Amana
Ivan	Lyddon	West Des Moines

Federal and State Code and Rules

- Federal Code 484.36, Centers for Medicare and Medicaid Services
- P.L. 100-203 Nursing Home Reform Act, Omnibus Budget Reconciliation Act (OBRA)
- Iowa Administrative Code, Chapter 24, Iowa Department of Elder Affairs
- Iowa Administrative Code, Chapter 25, Iowa Department of Elder Affairs
- Iowa Administrative Code, Chapter 58, Iowa Department of Inspections and Appeals
- Iowa Administrative Code, Chapter 80, Iowa Department of Public Health
- Iowa Administrative Code, Chapter 81, Iowa Department of Human Services
- Iowa Administrative Code, Chapter 114, Iowa Department of Inspections and Appeals

Core Competencies / Learning Objectives

Education and Training Orientation Core Competencies

This orientation is an agency-specific training, but should address the following components.

Confidentiality

1. All workers will demonstrate understanding of confidentiality laws (HIPAA) and the rights of the consumer regarding confidentially.
2. Shows respect for consumer and family and their rights and maintains visual and auditory privacy and confidentiality of information in all modes of communication.

Ethics and Legal

1. All workers will understand they can be personally held liable for illegal/unethical activities at work.
2. All workers understand they are responsible for behaving in an ethical manner as they work and conduct business.
3. Understands scope of responsibilities. Demonstrate knowledge of routine care tasks and limitations of scope of responsibilities and how to communicate decisions made.

Consumers' and Workers' Rights

1. All workers will provide services in ways that respect and enhance consumers' rights such as autonomy, privacy, self-esteem, and involvement of an individual in their own treatment.
2. All consumers have the right to receive services and support in an environment free from abuse.
3. All workers have the right to provide services and support in an environment free from abuse.

Person Directed/Consumer Centered Care

1. Discuss approaches to implement consumer centered care.
    a. Know each consumer
    b. Personalize care
    c. Build and support relationships
    d. Recognize culture change (change in attitudes towards self and aging/condition)
2. All workers will respect the dignity and independence of all persons for whom they provide services by only providing those supports that are identified in an individual assessment of need.

Cultural Competency

1. All workers will demonstrate the ability and knowledge to communicate and understand health behaviors influenced by culture and an individual's belief systems, in the affected population or population served.

Growth, Development, and Disability Specific Competency

1. Recognizes unique needs of consumers from the beginning of life to end of life.
2. Explains and performs all procedures in an age appropriate manner according to the level of understanding of the consumer/family.
3. Recognizes and understands the unique supports that may be specific to a targeted disability population.

Observation, Referral, and Reporting

1. Demonstrates and implements services, observes response to services, and implements appropriate changes within the worker's scope of practice.
2. Demonstrates responsibility concerning consumer rights to include proper reporting of abuse, neglect, and exploitation.
3. Reports observations to appropriate individual/entity.

Communication and Interpersonal Skills

1. Communicates appropriate information to staff members in a courteous, professional and approachable manner. Maintains professional composure at all times, ensures consumer care is delivered, and manages conflicts appropriately and in a timely manner.
2. Recognizes unique age and language appropriate communication needs of consumer and responds appropriately.
3. Read and/or follow simple direction/signs, and follow simple oral and/or written instructions in the language of the consumer.

Problem Solving

1. Uses own knowledge and experience base and other resources as necessary to make logical decisions and solve problems.

Safety and Emergency Procedures

1. All workers will demonstrate knowledge of emergency preparedness and procedures, such as what to do in case of illness or injury, fire, severe thunderstorm watch or warning, tornado watch or warning, winter storm watch or warning, flood, or personal injury related to assault or intruders.

Infection Control and OSHA Guidelines

1. All workers will demonstrate understanding of universal precautions.
2. Demonstrates ability to identify and reduce the risks of acquiring and transmitting infections between consumers, employees, and visitors.
3. Maintaining a clean, safe, and healthy environment.

Professional Training and Education

1. All workers shall receive information regarding inclusion on the Iowa Direct Care Worker Registry and will maintain certification as a direct care worker using this system.
2. Direct care worker students should have information available to them regarding professional development and training opportunities and organizations.

Environmental / Chore Core Competencies

Defined as functions that are necessary for an individual to live independently that encompasses heavier cleaning tasks, including outside maintenance and chores. There is no physical contact between workers and clients.

While education and training beyond the required education and training orientation is not recommended for individuals performing environmental / chore functions, services provided may include:

- Heavy household cleaning
- Garbage removal
- Shoveling snow
- Changing light bulbs
- Putting screens on windows
- Cover/uncover air conditioners
- Lawn care/mowing

Instrumental Activities of Daily Living Core Competencies

Defined as care to assist an individual to function independently. This care goes beyond basic needs and transcends into care necessary for an individual to be able to live independently. There is no physical contact between workers and clients.

Prevention of disease and injury (infection control)

1. Apply the principles of infection control to specific work environments.
2. Use and demonstrate basic infection control procedures.
3. Maintain a clean, safe, and healthy environment for the consumer.
4. Follow the concepts of universal precautions, demonstrate practices that reduce the transfer of infection such as disposing of articles in proper receptacles, cleaning equipment and using personal protective equipment.
5. Demonstrate effective hand washing techniques following all rules of asepsis.

Home management (using the phone, laundry, shopping, cooking, washing dishes, bed making, and light housekeeping)

1. Demonstrate how to operate common cleaning equipment.
2. Demonstrate an ability to work safely, lift and move lightweight objects.

Financial management (managing money, but not serving as a payee)

1. Demonstrate basic math skills, how to balance a checkbook, knowledge of budgets and finances.
2. Demonstrate how to assist consumers in managing monthly income and expenditures.

Food preparation and nutrition (food safety, shopping, awareness of special diets, but not cooking skills)

1. Demonstrate menu planning, feeding techniques, and the importance of fluid intake and temperature of food.
2. Demonstrate proper cleaning and sanitation, proper handling of potential hazardous foods, factors that affect food borne illness, good personal hygiene and food safety regulations.

Personal Care Support Core Competencies

Defined as providing support to individuals as they perform personal and instrumental activities of daily living (support role for activities of daily living – personal and instrumental). There is no physical contact between workers and clients.

The training and education approach needs to reflect how an individual teaches or supports an individual in Instrumental Activities of Daily Living and Personal Care Activities of Daily Living. While the training and education for this category will be focused on teaching and support skills, not performing the skills, individuals providing personal care support services will also have training in Instrumental Activities of Daily Living and Personal Care Activities of Daily Living (classroom, not clinical).

Teaching / Training

1. State and define the purpose of task analysis.
2. Demonstrate the use of task analysis.
3. Summarize the basic steps in conducting task analysis.
4. Describe four principles to guide instruction of persons with disabilities in task performance.

Observation / Recording / Documenting

1. Record and graph data using recording procedures.
    a. Observe and record behaviors
    b. Observe and record frequency of behaviors
    c. Record interventions used
    d. Record responses to interventions
2. Identify when to use each of the recording procedures.
3. Define observation, recording, and documentation terms.

Coaching / Supporting / Supervising

1. Acquisition of task performance skills.
    a. Showing
    b. Telling
    c. Assisting
2. Improve proficiency of tasks through physical assistance and feedback.
    a. Most-to-least prompting
    b. Least-to-most prompting
3. Strengthening safety skills.
4. Describe fading of assistance/support and generalization of tasks across multiple settings.
5. Describe the importance of fading and generalization.
6. Discuss ways to fade assistance by reducing prompting and using other cues.
7. Describe methods for reinforcing appropriate behavior.

Personal Care Activities of Daily Living Core Competencies

Defined as care to assist an individual in meeting their basic needs, acknowledging personal choices and encouraging independence. In most cases, physical contact would be involved between workers and clients.

Eating and feeding (swallowing, choking)

1. Briefly identify the basic body structure of the digestive system and the functions that occur during the digestive process.
2. Discuss digestive changes that may occur in consumers that affect nutrition.
3. List components of a well-balanced diet.
    a. Describe the food pyramid
4. Identify fluid needs of consumers.
    a. Describe guidelines to follow passing drinking water
5. Describe selected basic therapeutic diets.
6. Identify the worker's role in preparing the consumer's meals.
7. Identify the worker's role in feeding the consumer.
8. Demonstrate feeding a consumer.
9. Assist/feed the consumer with swallowing problems.
10. Discuss the possible causes related to choking.
11. Demonstrate proper administration of emergency intervention for choking victims.
12. Discuss the worker's role in food safety.

Bathing, back rubs, skin care, grooming (hair care, nail care, oral care, shaving), dressing & undressing, toileting (includes urinal, commode, bedpan)

1. Describe the worker's role in helping consumers meet daily living hygiene needs.
2. List the daily hygiene requirements of all consumers.
3. Describe some of the factors that affect a consumer's hygiene practice.
    a. List special considerations for helping consumers meet daily care needs
4. Assist consumer with oral hygiene to include care of the mouth, gums, teeth, and dentures: conscious, unconscious and dental care.
5. Assist consumer with bathing.
    a. Identify four purposes for bathing
    b. Discuss ways of bathing
    c. Determine when a partial bed bath should be given
    d. Demonstrate a partial bed bath
    e. Determine when a complete bed bath is given
    f. Demonstrate a complete bed bath
    g. Identify three purposes of a whirlpool
    h. Assist the consumer with a shower

   i. Discuss purpose, procedure and demonstrate a back rub
   j. Observe and report changes in skin condition
6. Assist consumer with shampooing hair.
7. Assist consumer with nail care.
8. Discuss the general principles of assisting the consumer with undressing, dressing and grooming.
9. Discuss the importance of assisting the consumer with a shave.
10. Discuss methods of assisting consumers with elimination needs.
11. Demonstrate the ability to assist a consumer with a urinal, bedpan, and commode.
12. Discuss pressure sores.
    a. Identify pressure points
    b. Identify consumers at risk for pressure sores
    c. Identify the conditions that can lead to formation of/or worsening of a pressure sore
    d. Describe the signs and symptoms of a pressure sore
    e. Discuss the stages of pressure sores
    f. Discuss the worker's role in prevention of pressure sores
    g. Discuss the special equipment that may be used in the prevention of pressure sores

Mobility assistance (transfers to chair/bed, walking, turning in bed, etc.)

1. Describe methods to safely transport consumers.
    a. Demonstrate safety with wheel chairs
    b. Discuss the safe use of a mechanical lift
2. Briefly identify and discuss the normal basic body structures of the muscular skeleton system.
    a. Identify the bony landmarks in the body
3. Discuss "safe patient handling" as it applies to the worker.
    a. List risk factors that put the worker at risk for musculoskeletal injury during consumer handling and movement
    b. Recognize high risk consumer care activities
    c. Recognize environmental conditions that cause high risk to workers
    d. Identify possible "best solutions" for consumer handling
    e. Discuss musculoskeletal disorders in workers
4. Discuss body mechanics as it applies to the worker.
    a. Demonstrate rules of correct body mechanics
    b. Demonstrate the ability to lift and move a consumer in bed
5. Discuss the proper use of the transfer/gait belt to transfer/ambulate consumer.
    a. Demonstrate the ability to transfer a consumer from bed to chair
    b. Describe the general use of assistive devices
6. Discuss the necessity of helping consumers maintain normal body alignment.
    a. Discuss the causes of postural changes in the elderly that affects positioning
    b. Discuss how the plan of care should be utilized in determining the positioning of the consumers
    c. Demonstrate correct positioning of a consumer in the supine and side lying position
7. Discuss disabilities that can occur as a result of immobility.
    a. Discuss the role of the worker in prevention of contractures or foot drop
    b. Assist the consumer to safely ambulate

Health Monitoring and Maintenance Core Competencies

Defined as medically-oriented care that assists an individual in maintaining their health on a daily basis. In most cases, physical contact would be involved between workers and clients.

Checking vitals - temperature, pulse, respiration, blood pressure, pain assessment; measuring height and weight; handling/gathering specimens

1. Provide routine care procedures within their scope of responsibilities.
    a. Discuss vital signs and define the abbreviations for each
    b. List methods of measuring body temperature

   c. Identify normal body temperature of adults and differentiate Fahrenheit and Celsius
   d. Discuss procedure to take an oral temperature
   e. List consumer conditions that require a rectal temperature
   f. Identify consumer conditions when an axillary temperature should be taken
   g. Demonstrate methods of obtaining oral, rectal and tympanic temperatures
   h. Accurately record temperature
   i. Determine when appropriate staff should be notified concerning consumer's temperature
2. Discuss the normal structure and function of the circulatory system.
   a. Identify the areas of the body where the pulse can be obtained
   b. Identify the normal pulse rates for adults (children, infants)
   c. Discuss the method of obtaining a radial pulse
   d. Define terms related to pulse
   e. Demonstrate the procedure to obtain and record a radial pulse
   f. Describe the abnormal pulse beats that should be reported to the appropriate staff
3. Discuss the respiratory system.
   a. Identify the normal respiratory rate
   b. Discuss the factors that affect respiration rate
   c. Demonstrate the procedure to obtain and record a respiration rate
   d. Determine when the appropriate staff should be notified concerning consumer's respirations
4. Discuss the circulatory system in relation to blood pressure (B/P).
   a. Name the two measurements that are obtained when measuring B/P
   b. Discuss factors that affect blood pressure in adults (children)
   c. Demonstrate the ability to correctly obtain a B/P
   d. Describe when the appropriate staff should be notified concerning a consumer's B/P
5. Discuss pain as the 5th vital sign.
   a. Recognize the influence of age, language, and culture on the perception of pain
   b. Realize that pain perception often changes with aging to include the minimization of normally acute symptoms (i.e. chest pain associated with myocardial infarction, pain associated with broken bones) in the geriatric population
   c. Alert appropriate staff and/or provider to the presence of pain
6. Identify measures for accurately weighing the consumer.
   a. Demonstrate the ability to weigh and measure a consumer with an upright scale

<u>Measuring intake and output; catheter care; ostomy care; urinary care; collecting urine and fecal samples</u>

1. Discuss the role of the worker to help consumers maintain fluid balance.
   a. Discuss the importance of accurately measuring and recording fluid intake and output
   b. Define abbreviations used for intake and output
   c. Identify the unit of measurement used in recording I & O
   d. Discuss the procedure to measure fluid intake
   e. Describe the interventions to accurately measure consumer input
   f. Describe the worker's role in encouraging fluids
   g. Identify methods for assisting the consumer who has fluids restricted
   h. List methods for assisting or caring for consumers who are NPO
   i. Discuss fluid output and the importance of measuring fluid output
   j. Demonstrate the ability to accurately measure output
   k. Recognize when your immediate supervisor should be notified concerning consumer's output
2. List common body specimens.
   a. Identify the role of the worker in obtaining specimens in maintaining medical asepsis
   b. Discuss the "ten rights" of specimen collection
   c. Label a specimen correctly
   d. Demonstrate the ability to correctly obtain a routine urine specimen
3. Discuss the normal anatomy of the gastrointestinal tract.
   a. Discuss other reasons associated with chronic gastrointestinal irregularities

   b. Describe the symptoms and complications associate with fecal impaction
   c. Discuss the symptoms and complications associated with constipation
   d. Discuss the worker's role in enema administration
   e. Discuss and identify the worker's role in prevention and treatment of gastrointestinal irregularity
   f. List alternative methods of bowel elimination
   g. Discuss the altered anatomy of a colostomy/ileostomy
   h. Discuss the difference between a colostomy and an ileostomy
   i. Identify various ostomy appliances and methods used to apply them
   j. Discuss the major ostomy problems that the worker should be aware of when giving care to a consumer with a colostomy
4. Identify devices used in the urinary draining system.
   a. Discuss the worker's role in a closed drainage system and its purpose
   b. Demonstrate the ability to give catheter care
   c. Demonstrate the ability to empty a drainage bag, measure the urine and re-close the system
   d. Describe the worker's role in care of the leg drainage bag
   e. Identify the important observations that a worker will make regarding any consumer that has a urinary catheter
5. Discuss the major causes of bowel and bladder problems of consumers.
   a. Recognize the factors that are associated with incontinence that make management more difficult
   b. Describe a bowel and bladder rehabilitation program
   c. List the observations/interventions that a worker can make that will assist in the development of a bowel and bladder program
   d. Demonstrate incontinent care

Application of TED hose; heat and cold packs; range of motion exercises

1. Discuss the worker's role in application of heat and cold.
2. Recognize the circulatory needs for TED hoses.
3. Describe the benefits of TED hose (anti-embolism stockings).
   a. Demonstrate application and removal of TED hose
4. Discuss complications that result from immobility.
5. Discuss factors related to range of motion (ROM).
   a. Define range of motion
   b. Define the types of ROM
   c. Discuss guidelines for ROM
   d. Discuss the effects of limited ROM on function
   e. Discuss factors that affect or influence muscle control
   f. Demonstrate active and passive ROM
6. Recognize when your immediate supervisor should be notified concerning changes in skin conditions, mobility, or pain.

Specialty Skills Core Competencies

Defined as functions that require additional education and training in order to provide specialty services to individuals. In most cases, physical contact would be involved between workers and clients. It is important to note that certain specialty skills must be delegated by licensed nurses in specific settings. This is not a comprehensive list of all skill areas. Direct care workers who have completed training not listed here will be able to indicate the additional training on the Iowa Direct Care Worker Registry.

Dementia and Alzheimer's Care

1. Explain the disease or disorder.
2. Identify symptoms and behaviors of memory impaired people.
3. Explain the progression of the disease.
4. Describe communication of CCDI residents.
5. Make adjustments to Care Facility Residency by the CCDI Unit or Facility.
6. Understand residents and how to deal with difficult individuals.
7. Discuss inappropriate and problem behavior of CCDI Unit or Facility.
8. Discuss Activities of Daily Living (ADL) for CCDI Residents.
9. Explain how to handle combative behavior.
10. Describe stress reduction for staff and residents.

Psychiatric care (including all mental health issues); plan activities and exercises for social, physical, and emotional/mental health

Core competencies and learning objectives need to be defined, but additional education and training should be undertaken by direct care workers in order to provide quality services to consumers.

Monitoring Medications

1. Explain the procedures of drug administration for non-parenteral medications.
2. Describe the procedure for supervising self-administration of medications.
3. Discuss the special considerations for monitoring.
4. Discuss rules for recording medications.

Administration of Medications

1. Administer the right medication in the right dose via the right route to the right consumer at the right time.
2. Identify consumer identity.
3. Understand the purpose of the medication and its intended effect.
4. Recognize signs and symptoms of anaphylaxis/overdose and acts appropriately.
5. Recognize and responds to unique medication needs of pediatric through geriatric consumers.
6. Respond appropriately by administering correct dose for age/weight and by monitoring medication effects.
7. Verify allergies before administration and documents medications given and the consumer's response.

Simple dressing changes; drawing blood, sputum & cultures; giving shots; giving enemas; respiratory management

1. Administer enemas
    a. Understand the purpose of enemas
    b. Identify types of enemas
    c. Describe appropriate precautions and procedures
2. Collect specimens
    a. Understand the purpose of collecting specimens
    b. Identify the types of specimens
    c. Discuss general precautions and procedures

Core competencies and learning objectives for simple dressing changes, drawing blood, sputum and cultures, giving shots, and respiratory management need to be defined, but additional education and training should be undertaken by direct care workers in order to provide quality services to consumers.

Hospice and Palliative Care

1. Clinical Judgment – Demonstrate critical thinking, analysis and clinical judgment in the care of patients and families experiencing life-limiting, progressive illness to address the physical, emotional, psychosocial needs of the patients and families.
2. Advocacy and Ethics – Incorporate ethical principles and hospice and palliative standards in the care of patients and families experiencing life-limiting, progressive illness as well as identifying and advocating for the wishes and preferences of patients and families.
3. Role Performance – Demonstrate knowledge, attitudes, behaviors and skills that are consistent with the performance standards, code of ethics and scope of practice for hospice/palliative direct care workers.
4. Collaboration – Encourage dialogue with patients and families experiencing life-limiting progressive illness and bereavement to actively address patient and family goals in collaboration with the interdisciplinary team and community.
5. Systems Thinking – Utilize resources necessary to enhance quality of life for patients and families experiencing life-limiting, progressive illness and bereavement through knowledge and collaboration within the health and human service systems.
6. Facilitator of Learning – Facilitate learning for patient, family, other team members and community through formal and informal education related to living with and dying from a life-limiting, progressive illness and the grief process.
7. Communication – Demonstrate the use of effective verbal, non-verbal and written communication with patients, families, other team members and community in order to meet the patient and families hospice/palliative goals and needs.

Protective Services

Core competencies and learning objectives need to be defined, but additional education and training should be undertaken by direct care workers in order to provide quality services to consumers.

Restorative and Strengthening Exercises – Ambulation

1. Mobility – Demonstrate use of appropriate mobility, balance and strengthening exercises as well as incorporate these into therapeutic activities.
2. Activities of Daily Living – Demonstrate and use task segmentation in assisting a resident to complete activities of daily living and appropriate use of adaptive equipment.
3. Restorative Dining – Demonstrate understanding of client specific goals related to restorative dining and swallowing deficits.
4. Restoring Continence – Document response to individualized toileting plans and compile elimination data to determine appropriate toileting plans.
5. Special Treatments – Demonstrate appropriate use of special treatments (i.e. heat and cold therapy modalities) according to state-specific regulations.
6. Prosthetic Care – Demonstrate appropriate prosthetic care and assistance.
7. Special Populations – Demonstrate techniques for working with clients with aphasia, dysarthria, emotional lability and other communication challenges or limitations.
8. Plan of Care – Report observations of client's condition or change in functional status based on developed plan of care using restorative concepts, documentation and communication.
9. Pain Management – Incorporate knowledge of care of clients with chronic pain.
10. Safety Issues – Demonstrate the safe use and maintenance of equipment.

Mentoring

1. Primary Purpose of Mentoring – Provide direction and orientation to other direct care workers who are either new to the organization or who are pursuing additional education and training.
2. Client Care – Provide oversight and assist in providing and demonstrating client care to meet the competencies for each apprenticeship and/or orientation in which a direct care worker is enrolled.

3. Client Rights – Provide oversight and demonstrate respect and adherence to all client rights to meet the competencies for each apprenticeship and/or orientation in which the direct care worker is enrolled.
4. Communication – Provide oversight and demonstrate therapeutic interactions with all clients, families, significant others as well as with peers to meet the competencies for each apprenticeship and/or orientation in which the direct care worker is enrolled.
5. Safety – Provide oversight and demonstrate the implementation of safety measures according to organization procedures to meet the competencies for each apprenticeship and/or orientation in which the direct care worker is enrolled.
6. Infection Control – Provide oversight and demonstrate the implementation of infection control measures according to organization procedures to meet the competencies for each apprenticeship and/or orientation in which the direct care worker is enrolled.
7. Monitoring – Assist in monitoring and verifying competence of the apprentice/orientee, provide direction and assistance in organization integration and serve as a resource/contact for questions or concerns that arise during the process.

State Review

Iowa

- Does the state have a governing body for direct care workers?
  Iowa does not currently have a governing body for direct care workers.

  If the state has a governing body, what responsibilities does that body have (discipline, training and education requirements, curriculum oversight, training and education providers, etc.)?
  Not applicable.

- Where is the Certified Nursing Assistant Registry housed?
  Iowa Department of Inspections and Appeals
  Lucas State Office Building
  321 East 12th Street
  Des Moines, Iowa 50319-0083
  (515) 281-7102

- Does the Registry include information about additional direct care worker types (beyond CNA, which is a federal requirement)?
  Not currently, but upgrades have been made to the Registry so that additional direct care worker types can be included.

- If so, which types are included (certified home health assistants/aides, medication aides, or medical assistants, etc.)?
  Not applicable.

- Are direct care workers registered, certified, or licensed (we know there are many different types of direct care workers so please ask the specific types as part of the question)?
  Iowa, like every state, has certified nursing assistants, but certification for all other direct care worker types is currently not a requirement.

- Are direct care workers responsible for keeping track of their credentials (training and education courses completed, continuing education, etc.)?
  In Iowa, employers currently keep track of direct care worker credentials.

Illinois

- Does the state have a governing body for direct care workers?
  No.

- If the state has a governing body, what responsibilities does that body have (discipline, training and education requirements, curriculum oversight, training and education providers, etc.)?
  Not applicable.

- Where is the Certified Nursing Assistant Registry housed?
  Illinois Department of Public Health
  535 West Jefferson Street
  Springfield, Illinois 62761
  (217) 524-0137

- Does the Registry include information about additional direct care worker types (beyond CNA, which is a federal requirement)?
  Yes.

- If so, which types are included (certified home health assistants/aides, medication aides, or medical assistants, etc.)?
  Certified nurse assistants who work in intermediate care facilities for the mentally retarded and home health aides. Training programs for aides to the developmentally disabled are coordinated through the Illinois Department of Human Services.

- Are direct care workers registered, certified, or licensed (we know there are many different types of direct care workers so please ask the specific types as part of the question)
  Certified.

- Are direct care workers responsible for keeping track of their credentials (training and education courses completed, continuing education, etc.)?
  Unknown.

Indiana

- Does the state have a governing body for direct care workers?
  No.

- If the state has a governing body, what responsibilities does that body have (discipline, training and education requirements, curriculum oversight, training and education providers, etc.)?
  Home health agencies and hospices must establish their own qualifications for home health aides. Home health aides must provide assistance under the direction of a physician, chiropractor, podiatrist or optometrist.

  State government does not certify training sites or syllabus for home health aides

- Where is the Certified Nursing Assistant Registry housed?
  Indiana State Department of Health
  2 N. Meridian Street
  Indianapolis, IN 46204
  (317) 233-1325

- Does the Registry include information about additional direct care worker types (beyond CNA, which is a federal requirement)?
  Yes.

- If so, which types are included (certified home health assistants/aides, medication aides, or medical assistants, etc.)?
  Nursing home aides, home health aides, hospice aides, and medication aides.

- Are direct care workers registered, certified, or licensed (we know there are many different types of direct care workers so please ask the specific types as part of the question).
  Nurse aides are certified. Home health aides are registered.

- Are direct care workers responsible for keeping track of their credentials (training and education courses completed, continuing education, etc.)?
  Providers must affirm that certified nurse aides, qualified medication aides and registered home health aides have completed the required work experience and/or in-service

Kansas

- Does the state have a governing body for direct care workers?
  No.

  If the state has a governing body, what responsibilities does that body have (discipline, training and education requirements, curriculum oversight, training and education providers, etc.)?
  Not applicable.

- Where is the Certified Nursing Assistant Registry housed?
  The Kansas Department of Health and Environment
  Curtis State Office Building
  1000 SW Jackson
  Topeka, KS 66612
  (785) 296-1500

- Does the Registry include information about additional direct care worker types (beyond CNA, which is a federal requirement)?
  Yes.

- If so, which types are included (certified home health assistants/aides, medication aides, or medical assistants, etc.)?
  Certified nurse aides, home health aides, and certified medication aides.

- Are direct care workers registered, certified, or licensed (we know there are many different types of direct care workers so please ask the specific types as part of the question).
  Nurse aides and medication aides are certified. There is no certification or other educational accreditation for home health aides.

- Are direct care workers responsible for keeping track of their credentials (training and education courses completed, continuing education, etc.)?
  No, employers are responsible for keeping track of their employees' credentials.

Michigan

- Does the state have a governing body for direct care workers?
  No.

- If the state has a governing body, what responsibilities does that body have (discipline, training and education requirements, curriculum oversight, training and education providers, etc.)?
  Not applicable.

- Where is the Certified Nursing Assistant Registry housed?
  The Michigan Department of Community Health
  Bureau of Health Professions
  Ottawa Building
  611 W. Ottawa Street, First Floor
  P.O. Box 30670
  Lansing, MI 48909-8170
  (517) 241-0554

- Does the Registry include information about additional direct care worker types (beyond CNA, which is a federal requirement)?
  No.

- If so, which types are included (certified home health assistants/aides, medication aides, or medical assistants, etc.)?
  Not applicable.

- Are direct care workers registered, certified, or licensed (we know there are many different types of direct care workers so please ask the specific types as part of the question).
  Nurse aides are certified.

- Are direct care workers responsible for keeping track of their credentials (training and education courses completed, continuing education, etc.)?
  Yes. The certified nurse assistants must keep track of their own training and education.

Minnesota

- Does the state have a governing body for direct care workers?
  Yes, the Minnesota Nursing Board.

- If the state has a governing body, what responsibilities does that body have (discipline, training and education requirements, curriculum oversight, training and education providers, etc.)?
  Licensure
  Education and training requirements
  Curriculum oversight
  Training and education providers
  Discipline

- Where is the Certified Nursing Assistant Registry housed?
  The Minnesota Department of Health
  Compliance Monitoring Division
  P.O. Box 64501
  Saint Paul, MN 55164-0501
  (651) 215-8705

- Does the Registry include information about additional direct care worker types (beyond CNA, which is a federal requirement)?
  No.

- If so, which types are included (certified home health assistants/aides, medication aides, or medical assistants, etc.)?
  Not applicable.

- Are direct care workers registered, certified, or licensed (we know there are many different types of direct care workers so please ask the specific types as part of the question).
  Nursing assistants are certified.

- Are direct care workers responsible for keeping track of their credentials (training and education courses completed, continuing education, etc.)?
  The form is divided – half must be filled out by the employee and half must be filled out by the employer.

Missouri

- Does the state have a governing body for direct care workers?
  No.

- If the state has a governing body, what responsibilities does that body have (discipline, training and education requirements, curriculum oversight, training and education providers, etc.)?
  Not applicable.

- Where is the Certified Nursing Assistant Registry housed?
  Health Education Unit
  Department of Health and Senior Services.
  P.O. Box 570
  Jefferson City, MO 65102-0570
  (573) 526-8526

- Does the Registry include information about additional direct care worker types (beyond CNA, which is a federal requirement)?
  Yes.

- If so, which types are included (certified home health assistants/aides, medication aides, or medical assistants, etc.)?
  Certified nursing assistants, certified medication technicians, level 1 medication aide (they work in residential care facilities), insulin administrators (certified medication technicians who have received additional training in administering insulin and who work in skilled nursing facilities, intermediate nursing facilities and residential care facilities).

- Are direct care workers registered, certified, or licensed (we know there are many different types of direct care workers so please ask the specific types as part of the question).
  Nursing assistants and medication aides are certified. In addition to being certified medication technicians, insulin administrators receive additional training.

- Are direct care workers responsible for keeping track of their credentials (training and education courses completed, continuing education, etc.)?
  In Missouri, employers are responsible for credentialing of direct care workers.

Nebraska

- Does the state have a governing body for direct care workers?
  No.

- If the state has a governing body, what responsibilities does that body have (discipline, training and education requirements, curriculum oversight, training and education providers, etc.)?
  Not applicable.

- Where is the Certified Nursing Assistant Registry housed?
  The Nebraska Department of Health and Human Services
  Regulation and Licensure Credentialing Division
  Nebraska State Office Building
  301 Centennial Mall South
  P.O. Box 94986
  Lincoln, NE 68509-4986
  (402) 471-0537

- Does the Registry include information about additional direct care worker types (beyond CNA, which is a federal requirement)?
  Yes.

- If so, which types are included (certified home health assistants/aides, medication aides, or medical assistants, etc.)?
  Facilities are certified not individuals, but nurse aides and medication aides must be listed on the registry in order to work at licensed facilities.

- Are direct care workers registered, certified, or licensed (we know there are many different types of direct care workers so please ask the specific types as part of the question).
  No.

- Are direct care workers responsible for keeping track of their credentials (training and education courses completed, continuing education, etc.)?
  Employers (and in some cases schools or nurse training programs) keep track of a certified nurse aide's credentials.

North Dakota

- Does the state have a governing body for direct care workers?
  No.

- If the state has a governing body, what responsibilities does that body have (discipline, training and education requirements, curriculum oversight, training and education providers, etc.)?
  Not applicable.

- Where is the Certified Nursing Assistant Registry housed?
  North Dakota Department of Health
  Health Facilities Division
  600 East Boulevard, Department 301
  Bismarck, ND 58505-0200
  (701) 328-2352

- Does the Registry include information about additional direct care worker types (beyond CNA, which is a federal requirement)?
  Yes.

- If so, which types are included (certified home health assistants/aides, medication aides, or medical assistants, etc.)?
  Certified nurse aides, certified medication aides, and certified home health aides.

- Are direct care workers registered, certified, or licensed (we know there are many different types of direct care workers so please ask the specific types as part of the question).
  Nurse aides, medication aides, and home health aides are certified.

- Are direct care workers responsible for keeping track of their credentials (training and education courses completed, continuing education, etc.)?
  It is the responsibility of the employer.

Ohio

- Does the state have a governing body for direct care workers?
  In part, Ohio has an advisory council which oversees its certified medication aide pilot project.

- If the state has a governing body, what responsibilities does that body have (discipline, training and education requirements, curriculum oversight, training and education providers, etc.)?
  The Ohio Board of Nursing assisted by the medication aide advisory committee. The Board of Nursing also regulates dialysis technicians.

  The Ohio Board of Nursing
  17 South High Street, Suite 400
  Columbus, OH 43215-7410
  (614) 466-3947

- Where is the Certified Nursing Assistant Registry housed?
  The Ohio Department of Health
  Nurse Aide Registry
  246 North High Street
  Columbus, OH 43215
  (614) 752-9500

- Does the Registry include information about additional direct care worker types (beyond CNA, which is a federal requirement)?
  Yes.

- If so, which types are included (certified home health assistants/aides, medication aides, or medical assistants, etc.)?
  Medication aides are certified. No other types of direct care workers are certified.

- Are direct care workers registered, certified, or licensed (we know there are many different types of direct care workers so please ask the specific types as part of the question).
  Medication aides are certified. Nurse aides are not.

- Are direct care workers responsible for keeping track of their credentials (training and education courses completed, continuing education, etc.)?
  Employers keep track of direct care workers' credentials.

Oklahoma

- Does the state have a governing body for direct care workers?
  Yes.

- If the state has a governing body, what responsibilities does that body have (discipline, training and education requirements, curriculum oversight, training and education providers, etc.)?
  Issuing licensure certificates
  Approving training and competency programs, including employer- and education-based programs.
  Determining curricula and standards for training and competency programs
  Establishing and maintaining a certified nurse aide registry for people practicing the profession and trainees.
  Establishing categories and standards for certification
  Issuing certificates
  Collecting fees

- Where is the Certified Nursing Assistant Registry housed?
  The Oklahoma Department of Health
  1000 N.E. Tenth, Room 1111
  Oklahoma City, OK 73117
  (405) 217-4085

- Does the Registry include information about additional direct care worker types (beyond CNA, which is a federal requirement)?
  Yes.

- If so, which types are included (certified home health assistants/aides, medication aides, or medical assistants, etc.)?
  Nursing assistants and feeding assistants.

- Are direct care workers registered, certified, or licensed (we know there are many different types of direct care workers so please ask the specific types as part of the question).
  Nursing assistants are certified.

- Are direct care workers responsible for keeping track of their credentials (training and education courses completed, continuing education, etc.)?
  The certified nurse assistant must keep track of their own training and education.

South Dakota

- Does the state have a governing body for direct care workers?
  Yes.

- If the state has a governing body, what responsibilities does that body have (discipline, training and education requirements, curriculum oversight, training and education providers, etc.)
  Curriculum oversight
  Education providers
  Maintenance of the registry

- Where is the Certified Nursing Assistant Registry housed?
  The South Dakota Board of Nursing
  4305 South Louise Street
  Sioux Falls, SD 57106-3115
  (605) 362-2760

- Does the Registry include information about additional direct care worker types (beyond CNA, which is a federal requirement)?
  Yes.

- If so, which types are included (certified home health assistants/aides, medication aides, or medical assistants, etc.)?
  Certified nurse assistants, medical assistants, and medication assistants.

- Are direct care workers registered, certified, or licensed (we know there are many different types of direct care workers so please ask the specific types as part of the question).
  Nurse aides are certified.

- Are direct care workers responsible for keeping track of their credentials (training and education courses completed, continuing education, etc.)?
  Direct care workers must keep track of their own credentials.

Virginia

- Does the state have a governing body for direct care workers?
  Yes.

- If the state has a governing body, what responsibilities does that body have (discipline, training and education requirements, curriculum oversight, training and education providers, etc.)?
  Curriculum oversight
  Training providers
  Discipline

  Virginia Board of Nursing
  6603 West Broad St., 5th Floor
  Richmond, VA 23230-1712
  (804) 662-9909

- Where is the Certified Nursing Assistant Registry housed?
  Virginia Department of Health Professionals
  Nurse Aide Registry
  6606 W. Broad St., 4th Floor
  Richmond, VA 23230-1717
  (804) 662-73l0

- Does the Registry include information about additional direct care worker types (beyond CNA, which is a federal requirement)?
  Yes.

- If so, which types are included (certified home health assistants/aides, medication aides, or medical assistants, etc.)?
  Medication technicians and advanced nurse aides.

- Are direct care workers registered, certified, or licensed (we know there are many different types of direct care workers so please ask the specific types as part of the question).
  Nursing assistants, medication technicians, and advanced nurse aide are certified.

- Are direct care workers responsible for keeping track of their credentials (training and education courses completed, continuing education, etc.)?
  No, employers are responsible for tracking credentials for direct care workers.

Wisconsin

- Does the state have a governing body for direct care workers?
  No.

- If the state has a governing body, what responsibilities does that body have (discipline, training and education requirements, curriculum oversight, training and education providers, etc.)?
  Not applicable.

- Where is the Certified Nursing Assistant Registry housed?
  Department of Health and Family Services
  1 West Wilson Street
  Madison, WI 53702
  (608) 266-1865

- Does the Registry include information about additional direct care worker types (beyond CNA, which is a federal requirement)?
  No.

- If so, which types are included (certified home health assistants/aides, medication aides, or medical assistants, etc.)?
  Not applicable.

- Are direct care workers registered, certified, or licensed (we know there are many different types of direct care workers so please ask the specific types as part of the question).
  Nursing assistants are certified.

- Are direct care workers responsible for keeping track of their credentials (training and education courses completed, continuing education, etc.)?
  Part of the form must be filled out by the direct care workers and part by the employer.

Focus Group Report

July 2006

Introduction

As part of the work of the Iowa Direct Care Worker Task Force, State Public Policy Group (SPPG), a third party public policy and research firm, was asked to conduct outreach on behalf of the Task Force. The outreach, six focus groups in this case, was designed to gather information for the Task Force regarding several training and education related issues for Iowa's direct care workforce.

The six focus groups were conducted during June of 2006 and the following report provides key findings from the focus groups conducted with consumers and family members, direct care workers, and employers. The middle section of the report contains the methodology for the focus groups and the final section contains the notes themselves: summaries of individuals' comments, which are non-attributable. *It should be noted that given the low turnout for several of the focus groups, this report is not able to be generalized over the broader populations.*

Key Findings

In general, focus group participants seemed to support the Task Force's approach to tackling the challenging questions related to training and education for Iowa's direct care workforce. Interestingly, there was some confusion about how to define a direct care worker. Some participants considered positions like nurses or maintenance personnel to be direct care workers. They considered anyone providing direct care to fall into this category. Consumers and family members, in particular, felt this way.

Additionally, participants' responses varied somewhat when they were asked what first came to mind when they heard the term direct care worker. Some listed titles of direct care workers, others referenced the hands-on work completed by direct care workers, and some used terms like "underpaid" and "turnover."

Direct Care Worker Titles and Familiarity with Training and Education

Similar to earlier discussions by Task Force members, focus group participants could list many different titles for direct care workers, which did not necessarily describe the services provided by that direct care worker.

"Trainer isn't inclusive, but we've been through so many titles it's whatever works. Trainer is the best we could come up with."

There were some differences of opinion regarding whether or not a direct care worker's title made it easy to determine what training and education an individual had had. The Certified Nursing Assistant (CNA) was the easiest job title for participants to link to training and education; other job titles were not as easily linked to training and education. Consumers and family members were least familiar with the training and education required by direct care workers.

"When I hear direct care worker, I think immediately, what kind of training has that person had? When you hear CNA, you know what training they have had."

Classifications of Direct Care Worker

For the majority of participants, the classifications identified by the Task Force made sense. It should be noted that the Task Force decided it may be more meaningful to identify existing direct care workers by the types of services they perform, regardless of setting or job title. This process resulted in the creation of six classifications: environmental/chore; instrumental activities of daily living; personal care support; personal care activities of daily living; health monitoring and maintenance; and specialty skills. Participants commented on the distinction between the classifications and were able to see that the classifications were primarily divided by the amount of care or assistance needed.

"When you get to health monitoring and maintenance core competencies and specialty core competencies, they seem to require a higher level of training and education."

Some participants commented that many of the direct care workers they interact with provide services in all of the classifications, although several noted that they thought only CNAs could be performing some of the services listed in the higher levels of care. There was also mixed feedback regarding whether or not training and education should differ based on setting. Some participants felt that the training and education should be the same no matter what setting the services were being provided in; others felt the skill sets were different depending on setting.

"The training should be the same regardless of setting. This is especially important for a home health aide because they are out working on their own. I believe they need the same training no matter whether they are working in a hospital or as a home health aide. The oversight is different."

"If you took me and moved me into the home health environment, I would be lost. I would need training that was different than what I got in hospitals. The skills are different. If you brought a home health aide into a hospital there could be different services and skills required."

Additional training and education objectives identified by focus group participants include:

- Behavioral support should be a training and education objective throughout all of the classifications.
- Anger management and grief training.
- Communication and team building skills.
- Basic skills such as documenting, writing, and comprehending information need attention.
- More attention should be paid to training and education focused on quality of life, and the importance of social interactions, and entertainment.
- Sign language or information about how to interact with an individual who is hard to understand.
- There was general support for trainings related to special populations.

Education and Training for Direct Care Workers

The three focus group participants who were currently serving as direct care workers all considered themselves to be "career direct care workers." All of them felt strongly that every direct care worker should have the same amount of training and education, stating that perhaps the CNA should be the minimum.

"The CNA position is becoming a career. We do many of the things that RNs used to do. There is a lifetime commitment to this profession just like nursing was years back. It is a necessity with our aging population too. We have gotten away from the term 'people'."

"Just like in high school, not everyone wants to take algebra, but everyone has to take algebra. Even if it's only three sentences in a paragraph, you'll know what an ostomy is – you never know what you're going to run into."

Many focus group participants referred to the need for more hands-on training, stating that many of the courses focus on how to perform a particular service, but not necessarily how to care for an individual. Many employers responded that while they would like to see the training and education requirements improved for the direct care workforce, this is difficult given the high turnover and low wages for workers. There was also recognition among all focus group participants that several barriers to training exist, including cost, availability, and access. Some participants referred to the increase in regulation as a barrier as well.

"Sometimes it is hard for them to go for training because it takes people away from working with consumers."

"We can't pay the wage to get people that are already trained. We have to do almost all of the training. About 99.9 percent come in untrained."

The orientation and training requirements varied greatly between employers. Several different types of agencies were represented making it easier to understand these differences. As a whole, the employers conducted their own orientation and training with new workers regardless of whether or not they had received training in the past.

"Even if a worker is on the nurse aide registry, they still have to go through the training and orientation."

When asked what level of care participants wanted for themselves or their family members, all responded that they wanted the highest level of care. Participants as a whole also agreed that philosophically individuals performing the same services should be required to take the same training. Some made a distinction between public and private funding, however.

"I think there is liability with receiving services from un-trained people."

"They may be given choice, but how informed is that choice? A family member can convince them that they can do this for them, but will they get the service they really need?"

"If private pay, that's one thing. I think if there are public funds involved then they can require additional education and training. The higher level courses should be required for those. Physical contact is an important distinction…that should necessitate a higher level of training. If it's someone private I am hiring, I expect them to already have some type of formal training."

Direct Care Registry

The group of questions focused on the Registry varied the most by the population of focus group participants. Not surprisingly, the consumer and family members knew the least about the Registry. There is certainly an opportunity for additional information to be made available to the general public about the Registry.

There were also differences of opinion regarding use of the Registry between employers and direct care workers. Direct care workers, in general, supported the expansion of the Registry, while only some employers supported its expansion. Many of the employers had checked the Registry during a hiring process, but many said the information was out-of-date. Several employers wondered what purpose the Registry served since they are required to conduct mandatory abuse and criminal checks. Finally, a couple of employers saw expanding the Registry as an additional burden; they would need to hire more workers to keep the Registry up-to-date.

"I think the CNA training should be the basic and then include the specialty fields below nursing. An individual could use the database to find a person that is appropriate for what they are looking for."

"It should be everybody; it should be the home health aide; hospice; anybody who has direct care with a person, you want someone who has the training and will not abuse the person financially or emotionally."

"I don't want it expanded. We would have to hire a full time person to keep up with it. I don't want to spend my limited money on this. We already do a lot of checks. If we were to expand it, and I hope we don't, it would include my resident aides. It would not be a resource worth the cost."

"I think the CNAs should, on their own, keep the information updated. Then, they can print their own information out when going for a job interview. They should be responsible for themselves."

Implementation and Systems Change

Focus group participants had mixed responses regarding the grandfathering-in of workers given a change in training and education requirements. Some participants felt all workers should be required to meet the new training and education standards, whether they took courses or tested-out. The other participants thought that workers who had a certain number of years experience should be exempt

from any changes in requirements; there was no agreement on the number of years of experience a direct care worker should have.

"You would have to have at least a certain number of years on-the-job. They would need to have some accumulated experience. There needs to be a certain line drawn in the sand."

"I would give it consideration. I think it would be up to the facility to pass on it or require the new training requirements based on individual workers. It's more fair to require it for all, though."

There were also differences in opinion about where training should be provided. The majority of employers wanted to be able to provide training in-house. However, differences varied between those who wanted to create their own curriculum versus those who would send curriculum in to the state for approval or who would bring in an outside trainer.

"Training in-house seems to imply they are trying to find a cheaper way to provide the training."

"It is more expensive to send people to be trained. It is more cost effective to train in-house."

"I would prefer to develop our own curriculum and then send it in to the state for approval."

The notion of a governing board also caused focus group participants to share various opinions. Some participants thought an efficient way to create a governing board for the Direct Care Worker Registry would be to create one that would be managed by the Iowa Board of Nursing. Rationale for this idea was based on not having to create a totally new entity and also to build off the successes of another governing body. Others, primarily the direct care workers, thought a governing board was needed, but they thought the direct care workforce would benefit from a structure outside of any existing entity.

"I think the Iowa Board of Nursing is an excellent resource for that. They are already doing it. I would use them to do this and not set up a separate body. It seems to be more cost-effective."

Other Thoughts

As part of the focus group script, each focus group participant was asked a final, open-ended question, "Pretend you are king or queen of the world. Resources and money are not an issue. You can do anything. What would you like the Task Force to know as they prepare recommendations for the Legislature?" The following selected comments were captured during this last question.

"We need a basic level of care and we need all direct care workers in this system. The biggest issue for direct care givers is they have reached the point in their development where they are looking for recognition and respect for the skills they have. They no longer think, "I can't be a nurse, I'm an aide." It is a career and they really don't want to be a nurse. They want the direct hands-on with people. We are not so much a nurse's aide anymore; we are a source of additional help to the patient, not just to the nurses. Our activities are very much self-starting and self-motivating. We are taught the skills, we learn, we do, and we are responsible for what we do. I would like to see the Task Force change the terminology from nurse aide to direct care giver; it is more descriptive and gives credit to what we do."

"CNAs don't have access to request their own certification – that's not fair. If you get another job, the employer has to access that for you. A problem especially when your hire is contingent upon whether you have the adequate training. We are supposed to keep our own certificate, but they don't go by that, they still have to get the phone call from the state."

"If we provide the funding and require education and training, we are going to weed out the direct care workers that are at the bottom of the barrel. With tougher guidelines you may weed them out faster. If you're going to pay them appropriately, then we'll get the right people and they'll keep that job."

"My best guess and wish would be that before legislators dictate they would come and spend a day at an ICF or nursing facility. Things look good on paper, but can you pull them off in real life? Most of the legislators don't have a clue about what is going on in the health care industry. They need to work a day in the facility."

Follow Up

Since the turnout was low for several of the focus groups, this report is not able to be generalized over the broader populations. Given this, members of the Task Force decided to pursue additional information-gathering through an online survey, which will be disseminated statewide to consumers and family members, direct care workers, and employers.

Focus Group Methodology

While the subject matter of the focus groups was targeted to the particular participants, the structure of the focus groups was consistent. Each facilitator worked from a script that was designed to elicit the desired information without leading the responses of participants. The script was comprised of a series of six premise paragraphs, each followed by several questions. The premises helped participants understand the frame of reference for the follow up questions.

Each session had a staff person stationed at a laptop computer to document participants' responses to the questions. All comments were non-attributable – responses were never associated with the individual making them. Participants, while encouraged to respond to questions, were not required to do so. The structuring of the premises is designed to encourage participation and allow more reticent individuals to "warm up" by responding to a couple of relatively simple questions. The facilitator worked to ensure that participation was easy and freely given, and that one or a few individuals did not control the conversation.

Selection of Sites

As is the case with any research project, one crucial consideration is the budget. Adjusting to the reality of the funds available meant that only a limited number of focus groups could be conducted, so selection of sites was considered carefully. Ultimately, three communities, which each hosted two separate focus groups – Clarinda, Mason City, and Davenport – were chosen for geographic and population differences.

Selection of Participants

The Task Force requested that outreach be conducted with three different populations: consumers and family members, direct care workers, and employers. Two focus groups were conducted with each population and following is a table which contains the number of individuals who were invited, RSVPed, and attended each focus group by location.

Direct invitations were sent via email to the employers and direct care workers. SPPG used lists from the Department of Inspections and Appeals, Iowa Department of Public Health, and the Iowa CareGivers Association. Phone calls were extended to consumers and family members using list of individuals provided primarily by facilities. The Governor's DD Council was extremely helpful in trying to recruit consumers to participate in the focus groups. Attempts to contact several additional consumer and family advocacy organizations did not yield any increased participation in the focus groups.

Follow up phone calls were made with each group with the goal of increasing the participation at each focus group. The low turnout illustrates some of the challenges that exist for direct care workers and consumers. SPPG speculates that the low number of RSVPs and the even lower turnout for the focus groups for direct care workers and consumers/family members can be attributed to several issues:
Employers are more familiar with focus groups and may consider attending them as part of their job. They also can easily identify the impact the work of the Task Force may have on their organizations.
Individuals receiving direct care services may have limited mobility.
Transportation and child care is likely a barrier for some direct care workers and consumers.
Direct care workers and consumers may also be less familiar with focus groups and their purpose.

Site and Population	Invited	RSVPs	Attendees
Clarinda Employers	43	13	9
Clarinda Direct Care Workers	84	7	2
Mason City Direct Care Workers	128	7	1
Mason City Consumers/Family Members	39	4	1
Davenport Employers	60	8	3
Davenport Consumers/Family Members	35	6	2
Consumers/Family Member Totals	74	10	3
Direct Care Worker Totals	212	14	3
Employer Totals	103	21	12
Totals	**384**	**45**	**18**

Focus Group Notes

Clarinda Focus Group – Employers
June 27, 2006
3:00 – 5:00 p.m.
Eight participants

Discussion Topic 1: Self Introductions and Warm Up

As we begin our discussion, I thought we could introduce ourselves. First names only, please. Also tell us about your role/relationship as/with a direct care worker(s) so we can better understand your perspective.

- **The term direct care worker is used broadly in the health care delivery system. When you hear the term direct care worker, what comes to mind?**
  - CNA
  - Someone who is hands-on
  - Turnover
  - Underpaid
- **What services do you provide/receive?**
  - Assistance with daily care
  - Personal hygiene, domestic skills, laundry, cooking, vocational activities
  - Teaching consumers…not just doing for them
  - Educational activities and programming
  - Medication (Certified Medication Aides)
  - Data collection in a way that is understandable
  - Behavior support plans for almost everyone
  - Interaction with families and other people in community
- **What is your title or the title of the person providing those services?**
  - **Does the title tell you what they know, what services they are trained to provide, or what they are allowed to do?**
    - Training Specialists – they teach training
    - CNAs
    - Supported Community Living Specialists
    - Resident Treatment Workers, but I would like to call everyone a direct support professional
    - CNAs, CMAs, and Restorative Aides but looking at calling them universal workers.
    - Trainers, Trainer I and II, CNAs
    - Not exactly sure, we have CNA, LPNs, RNs
    - I think our titles indicate they know; there is a difference between Med Tech and Specialist.
    - I don't think our titles indicate training. We don't call people who live there residents anymore…we call them people. We have a lot of long-term staff, so using people friendly words is a change.
    - Trainer isn't inclusive, but we've been through so many titles it's whatever works. Trainer is the best we could come up with.
    - The term certified makes the distinction that they have received some training in that area.
  - **How do you know what kind of training a worker has had?**
    - We hire CNAs and nurse aides that have not been certified, so the title indicates level of training.
    - Ours come untrained. Most have no background, so you start from square one and give them the training they have.

- You don't do any work at our place until you've been fully trained. We get people with experience, but it isn't always what you want. There is often a lot of training that is added to their experience.
- We can't pay the wage to get people that are already trained. We have to do almost all of the training. About 99.9 percent come in untrained.
- These positions are high stress and people get burned out. So, there are not a lot of trained workers available.
- We have our own trainer that puts on the CNA class.
- The RTW class is the equivalent of a CNA, but it is not transferable. The CMTs are the same way…they are on the registry, but they can't take it and be a CNA.

Discussion Topic 2: Classifications of Direct Care Workers

In order for the Task Force to make recommendations regarding direct care workers, they were first charged with identifying the existing classifications of direct care workers. Given the size of this workforce and the wide range of services they provide, opinions can differ on the types of workers included in the population we are discussing.

The first inclination of the Task Force was to organize the existing classifications of direct care workers by job title. The group quickly discovered that job titles vary dramatically by agency and setting, and do not always reflect the functions those workers perform. The Task Force decided it may be more meaningful to identify existing direct care workers by the types of services they perform, regardless of setting or job title. This process resulted in the creation of six classifications.

- **What are your thoughts on the way direct care worker functions have been organized?**
  - I think it is helpful that it is divided by the amount of care or assistance needed.
  - I think it's fine, but we have such a broad representation of people that live in our homes. We have medically fragile that are mixed in with independent individuals.
  - Most of our staff is expected to be doing all of this.
  - I would agree.
  - Yeah, they would all be trained on the same things. But there may be circumstances where they need more training on certain things.
  - And, they may adapt over time depending on the needs.
- **Do you see any gaps or overlap among the functions listed for any classification?**
  - I don't see behavioral support on here.
  - Yeah, that is a huge one. Even as a part of community living because we have staff that does that.
  - Behavioral support should be throughout all of these.
  - Sometimes that is the first reason they can't live at home anymore…because of the high need for behavioral support.
  - Behavioral support is much more than just specialty training.
  - We spend twelve hours on behavioral support before they even go to work and then they get trained on each individual.
  - It is critical on all levels.
  - There is not really any help with training for behavioral support out there…not being listed here is indicative of the lack of recognition.
  - Many rural areas don't have access to programs for behavioral support training.
- **In your opinion, are the functions grouped appropriately under each category for the level of skill necessary for a direct care worker to perform or provide assistance to consumers?**
  - Probably…if you include the behavioral modification and management aspect.

- **Are the functions grouped logically in relation to the type and level of training needed to perform the functions?**
    - We would probably just group the last three all together. For us, to break them down like that wouldn't make sense. We would be looking for an individual that has all three of those.
    - We got a call from Sioux City because they were having a hard time pulling dual diagnosis stuff together for DCWs. I think that is hard for some people…trying to teach those direct support individuals to integrate mental retardation and mental health issues.
    - The environmental/chore category…most of our DCWs do not do most of those things because we have a maintenance department that does those services and do not have contact with clients. Our direct care would not be doing most of that stuff.
    - Our direct care shovels snow, changes light bulbs, etc.
    - Maintenance people are not direct care workers in our agency. We have a man hired that mows the yard, and we have residents that sit outside and watch him mow and visit with him. If that is direct care, then I take back what I said.
    - One thing that is lacking is completing paperwork. That would fall into each of these categories as well.
    - Yes…documentation.
    - One of my main concerns is the skills for documenting, reading, and comprehending.
    - Years ago we did an assessment to determine the level of skills, but that was done away with because it was discriminatory. I'd like to see some type of assessment so we can see if a basic level of skill is there.
    - We do a screening for basic reading and comprehension.
    - We had to do away with ours. I'm interested in finding more out about that. I think it was used as yes, we will hire or no, we will not.
    - It is based on a requirement of the job…so it's not discriminatory.

Discussion Topic 3: Education and Training for Direct Care Workers

The primary charge of the Direct Care Worker Task Force is to determine the appropriate training and education requirements for each direct care worker classification. The Task Force has been asked to consider this issue from the perspectives of direct care workers, employers, and consumers/family members.

- **Tell us a little bit about the training and education you/workers in your agency have received.**
    - Everyone starts with a four-day orientation, including DCWs. Then, they have two days of MANDT training (communications skills, team building, physical management, crisis intervention, etc), eight hours of first aid, and seventy-six hours of a basic skills class (basically the CNA course).
    - We do the state required 100 and some hours of CNA training.
    - We are required to do 12 CEUs each year on different topics in addition to the basic training.
    - We have the dementia unit that is required to have 12 hours as well.
    - We have supervisors all do an orientation (two or three days), job shadowing/mentoring, orientation through the main office of the organization (four days), CPR training, and then every year there are requirements for certain hours of training. Then, there is also regular mandatory reporting training (every five years).
    - We do a five-hour orientation, two weeks of job shadowing/mentoring, a checklist of activities follows them, 10 hours of orientation, and monthly trainings throughout that include safety and other issues. Then, there are other trainings offered monthly that some people attend.

  - Our residents are all elderly and fairly independent. The basic CNA class is very good. I'm finding it hard to find people that have a good work ethic. We have people that aren't reliable. We'd like to see more basic job skills incorporated into the training.
  - We have three to four days, depending on the number of people going through the orientation. We also do the mentoring or job shadowing for two weeks. Then, there is a checklist that is completed for three months.
  - Even if a worker is on the nurse aide registry, they still have to go through the training and orientation.
- **What level of training would you expect if a direct care worker was providing care to a member of your family?**
  - **Minimum v. Maximum**
    - I would want the person to be perfect and know everything.
    - You want the highest level of training, but sometimes compassion is just as important and you can't train that.
    - I would prefer someone to have the highest level of skill...but I want compassion, too.
- **Given the incredible responsibility and importance that the direct care workforce plays in the overall health care system, do you feel that the current, required training and education is adequate? (Remember we are talking about all types of direct care workers, not just CNAs)**
  - I'm not familiar with state requirements.
  - Our HR person said she would like to see CPR included in the training.
  - Our initial training is good. We fall down on the ongoing training. Sometimes they work with people that don't need all those skills and don't keep the skills up.
    - **What additional skills do workers need to know?**
      - Communication skills. We are starting to get people in their twenties who are becoming CNAs and do not know how to approach or talk to someone in their 80s. There is a huge gap in communication between younger and older individuals.
    - **Flexibility to offer special training or training focused on specific populations (i.e. MR, Alzheimer's, cultural competencies)?**
      - Our employees come in without good communications skills or good math skills. We don't focus on those basics...we hope that they pick it up and improve it. They don't have the skills. I think that's a real gap, but I don't know how to address it. Most of the workers are high school graduates and they're skills are very poor.
      - I know our high school has a health occupation class. I think that's a good place to start. This provides them some good skills learned early in life that can be applied later. It's a good start and foundation that encourages young people to enter the health field. This is something the Task Force should consider...encouraging health occupations.
      - We get some that have gone through the CNA class and cannot spell.
      - I think it goes back to the school standards...and I know the state is addressing it. They've graduated from school, but the standards haven't been high enough and demanded it. My concern is why should we be addressing those issues? With a high school degree, they should be able to read and write and do math.
      - Employers should contact their local school district and ask to be on their school improvement committee. That is the most proactive thing someone can do to push increased standards and prepare students for the workforce.
      - Pay is also an issue. We are getting the people that will settle for less. We've recently tried to up our wages to see if we can get others to apply.
      - In our community, we've saturated our pool of people available.
- **Do you see any differences regarding the training and education of direct care workers that may be performing similar duties?**

  - **How does this differ based on setting? (i.e. nursing homes v. assisted living v. home care)**
    - Med manager vs. the CNA.
    - We have an even lighter med. course (five hours) that we offer internally, but we have to do the med. manager course for people living in group homes. This is all based on regulations.
  - **Should direct care workers employed at private pay agencies also be required to have the same training and education? Why?**
    - We have a combination of private and public funding.
    - Yes (from private pay facility manager).
    - I think so.
- **The goal of the Task Force is to ensure that direct care workers receive the appropriate level of training and education to provide quality service to all Iowans, regardless of where those services are delivered. How can the Task Force structure training and education requirements to ensure flexibility and allow for consumer choice? (i.e. consumer choice options or self-direction)**
  - Consumers' rights and responsibilities need to be a part of the training.
  - The workers most definitely need to have the same training.
  - What happens when you hire a family member? I have mixed feelings.
  - The best possible worker for the client should be well trained.
  - You're talking about the type of system where the consumer can hire whoever they want. How are you going to say that the person has all of this training…it's going to take some choice away from them.
  - Some counties don't have as much funding as others in terms of reimbursement levels. That's an issue for some people.
  - They may be given choice, but how informed is that choice? A family member can convince them that they can do this for them, but will they get the service they really need?
  - I think there can be a lot of abuse under that system (CDAC). Consumers don't get the service they need, or at least the potential is there for abuse of the system.
- **What do you see as major barriers to training direct care workers – both existing and future barriers? (i.e. cost, turnover, emerging models of care)**
  - Cost
  - Availability of the pool of people you are talking about training.
  - The information available; we need to provide curriculum to agencies or teach them how to teach.
  - Time
- **Would you prefer to send DCWs out to be trained at a community college or university or train them in-house?**
  - We would prefer to do the training in-house.
  - It would be nice to have a basic curriculum that we could then adapt to our own situation.
  - I would prefer to develop our own curriculum and then send it in to the state for approval.
  - DIA can tie our hands. If you have one thing go bad, DIA can take your training away for up to two years and then you have send employees out to be trained.
  - It is more expensive to send people to be trained. It is more cost effective to train in-house.
  - Collaboration among agencies for training makes sense.
  - Our training primarily comes through the community college.

Discussion Topic 4: Direct Care Worker Registry (Formerly Nurse Aide Registry)

As you may know, the Iowa Department of Inspections and Appeals maintains a database of all certified nursing assistants (CNAs) eligible to work in long-term care facilities and other entities throughout the State of Iowa. The Registry is used in three ways:

1. By employers in determining eligibility of a worker for employment and to review/update the status of employed CNAs.
2. By CNAs to update personal information and access certification documents.
3. By consumers interested in reviewing the status and history of CNAs.

Currently, the Direct Care Worker Registry contains information pertaining only to CNAs. The Registry has the capacity to include information regarding additional health care occupations. The Task Force is also required to make recommendations regarding the potential expansion of the Registry.

[*For Employers and Direct Care Workers*]

- **As previously stated, the Registry currently includes only information pertaining to Certified Nurse Aides. If the Registry were expanded, what types of direct care workers should be included?**
  - CMAs
  - But, they have to be a CNA to be a CMA.
  - We've had problems with the Registry not being up-to-date.
  - In the last four months, there has been a change. It used to be a person working in a residential care facility did not count towards their CNA requirement. Now it does.
  - I do not use the registry because none of our people are CNAs, so it's not used at all.
  - *About half of the group indicated they use the Registry; the other half did not.*
  - If expanded, having the employers be responsible for submitting the information would require at least two more positions just to provide the information. DCWs don't all have computer access and ability to update information.
  - I don't see any point to broadening it unless there are positions that everyone uses.
  - I think it's duplicative. If they want the job, they should include it on their job application.
  - I think the CNAs should, on their own, keep the information updated. Then, they can print their own information out when going for a job interview. They should be responsible for themselves.
  - What about employees that say they have extra training but did not attend?
  - How has the current registry helped and who has it helped should be answered before consideration of expanding it.
  - We have to pay for CNA training. If we require the training, then we have to pay for it.
- **With the understanding that many direct care workers are not licensed, registered, or certified with the state, how do employers, consumers, and the workers themselves currently track or access status and qualification information?**
  - No responses given.

Discussion Topic 5: Implementation and Systems Change

It was the intent of the Legislature and is the intent of the Task Force to streamline and improve the level of training and education available to direct care workers and continually improve the quality of services to all Iowans. You have already discussed numerous issues relating directly to training and education of Iowa's direct care workforce. These changes have implications for the broader direct care workforce system.

- **Recognizing that there are many direct care workers already in practice, the issue of grandfathering these workers into a new training and education system will be an important element of Task Force recommendations. What considerations relating to this issue would you like the Task Force to address?**
    - I think you do have to think about it.
    - If you had a curriculum that was identified, couldn't you grandfather them in with an understanding that they will complete the curriculum within five years or so?
    - Or, have a competency test that will allow them to test out of it.
    - We have some DCWs that are over 30 year employees and they keep their training up and are current. They are excellent employees.
    - You could draw a line of years where you would grandfather in...four and over or six and over.
- **What is your opinion regarding agencies offering training and education in-house versus direct care workers accessing training and education from more traditional educational institutions (including continuing education)?**
    - For me, I would like to have staff be trained and certified so they could then provide the training in-house.
    - Yeah, right.
- **The Task Force continues to place importance on having a structure in place that will monitor and respond to system, workforce, and consumer needs. The idea of a governing body such as the Iowa Board of Nursing has been suggested as a mechanism to continually oversee and review training and education for all direct care workers. What considerations relating to this issue would you like the Task Force to address?**
    - My fear or worry is that we would move back towards more of a medical model, and that's what we have tried to move away from. Everything is so scripted.
    - Consider issues of reciprocity with other states.

Discussion Topic 6: Round Robin King/Queen of the World

For our final premise, we have what we refer to as the King or Queen of the world question. We asked you a lot of questions, some general and many specific. Regardless, we asked you about what WE wanted. However, you came here to tell us something. Is there something you want to make sure you tell us tonight?

Pretend you are king or queen of the world. Resources and money are not an issue. You can do anything. What would you like the Task Force to know as they prepare recommendations for the Legislature?

- I think the Queen has on the dunce hat today...I'll pass.
- That's difficult because in the real world, finance is a part of everything. My ideal would be to have very knowledgeable, caring, compassionate people. In my setting, we work with many entities. We want people who can communicate on every level because we all wear different hats in our jobs. We need to start at younger ages to address the work ethics, more communication skills, etc.
- We need to get back to person-centered care...what they want. They ought to have choices and not have everything dictated to them. Get back to being people
- I agree with her. For $500/day, we deserve the best. They deserve high quality of care. I don't believe a cut and paste model for every entity is good. Each individual has different needs.
- The Task Force should not be dictatorial.
- On staff right now, I have a CMA that could blow away some nurses with her skills. If there were a way for her to prove her knowledge and skills to qualify to do more, that would be great.

- Be more people oriented and less focus on regulations. My staff continually complains about the amount of paperwork that takes away from the time spent with people we serve. I think an overarching curriculum would be very difficult. If it is divided up, agencies can pick and choose about what they need. I think the age old stereotypes and fears still drive problems (i.e. working with mental retardation). We need to educate the public in general.
- We have a limited well-educated work pool. We need a bigger pool of educated people to draw from that have a good work ethic. We can teach the skills, but the work ethic and basic education is critical. And, if we could do away with a lot of the documentation; the HCBS waiver requires a lot of documentation.

Clarinda Focus Group – Direct Care Workers
June 27, 2006
5:30 – 7:30 p.m.
3 participants (2 direct care workers and 1 employer)

Discussion Topic 1: Self Introductions and Warm Up

As we begin our discussion, I thought we could introduce ourselves. First names only, please. Also tell us about your role/relationship as/with a direct care worker(s) so we can better understand your perspective.

- **The term direct care worker is used broadly in the health care delivery system. When you hear the term direct care worker, what comes to mind?**
  - Home health aide
  - CNA
  - Hands on
  - Direct contact
- **What services do you provide/receive?**
  - Hands on care, bathing, IADLS, house work, errands, grocery shopping, laundry – any needs from the home
  - Assisting nurses with procedures and direct care in hospitals
- **What is your title or the title of the person providing those services?**
  - RN
  - CNA
  - CNA, orderly, nurse aide – the title changes, but the job is still the same
  - **Does the title tell you what they know, what services they are trained to provide, or what they are allowed to do?**
    - Any more the title CNA is a misnomer. Currently most CNAs work as a separate entity. In the hospital, we have specific duties – direct daily care. The CNA title is outdated. Direct care giver would be more descriptive. People like their jobs and CNA makes it sounds like we want to become nurses.
    - When I hear direct care worker, I think immediately, what kind of training has that person had? When you hear CNA, you know what training they have had.
  - **How do you know what kind of training a worker has had?**
    - As an employer, I just ask questions and check out their credentials and past care experience. I don't care if they are a family member or not, I do believe they need training. That is a big concern.

Discussion Topic 2: Classifications of Direct Care Workers

In order for the Task Force to make recommendations regarding direct care workers, they were first charged with identifying the existing classifications of direct care workers. Given the size of this workforce and the wide range of services they provide, opinions can differ on the types of workers included in the population we are discussing.

The first inclination of the Task Force was to organize the existing classifications of direct care workers by job title. The group quickly discovered that job titles vary dramatically by agency and setting, and do not always reflect the functions those workers perform. The Task Force decided it may be more meaningful to identify existing direct care workers by the types of services they perform, regardless of setting or job title. This process resulted in the creation of six classifications.

- **What are your thoughts on the way direct care worker functions have been organized?**
  - Some of the specialty skill functions seem to require that you be a nurse. Many of those skills are what CNAs do.
  - It looks pretty good as a generalization because each environment is different. There are differences in each setting and these are critically important.
  - The training should be the same regardless of setting. This is especially important for a home health aide because they are out working on their own. I believe they need the same training no matter whether they are working in a hospital or as a home health aide. The oversight is different.
  - We are the eyes and ears for the nurse, but in hospitals the direct care worker works side-by-side with the nurse.
  - People are sent home sooner than they used to be with the DRGs. So home care aides are doing the monitoring you would see in the hospitals.
  - If you took me and moved me into the home health environment, I would be lost. I would need training that was different than what I got in hospitals. The skills are different. If you brought a home health aide into a hospital there could be different services and skills required.
- **Do you see any gaps or overlap among the functions listed for any classification?**
  - From what I see here, it looks like in the health monitoring and maintenance category, there is some cross-over with the personal care ADLs and with the specialty skills. I don't know how you could get a way from the cross-over with the classifications.
  - The classifications cover it.
- **In your opinion, are the functions grouped appropriately under each category for the level of skill necessary for a direct care worker to perform or provide assistance to consumers?**
  - As basic guidelines, I would say so.
  - Yes.
- **Are the functions grouped logically in relation to the type and level of training needed to perform the functions?**
  - I think so because as you go from chore to specialty skills, the skills require additional training and education. The environmental through personal care ADLs are performed by the homemakers. Beyond the personal care ADLs, only the CNAs can perform those functions.

Discussion Topic 3: Education and Training for Direct Care Workers

The primary charge of the Direct Care Worker Task Force is to determine the appropriate training and education requirements for each direct care worker classification. The Task Force has been asked to consider this issue from the perspectives of direct care workers, employers, and consumers/family members.

- **Tell us a little bit about the training and education you/workers in your agency have received.**
  - I have had the 72 hours for the CNA and then 12 hours per year for in-service each year. For the home health aide course, there were 6-8 hours of CNA training, but that wasn't like the training that exists now – it was hit and miss and specific to home care.
  - My training was very much OJT as I grandfathered into the system. The course provided me with the basics (the CNA course), but only the basics. And, I think people settle for that and not more. There is more needed to provide services and I think direct care workers need to specialize and seek additional training. My biggest concern is the training we receive from the community colleges – we cover non-functional things like aromatherapy and don't cover how to lift and this is the biggest thing that hurts aides. I haven't seen this covered in a long time.
  - I agree. Health care has moved to specialty areas and the basic training is not enough. It needs to be geared toward what the aides are doing in their job. I think the community colleges are

trying to give the aides a day-off with those in-services, like when they deal with aromatherapy. I wish it could be more.
    - The CNA position is becoming a career. We do many of the things that RNs used to do. There is a lifetime commitment to this profession just like nursing was years back. It is a necessity with our aging population too. We have gotten away from the term people.
- **What level of training would you expect if a direct care worker was providing care to a member of your family?**
    - **Minimum v. Maximum**
        - The highest possible. It would depend greatly on the agency they were from (private vs. public), the level of care needed by the loved one, and our own personal biases as to what is best and what is perfection. Our standards are higher when it comes to our families.
        - It is not the amount of training and education they have had; it is the frequency and approach the supervisor has. I want to see that hands-on and direct supervision and education; that is more important to me.
        - That is a good thing to take back to the Task Force.
- **Given the incredible responsibility and importance that the direct care workforce plays in the overall health care system, do you feel that the current, required training and education is adequate? (Remember we are talking about all types of direct care workers, not just CNAs)**
    - **What additional skills do workers need to know?**
        - More emphasis in technical skills, communication, and patient rights.
        - You can take all the training you want, but we need more hands-on training. Range of motion is a good example of this. One woman wasn't responding to the range of motion stuff and then after a couple of weeks working with you, she responded, and this is what I mean by hands-on.
        - One of the big things is the changing the regulations. There is more regulation compared to 10 years ago; it has probably quadrupled. We have more paper work than we have ever had. It is the constant change in regulations that is hard to keep up with.
    - **Flexibility to offer special training or training focused on specific populations (i.e. MR, Alzheimer's, cultural competencies)?**
        - Definitely. That is one of the few things they toss into training that we can use (Alzheimer's).
        - MR is definitely needed more.
        - Dual diagnosis is a huge issue and mental health diagnoses.
- **Do you see any differences regarding the training and education of direct care workers that may be performing similar duties?**
    - I don't see a whole lot of variation between what most direct care workers get. It is pretty generic.
    - Based on setting, home agencies are different. They have training in those areas, but not in the specialty areas. They don't want to do those specialty skills and I do believe the specialty skills warrant additional training. If it was my mom, I would want that specialty skills person doing it. It is hard to get away from the titles that exist and still convey what they know.
    - **How does this differ based on setting? (i.e. nursing homes v. assisted living v. home care)**
        - No responses given.
    - **Should direct care workers employed at private pay agencies also be required to have the same training and education? Why?**
        - Yes, why not? I am part of this private system and my staff should be trained just as well as anyone else. I do have public and private pay. They should still be trained to the highest level and the state should require this.
        - The private pay people expect their care workers to be trained and they should have it.
        - I think there is liability with receiving services from un-trained people.

  - I do think family members need the training; we are hired by DHS to supervise the CDAC workers and if they receive payment to provide services, they need the training.
  - The training needs to be available for the family members. At least have the training there for them to use - online or a night class training would help them help their loved ones. If you aren't doing it for pay, the availability and cost of training can be an issue, but if you are getting paid, you need some basic certification. If not, anyone can say they are a care giver.
- **The goal of the Task Force is to ensure that direct care workers receive the appropriate level of training and education to provide quality service to all Iowans, regardless of where those services are delivered. How can the Task Force structure training and education requirements to ensure flexibility and allow for consumer choice? (i.e. consumer choice options or self-direction)**
  - First, the training has to be made available and it needs to be affordable. And people need information about what is required. It would have to be legislated.
  - People have to be made aware of the options; family members are ignorant as to what is available out there. They are told by doctors or social services that there is a plan available, but it may not be suitable for their specific needs. There needs to be a clearinghouse for what is available for families. The training should be a part of this clearinghouse so you know what you are getting and you know what direct care worker has had the training and has provided the needed services.
  - You have to experience the hands-on to provide the services.
  - The hands-on is a plus in training. The classes we've had have had very little hands-on. We listen to the speaker and eat cookies.
  - I had a class on colostomy care and it didn't help me to provide that service.
  - People in any position need to be held to a basic standard. The starting point is to take the 72 hour CNA class and then expand from there. I think the CNA class is basic information and it is stuff that anyone should know.
  - You don't have to take the CNA course because you can test out, but the training really benefited me so I'm glad I had it even though I wasn't required to.
  - It's like any profession; you have your basic requirements and then you make yourself more marketable by taking additional training and education. It is a career field.
- **What do you see as major barriers to training direct care workers – both existing and future barriers? (i.e. cost, turnover, emerging models of care)**
  - Availability and cost are the biggest barriers for any kind of training. I would hate to think about what a good speaker costs. And, it is hard to get people off work to take a training; staffing is very tight. We don't have the availability to fill the gap if someone goes on vacation; we just work short because the good help is not available.
  - I took a day off of work last week which is rare. And the aide that filled in did not shave one of my patients. You can have someone fill in, but they might cut corners.
  - Cost is a huge barrier and it would have been for me if my mom didn't help me out.
  - That would be a good use for some of the money floating around the state – offering free training to individuals interested in health care careers.
  - The biggest thing is the cost from the home health standpoint. The availability to get to training is challenging as well. Some direct care workers do not have cars.

Discussion Topic 4: Direct Care Worker Registry (Formerly Nurse Aide Registry)

As you may know, the Iowa Department of Inspections and Appeals maintains a database of all certified nursing assistants (CNAs) eligible to work in long-term care facilities and other entities throughout the State of Iowa. The Registry is used in three ways:

1. By employers in determining eligibility of a worker for employment and to review/update the status of employed CNAs.

2. By CNAs to update personal information and access certification documents.
3. By consumers interested in reviewing the status and history of CNAs.

Currently, the Direct Care Worker Registry contains information pertaining only to CNAs. The Registry has the capacity to include information regarding additional health care occupations. The Task Force is also required to make recommendations regarding the potential expansion of the Registry.

[*For Employers and Direct Care Workers*]

- **As previously stated, the Registry currently includes only information pertaining to Certified Nurse Aides. If the Registry were expanded, what types of direct care workers should be included?**
  - CDAC providers and in-home health providers.
  - I think the CNA training should be the basic and then include the specialty fields below nursing. An individual could use the database to find a person that is appropriate for what they are looking for.
  - The registry should expand to cover the whole field; that would be wonderful for employers.
- **With the understanding that many direct care workers are not licensed, registered, or certified with the state, how do employers, consumers, and the workers themselves currently track or access status and qualification information?**
  - You would have to go with their application and check their previous employers which can or cannot be accurate.
  - When I interview someone, I do check the registry. If they are not on there, I can provide training to get them on the registry because I am qualified to do that. I have an assistant who sends in a report to the registry monthly. Someone needs to be required in each agency to do this. We need to make sure workers have had their training and that they are on the registry. We already do it for the CNAs so it would not be much more to do this for all direct care workers.

Discussion Topic 5: Implementation and Systems Change

It was the intent of the Legislature and is the intent of the Task Force to streamline and improve the level of training and education available to direct care workers and continually improve the quality of services to all Iowans. You have already discussed numerous issues relating directly to training and education of Iowa's direct care workforce. These changes have implications for the broader direct care workforce system.

- **Recognizing that there are many direct care workers already in practice, the issue of grandfathering these workers into a new training and education system will be an important element of Task Force recommendations. What considerations relating to this issue would you like the Task Force to address?**
  - If you are going to grandfather in, you could let them do a challenge test.
  - That could be expensive.
  - Would it be more expensive than having to take the CNA course?
  - Most people who would grandfather in know what they are doing. You could do a written challenge, or include a hands-on challenge too, which I think would be good.
  - You would have to have at least a certain number of years on-the-job. They would need to have some accumulated experience. There needs to be a certain line drawn in the sand.
  - Who pays for all of this? The CNA can't afford to do this. I believe it is $150 to just challenge the test at the community college.
  - Maybe you could eliminate the time period and have everyone take the test. The cost is an issue and it does matter how you deliver the test; would it be in-person or on-line?

  - I think you should take the training no matter what, but I wouldn't have been able to afford it so the cost is an issue. Experience is worth a lot. But, I learned so much from the course so I would encourage anyone to take it. It helped my self-esteem.
  - It is easier for employers if everyone had the CNA course because otherwise it is a guessing game until you get them trained.
- **What is your opinion regarding agencies offering training and education in-house versus direct care workers accessing training and education from more traditional educational institutions (including continuing education)?**
  - Training in-house seems to imply they are trying to find a cheaper way to provide the training.
  - It has been helpful for us to pick up our continuing education hours through a provider; that helps us all. If an agency is capable of doing it, they should be able to.
  - The employer can also focus on what the workers need. We do a combination of both; six hours in-house and then six hours at the community college.
- **The Task Force continues to place importance on having a structure in place that will monitor and respond to system, workforce, and consumer needs. The idea of a governing body such as the Iowa Board of Nursing has been suggested as a mechanism to continually oversee and review training and education for all direct care workers. What considerations relating to this issue would you like the Task Force to address?**
  - I think the Iowa Board of Nursing is an excellent resource for that. They are already doing it. I would use them to do this and not set up a separate body. It seems to be more cost-effective.
  - It would depend on the volume. If we expanded this to cover all direct care workers, would their system be able to absorb all of this? Perhaps having an organization to cover the direct care workers would be good; it could be a separate branch. They already have to keep a lot of records. How much information that goes in there would be used? That is an important question as well.
  - This sounds good to me.
  - I like the idea of an entity like this taking some disciplinary action; this would be helpful to an employer. We should use the same system if we can.

Discussion Topic 6: Round Robin King/Queen of the World

For our final premise, we have what we refer to as the King or Queen of the world question. We asked you a lot of questions, some general and many specific. Regardless, we asked you about what WE wanted. However, you came here to tell us something. Is there something you want to make sure you tell us tonight?

Pretend you are king or queen of the world. Resources and money are not an issue. You can do anything. What would you like the Task Force to know as they prepare recommendations for the Legislature?

- To make available education and training for all direct care workers; that is number one. Provide enforcement so care givers are accountable because there are certain levels of care givers that are not accountable.
- Offer grants for training; we could apply for them to get assistance in the costs of training.
- We need a basic level of care and we need all direct care workers in this system. The biggest issue for direct care givers is they have reached the point in their development where they are looking for recognition and respect for the skills they have. They no longer think, "I can't be a nurse, I'm an aide." It is a career and they really don't want to be a nurse. They want the direct hands-on with people. We are not so much a nurse's aide anymore; we are a source of additional help to the patient, not just to the nurses. Our activities are very much self-starting and self-motivating. We are taught the skills, we learn, we do, and we are responsible for what we do. I

would like to see the Task Force change the terminology from nurse aide to direct care giver; it is more descriptive and gives credit to what we do.

- There is some movement toward direct care worker.
- In hospitals, we have not gotten there. I used to be called an orderly, which is another one of those generic titles. Then I became a CNA. We are now part of the team and our work actually means something.
- Make sure the Task Force considers sufficient supervision of direct care workers.
- We also need a sufficient staff to patient load. This seems to be a big problem in nursing homes, especially.
- There are regulated ratios.
- When people are in the nursing homes and there isn't a good ratio, they don't get to spend time with the patient and this is hard for the patient and the worker.

Davenport – Employers
June 29, 2006
3:00 – 5:00 p.m.
3 participants

Discussion Topic 1: Self Introductions and Warm Up

As we begin our discussion, I thought we could introduce ourselves. First names only, please. Also tell us about your role/relationship as/with a direct care worker(s) so we can better understand your perspective.

- **The term direct care worker is used broadly in the health care delivery system. When you hear the term direct care worker, what comes to mind?**
  - My resident aides, shift supervisors, and nursing staff; any spending half their time at least with hands-on with the residents.
  - CNAs, activities people, housekeeping, and dietary.
  - Every employee in my building that has the responsibility for providing care and I would include the maintenance man – delivering care to our patients.
- **What services do you provide/receive?**
  - Nursing services, speech, PT/OT, rec. therapy, ADLS
  - Nursing, ADLs, recreation, dietary, and housekeeping
  - Skilled and intermediate nursing care – dietary, physical, emotional – all types of care
- **What is your title or the title of the person providing those services?**
  - Resident aides, program leads which do the aide work, but are also responsible for programming, speech, and rec. program specialists, RNs, and LPNs
  - RN, CNAs, CMAs, universal workers, dieticians, dietary aide, activities coordinator, and maintenance and housekeeping
  - Administrative staff, specialty nurses, activity directors, dieticians, and we consult with other specialties, med. aides, cooks, dietary workers, CNAs, beauticians, doctors
    - **Does the title tell you what they know, what services they are trained to provide, or what they are allowed to do?**
      - Resident aides are pretty explanatory, but the program specialists, and speech and rec. specialists are not as explanatory in terms of what they know. We have the same problem with PT/OT specialists; it appears they have had formal training in this area, and they don't.
      - Our titles are CNA, CMA, and universal worker, which are not specific, but the others seem to be, dietary, maintenance and housekeeping seem to explanatory.
      - We call our CNAs, resident care techs. and the state regulates what their education is. We also use med. techs, which have specific requirements. I do think this is explanatory.
    - **How do you know what kind of training a worker has had?**
      - No responses given.

Discussion Topic 2: Classifications of Direct Care Workers

In order for the Task Force to make recommendations regarding direct care workers, they were first charged with identifying the existing classifications of direct care workers. Given the size of this workforce and the wide range of services they provide, opinions can differ on the types of workers included in the population we are discussing.

The first inclination of the Task Force was to organize the existing classifications of direct care workers by job title. The group quickly discovered that job titles vary dramatically by agency and setting, and do not always reflect the functions those workers perform. The Task Force decided it may be more meaningful to identify existing direct care workers by the types of services they perform, regardless of setting or job title. This process resulted in the creation of six classifications.

- **What are your thoughts on the way direct care worker functions have been organized?**
  - I see IADLs and Personal Care ADLs as the same.
  - My question is about physical contact – no one in my agency would only do the IADLs, for example.
  - Specialty skills – I am confused about the Iowa Board of Nursing comment.
  - I can see how this is divided up, but I am also confused by the Iowa Board of Nursing comment.
- **Do you see any gaps or overlap among the functions listed for any classification?**
  - There is a lot of overlap in the services, but that physical contact seems to be the dividing line.
  - When you get to health monitoring and maintenance core competencies and specialty core competencies, they seem to require a higher level of training and education.
  - If you aren't talking about professionals, how can you put psychiatric care there?
  - In our agency, our direct care workers would implement a behavioral services plan so I could see where psychiatric care would be included.
- **In your opinion, are the functions grouped appropriately under each category for the level of skill necessary for a direct care worker to perform or provide assistance to consumers?**
  - What do you mean by protective services? This might need to be better defined.
  - We often will get protective services involved at discharge if we feel it isn't safe for them to leave our agency.
  - It could also refer to keeping people safe from a fall or altercation.
- **Are the functions grouped logically in relation to the type and level of training needed to perform the functions?**
  - I have one issue with the IADLs – the money management and I totally disagree with that. If you send someone, even a CNA that has been trained, most of them frankly don't even have a bank account. Most girls cash their check and don't know what a bank account is. I don't think many of my girls could count back change.
  - I would agree with that.
  - There is no discipline when it comes to finances. The exception knows how to balance a bank account. If you expect an IADL worker to go into a home and do this, they will need additional training. There needs to be additional training.
  - You would need them to pass a budgeting competency test.
  - I don't know if some of them would know how to write a check – sounds terrible, but it is the fact.
  - The rest of it fits pretty well.
  - Cooking is another area – I have staff that don't know how to cook. In a home or HCBS apt. this is a huge thing – not only cooking food, but nutritious food. They would need training on this.
  - This is how they have grown up; they fended for themselves and were latchkey kids.
  - When you get past the personal care support and get to personal care ADLs, is that where a CNA begins?

Discussion Topic 3: Education and Training for Direct Care Workers

The primary charge of the Direct Care Worker Task Force is to determine the appropriate training and education requirements for each direct care worker classification. The Task Force has been asked to consider this issue from the perspectives of direct care workers, employers, and consumers/family members.

- **Tell us a little bit about the training and education you/workers in your agency have received.**
  - I used to be a direct care worker and I received very little training. This was 18 years ago and I was trained in five days by another DCW.
  - We have health care skills training, policy, and safety training, and a minimum of eight days of on-the-job training. We are licensed by DIA so there are some minimum standards.
  - Infection control, first aid, CPR, dietary training for all employees, medication management, and Alzheimer's training before they are on the floor. They have to be on the floor three full days before being on their own, checking vitals, safety training, and mandatory abuse training. We also have the minimum CNA training.
  - The bulk of my workers are CNAs, but if they aren't there are 16 hours of training we do and then they have to complete the CNA training within a certain number of days.
- **What level of training would you expect if a direct care worker was providing care to a member of your family?**
  - **Minimum v. Maximum**
    - My mother has been in the nursing home where I work and she was given very adequate care, but probably out of fear. I don't think our staff is uneducated, I think the state takes a pretty good whack at mandating so many hours of training, so when they come out of the classes I think they have skills. But, they aren't necessarily competent at being a direct care worker; they need more of the hands-on. We have people who are mastered in nursing, but that doesn't mean they are a better nurse. It is more about wanting to provide care and be compassionate. You can't legislate or educate compassion and a work ethic into people.
    - If I had a family member, I would want the worker to have at least education and training that the person wouldn't do harm. If there is going to be a minimum standard, it needs to be with on-the-job training. This would help us with turnover because people are overwhelmed when we throw them in. I'm huge on the hands-on even though the classroom is important.
    - I want someone taking care of me or my family that wants to take care of me. You learn by trial and error and what you really need is the compassion. They need basic education, however, and this doesn't replace compassion.
    - Working with folks cannot be a job and that is not anything you care teach.
- **Given the incredible responsibility and importance that the direct care workforce plays in the overall health care system, do you feel that the current, required training and education is adequate? (Remember we are talking about all types of direct care workers, not just CNAs)**
  - Realistically more training would be wonderful for the direct care workers, but cost wise, we can't put them through three months of training and then have them quit in two days. I wonder how many would successfully complete the training. It could be difficult for them with real structured training.
  - I agree with everything she said; you just can't afford to do it. The CNAs are my primary focus here. I don't know that you can train people to do – work ethic – I'm not sure if they can be trained to have that. That is our biggest problem. We have a group of workers that have no inclination about what respect and common sense means; you can't teach that. You can train someone to be extremely skilled, but have no sense of duty.
  - This is a generation of entitlement and the baby boomer generation.
  - I also agree with these comments. To have the ideal amount of training would shut the doors of our agencies. Federal and state dollars and private pay do not want to put more money into our agencies.
  - I don't know if more training is guaranteed to result in better care.
  - **What additional skills do workers need to know?**

        - With my folks we do disability sensitivity training because people do not understand what it is like to have to wait for someone to come and take you somewhere. My best staff are the ones that stay long enough to develop a connection with an individual. You can't teach that.
    - **Flexibility to offer special training or training focused on specific populations (i.e. MR, Alzheimer's, cultural competencies)?**
        - You can't take a CNA and throw them into an Alzheimer's unit, same thing with the MR. Perhaps training for the hospice patient. We love it when our staff becomes attached to our residents because the care goes up, but they are not emotionally equipped to deal with that loss. Some training on how to deal with loss would be important. I also think anger management would be good thing to require as well; it is a high stress job. Some of our young care workers have grown up in very hostile environments so they don't have good coping skills. The day is not smooth.
        - I agree with the grief training and the anger or stress management; this could take place under the overarching education and training.
        - Team building training would be a good thing to add. Communication to the next team is key to the job. What is means to be a part of a team; that would be very helpful. Our staff bring a lot of baggage and drama to their jobs.
- **Do you see any differences regarding the training and education of direct care workers that may be performing similar duties?**
    - I know there is between our folks and CNAs. Our folks are responsible for two to three residents and I think CNAs have more like 15. Some of the infection control procedures could be different depending on the setting.
    - A home setting would be different; you have to be really responsible because you are likely to be the only person seeing the person. In other agencies, you have immediate support for nursing staff. Knowing how to problem solve is critical and no one knows how to do this anymore.
    - In a home setting it seems you would need more basic medical training.
    - **How does this differ based on setting? (i.e. nursing homes v. assisted living v. home care)**
        - No responses given.
    - **Should direct care workers employed at private pay agencies also be required to have the same training and education? Why?**
        - Absolutely. They are no different than anyone. If you are going to be a caregiver, you need to have the same training.
        - I have issues with CDAC.
        - You can't legislate everything; the only way to control this is through social services or protective services. This would be an abuse situation in a home. If the state is paying, you can say the training is required.
        - If I am hiring someone to come in from an agency, then I would expect that training. If I am hiring my neighbor or family member, than it seems you can't touch this.
- **The goal of the Task Force is to ensure that direct care workers receive the appropriate level of training and education to provide quality service to all Iowans, regardless of where those services are delivered. How can the Task Force structure training and education requirements to ensure flexibility and allow for consumer choice? (i.e. consumer choice options or self-direction)**
    - It is a lot easier to deal with an agency, but I don't know how you legislate or regulate an individual; I don't think you can.
    - I believe if someone is receiving state or federal funds there should be requirements; they need to meet those minimum requirements.
    - If our tax dollars are paying, there needs to be some control.

- **What do you see as major barriers to training direct care workers – both existing and future barriers? (i.e. cost, turnover, emerging models of care)**
  - Time and money.
  - Time and money. And, workers attitudes and ethics. I don't see them getting any better.
  - I would agree.

Discussion Topic 4: Direct Care Worker Registry (Formerly Nurse Aide Registry)

As you may know, the Iowa Department of Inspections and Appeals maintains a database of all certified nursing assistants (CNAs) eligible to work in long-term care facilities and other entities throughout the State of Iowa. The Registry is used in three ways:

1. By employers in determining eligibility of a worker for employment and to review/update the status of employed CNAs.
2. By CNAs to update personal information and access certification documents.
3. By consumers interested in reviewing the status and history of CNAs.

Currently, the Direct Care Worker Registry contains information pertaining only to CNAs. The Registry has the capacity to include information regarding additional health care occupations. The Task Force is also required to make recommendations regarding the potential expansion of the Registry.

[*For Employers and Direct Care Workers*]

- **As previously stated, the Registry currently includes only information pertaining to Certified Nurse Aides. If the Registry were expanded, what types of direct care workers should be included?**
  - I don't want it expanded. We would have to hire a full time person to keep up with it. I don't want to spend my limited money on this. We already do a lot of checks. If we were to expand it, and I hope we don't, it would include my resident aides. It would not be a resource worth the cost.
  - I would think as long as you are doing criminal and adult abuse, I'm not sure what it would serve. It is supposed to track the two years issue for CNAs and also the abuse, but the timeliness is an issue; it isn't helpful.
  - I think the registry could be helpful if it provided an up-to-date reference.
  - We would have to do the abuse and criminal checks regardless of whether this information was included on the registry.
  - For CDAC folks or people seeking their own care giver, I could see where it would be helpful for them to see what training a worker has had. In our agency, they would have to go through our training regardless of what they had before coming to us.
- **With the understanding that many direct care workers are not licensed, registered, or certified with the state, how do employers, consumers, and the workers themselves currently track or access status and qualification information?**
  - Our minimum requirement is two, preferably three references, and then the adult abuse and criminal checks. We are regulated by the state to do this.
  - We do the same thing.

Discussion Topic 5: Implementation and Systems Change

It was the intent of the Legislature and is the intent of the Task Force to streamline and improve the level of training and education available to direct care workers and continually improve the quality of services to all Iowans. You have already discussed numerous issues relating directly to training and

education of Iowa's direct care workforce. These changes have implications for the broader direct care workforce system.

- **Recognizing that there are many direct care workers already in practice, the issue of grandfathering these workers into a new training and education system will be an important element of Task Force recommendations. What considerations relating to this issue would you like the Task Force to address?**
  - It depends on the criteria of the new system.
  - It depends on who is going to pay for it.
  - I would only send my old people if someone else paid for it. If no one was going to pay for it, I would only be able to send my new workers. If they went to work in a new position, they would need the training.
  - The turnover rate in health care is phenomenal and the training and advertising costs to bring someone on is ridiculous so cost is an issue. It costs so much for us to train them. We pay their way through CNA training and then less than 60 days they are usually gone for a job that can pay them more.
  - To me the way this handout is set up, it seems we could be cited or fined for not including this content in our agency training.
  - I can see that this would lead to some consistency across the state.
- **What is your opinion regarding agencies offering training and education in-house versus direct care workers accessing training and education from more traditional educational institutions (including continuing education)?**
  - If there were some core topics to cover and each agency did it, that makes sense to me. But, we have to recognize that there are differences in the populations we serve; the agency would be best suited to provide this. I could see a need for some consistency in those core topics. All of our training is currently provided in-house.
  - We do all of our own mandatory things; fire and safety, transferring and lifting, OSHA, and abuse. I have to have a calendar so the state can see those things scheduled. We do not do the CNA training in-house because this would be a big cost for us. We allow the college to do this certification. If I have a qualified staff person that can teach courses, it is cheaper for me.
- **The Task Force continues to place importance on having a structure in place that will monitor and respond to system, workforce, and consumer needs. The idea of a governing body such as the Iowa Board of Nursing has been suggested as a mechanism to continually oversee and review training and education for all direct care workers. What considerations relating to this issue would you like the Task Force to address?**
  - The state already monitors and dictates a lot of this. If I have a CNA in my agency, the state determines whether they continue to work based on an incident. I have to report anything.
  - DIA already does this; maybe they would just add additional questions to their survey.
  - The Iowa Board of Nursing can't take care of what they are supposed to do right now.

Discussion Topic 6: Round Robin King/Queen of the World

For our final premise, we have what we refer to as the King or Queen of the world question. We asked you a lot of questions, some general and many specific. Regardless, we asked you about what WE wanted. However, you came here to tell us something. Is there something you want to make sure you tell us tonight?

Pretend you are king or queen of the world. Resources and money are not an issue. You can do anything. What would you like the Task Force to know as they prepare recommendations for the Legislature?

- I would like the Legislature to really fully explore things before they pass legislation they expect us to fulfill. They don't seem to look at how things will be paid for and don't seem to look at the broad impact. There is a reality of finances that are involved in every decision.
- My best guess and wish would be that before legislators dictate they would come and spend a day at an ICF or nursing facility. Things look good on paper, but can you pull them off in real life? Most of the legislators don't have a clue about what is going on in the health care industry. They need to work a day in the facility.
- We also have a shallow pool of workers here in the Quad Cities and I don't think the legislature knows this. They don't know what kind of care these people need. Where would these people go if they shut down our facilities?
- Health care costs are rising and the legislature getting involved will only increase costs; the taxpayer and consumer will pay for this. What is implemented will not be enforced.

Davenport Focus Group – Consumers/Family Members
June 29, 2006
5:30 – 7:30 p.m.
2 participants (both were family members)

Discussion Topic 1: Self Introductions and Warm Up

As we begin our discussion, I thought we could introduce ourselves. First names only, please. Also tell us about your role/relationship as/with a direct care worker(s) so we can better understand your perspective.

- **The term direct care worker is used broadly in the health care delivery system. When you hear the term direct care worker, what comes to mind?**
  - Home health care
  - Home health care and all of the different caregivers, the nurses, nurse aides, and cafeteria workers.
- **What services do you provide/receive?**
  - We have a social worker that helps with paperwork, regular therapy sessions (muscle therapy and help with walking) in addition to day-to-day care.
  - A lot of medical care, medication giving, bathing, dressing, getting in and out of bed, and physical therapy.
- **What is your title or the title of the person providing those services?**
  - **Does the title tell you what they know, what services they are trained to provide, or what they are allowed to do?**
    - A CNA is underestimated, underpaid, undervalued…they use it as a defining thing, but they do ten times that. They do a lot more than just physical therapy…they do emotional therapy. They do more than the title.
    - The titles meant absolutely nothing to me. It took quite a few months to figure it out…who did what.
  - **How do you know what kind of training a worker has had?**
    - No, I figured that out over the years. I assumed they had some type of training but probably not a university degree.
    - I don't know.

Discussion Topic 2: Classifications of Direct Care Workers

In order for the Task Force to make recommendations regarding direct care workers, they were first charged with identifying the existing classifications of direct care workers. Given the size of this workforce and the wide range of services they provide, opinions can differ on the types of workers included in the population we are discussing.

The first inclination of the Task Force was to organize the existing classifications of direct care workers by job title. The group quickly discovered that job titles vary dramatically by agency and setting, and do not always reflect the functions those workers perform. The Task Force decided it may be more meaningful to identify existing direct care workers by the types of services they perform, regardless of setting or job title. This process resulted in the creation of six classifications.

- **What are your thoughts on the way direct care worker functions have been organized?**
  - It seems to be logical…it seems to make sense.
  - I don't really have experience working with many of them. Not knowing enough, I really have no opinion on it. This looks like a good breakdown.

- **Do you see any gaps or overlap among the functions listed for any classification?**
  - Entertainment is part of their emotional needs that is not included in here. There's nothing there that gets at quality of life and the social aspect of living. I consider social coordinators just as much a direct care worker as CNAs.
  - I agree.
- **In your opinion, are the functions grouped appropriately under each category for the level of skill necessary for a direct care worker to perform or provide assistance to consumers?**
  - I would say how they're grouped is probably how they are appropriately educated. If there was a problem, I wouldn't know how to identify it.
- **Are the functions grouped logically in relation to the type and level of training needed to perform the functions?**
  - No responses given.

Discussion Topic 3: Education and Training for Direct Care Workers

The primary charge of the Direct Care Worker Task Force is to determine the appropriate training and education requirements for each direct care worker classification. The Task Force has been asked to consider this issue from the perspectives of direct care workers, employers, and consumers/family members.

- **Tell us a little bit about the training and education you/workers in your agency have received.**
  - The nurses have nursing degrees. I know the CNAs go through a training period usually through the Community College that involves approximately a 6 – 10 month program with a variety of courses. There are care assistants that are usually currently in school to be a CNA and are in the home or agency doing minimal care activities. I think the social directors have degrees in social work for most of the administration people.
  - I don't have anything to add.
- **What level of training would you expect if a direct care worker was providing care to a member of your family?**
  - **Minimum v. Maximum**
    - To me, it depends upon the sort of care they are giving. The minimum would be the ten month thing for any sort of medical care and then to the two-year or four-year degree. I think there are some jobs that people are capable of that don't require even a high school degree.
    - For me, it's a difference between what I want them to have and what I know they have. I would want them to all have college degrees. The CNAs don't always have the training that I think they need. The nurses aren't sometimes aware of some of the changes in the marketplace relating to equipment, for example. Other areas include dietary that may have very minimal training and I have problem with that. I'm sure they have some background in dietary science.
- **Given the incredible responsibility and importance that the direct care workforce plays in the overall health care system, do you feel that the current, required training and education is adequate? (Remember we are talking about all types of direct care workers, not just CNAs)**
  - Yeah, it's adequate.
  - I'd say it's very dependent upon the person and situation. Some need more and others not.
  - **What additional skills do workers need to know?**
    - I think in a care facility, many of them are either hard of hearing or difficult in talking. I find the nurses or aides can't understand what the residents are trying to say. They could use training similar to what you get for sign language to help them recognize what

residents are trying to say. That's a common problem. I don't know if there are classes along that line, but there should be.
    - I think that makes good sense. Just like teachers have to have so many hours a year, we should have a continuing education program for workers.
  - **Flexibility to offer special training or training focused on specific populations (i.e. MR, Alzheimer's, cultural competencies)?**
    - There is a great value in that and a real need for that.
    - I agree. In any care facility, you're going to reach many of those special populations so the workers should be required to take courses in those areas.
- **Do you see any differences regarding the training and education of direct care workers that may be performing similar duties?**
  - I'm not aware of the different training or education. I am aware of the different experiences that people have had. There are problems or complaints associated with different agencies. You notice the staff when you walk in facility and can see how they respond to residents.
  - I'm aware of the different jobs and levels on the floor: the nurses, the med. aides, the care assistants. I don't see nurses doing the CNA duties. I do see med. aides doing CNA duties even though they're not a CNA.
  - **How does this differ based on setting? (i.e. nursing homes v. assisted living v. home care)**
    - I don't have experience to speak of.
    - We had physical therapists, nursing, and a social worker. I don't think there is much difference as far as quality of care.
  - **Should direct care workers employed at private pay agencies also be required to have the same training and education? Why?**
    - Yes, and they probably actually have more.
    - Yes, I think they definitely should have the same, at least.
    - Perhaps no. We did have someone who had a background in the medical field that we paid to have him care for my father. I would not expect him to get additional education to provide that care. He wasn't a full-time care person. If the family is choosing to get that care, then they can't put requirements on it.
    - I don't know how you could restrict or require…you could suggest it.
    - The family is paying for this, so it's different. If Medicare or Medicaid were paying for the service, then they have the right to dictate the education requirements.
- **The goal of the Task Force is to ensure that direct care workers receive the appropriate level of training and education to provide quality service to all Iowans, regardless of where those services are delivered. How can the Task Force structure training and education requirements to ensure flexibility and allow for consumer choice? (i.e. consumer choice options or self-direction)**
  - That's a hard one…I don't know how you could balance the two.
  - Forcing them to have some education background could be done but enforcing it could be difficult. Some families will hire and pay them under the table.
  - Even like a junior college course for general contact care workers…is there such a course? Because high school kids are actually good with them and some are very good. It could be community hours, a summer job, or part-time job.
  - If private pay, that's one thing. I think if there are public funds involved then they can require additional education and training. The higher level courses should be required for those. Physical contact is an important distinction…that should necessitate a higher level of training. If it's someone private I am hiring, I expect them to already have some type of formal training.
- **What do you see as major barriers to training direct care workers – both existing and future barriers? (i.e. cost, turnover, emerging models of care)**

- Time and accessibility. Time off from work is a factor…most of them don't have time aside from work hours.
- Accessibility is a big issue. Scheduling is a problem for many that have a full schedule. And, will the worker be paid for the time they spend in training?
- Maybe some financial assistance.

Discussion Topic 4: Direct Care Worker Registry (Formerly Nurse Aide Registry)

As you may know, the Iowa Department of Inspections and Appeals maintains a database of all certified nursing assistants (CNAs) eligible to work in long-term care facilities and other entities throughout the State of Iowa. The Registry is used in three ways:

1. By employers in determining eligibility of a worker for employment and to review/update the status of employed CNAs.
2. By CNAs to update personal information and access certification documents.
3. By consumers interested in reviewing the status and history of CNAs.

Currently, the Direct Care Worker Registry contains information pertaining only to CNAs. The Registry has the capacity to include information regarding additional health care occupations. The Task Force is also required to make recommendations regarding the potential expansion of the Registry.

[*For Consumers*]

- ***How do you currently choose your direct care service provider/agency?***
  - I talk to a lot of friends and people and the social worker at the hospital and we visited many. It ended up being more of an intuitive thing dealing with how I felt.
  - At home, my father was the first experience I had. We talked to the doctor, nurse, and friends. He had a good level of care. My mother went on lifeline for a while and that was short-lived. During that time, we realized we needed to go to a different level. It was probably about three months where we were looking at different nursing homes and discussed options. We looked at three in the area, and she picked one she liked best primarily because of the privacy issue…private rooms. She basically made the decision on her own. I did some research on my own and then went to check them out.
  - I did go to some website that rated different nursing homes.
- **Are you familiar with the Registry? Have you ever accessed the Registry for information about a CNA?**
  - No.
  - No.
- **If the Registry were to be expanded, what types of Direct Care Workers should be included?**
  - RNs, physical therapists.
  - LPNs, RNs, but therapists would be difficult to register. The CNAs are the obvious ones. There is also the other side of it…administration…social directors…I do think they should be registered with their educational background.
  - I would think the home health aide or medications director should be. The dietary aide probably doesn't need to have an educational background. The dietician should. The cooks don't need it…they're following a recipe card as far as I know.
- **What information would you like to know when considering the qualifications of a direct care worker?**
  - Education, experience, previously employment.
  - I don't know that there would be a better business bureau entity. Is there a complaint file or some way to see if there is a black mark on the record? I would like to see that, but I don't know

how that would be legal. I would expect to see state licenses…to see if they lost the license and got it back six months later.

Discussion Topic 5: Implementation and Systems Change

It was the intent of the Legislature and is the intent of the Task Force to streamline and improve the level of training and education available to direct care workers and continually improve the quality of services to all Iowans. You have already discussed numerous issues relating directly to training and education of Iowa's direct care workforce. These changes have implications for the broader direct care workforce system.

- **Recognizing that there are many direct care workers already in practice, the issue of grandfathering these workers into a new training and education system will be an important element of Task Force recommendations. What considerations relating to this issue would you like the Task Force to address?**
  - I'm assuming that whatever new policies they come up with will be more stringent. I think there should be some requirements that everyone take those courses, but there needs to be some time allotment for taking the courses. I think every worker needs to be included and required.
  - I would give it consideration. I think it would up to the facility to pass on it or require the new training requirements based on individual workers. It's more fair to require it for all, though.
- **What is your opinion regarding agencies offering training and education in-house versus direct care workers accessing training and education from more traditional educational institutions (including continuing education)?**
  - Convenience-wise, it's nice to have it in-house. Perhaps some combination would be best. Some people don't have access to transportation.
  - I'm mixed, I guess. It's much more convenient to do it in-house…if you have the accredited people doing the training. You're going to get the employees in there. If you have to go to a college campus, you will have people not showing up for class. Also, if they have the place to do the training at the facility, but they have to have the certified people. It should be the people coming in from the college to perform the training.
  - I agree with that.
- **The Task Force continues to place importance on having a structure in place that will monitor and respond to system, workforce, and consumer needs. The idea of a governing body such as the Iowa Board of Nursing has been suggested as a mechanism to continually oversee and review training and education for all direct care workers. What considerations relating to this issue would you like the Task Force to address?**
  - Yeah, they should be held to the same limitations. We're monitoring you. Whatever you're doing as a CNA, you have to take responsibility. And, if you're not, some body will step in.
  - I don't think it would be a bad idea…I don't think it would be a bad idea or a bad thing.
  - I wouldn't expect a citizen to go to the board and file a complaint. I think it should go through the proper channels instead of tattling on someone and jumping over somebody's head to do it. For these direct care people, they should be held to those same standards of a Nursing Board.
  - If you start making requirements, then you need an overseer.

Discussion Topic 6: Round Robin King/Queen of the World

For our final premise, we have what we refer to as the King or Queen of the world question. We asked you a lot of questions, some general and many specific. Regardless, we asked you about what WE wanted. However, you came here to tell us something. Is there something you want to make sure you tell us tonight?

Pretend you are king or queen of the world. Resources and money are not an issue. You can do anything. What would you like the Task Force to know as they prepare recommendations for the Legislature?

- The CNAs need to be paid more. Nurses are paid plenty.
- A lot of the direct care workers need to be paid more.
- We need more DCWs per patient.
- And once they start to get paid more, there is more openness to looking at the issues we're going to be dealing with.
- If we provide the funding and require education and training, we are going to weed out the direct care workers that are at the bottom of the barrel. With tougher guidelines you may weed them out faster. If you're going to pay them appropriately, then we'll get the right people and they'll keep that job.
- I didn't realize that different states have different Medicaid laws. Iowa ranks really low for the funding we get for Medicare and Medicaid. The differences are significant. Kansas treats assisted living just as they do long term care. My mother could get as close to a normal life as much as she could expect.
- If they can keep more people home longer, that would be a big thing. The quality of life is important. Less institutionalization would be good. There's been a movement, too, in retirement communities going up...but they're not attached to long term care facilities. I think they need to be attached to long term care facilities so they don't have to move five miles away when they lose their independence and move away from their setting and friends.

Mason City Focus Group – Direct Care Workers
June 29, 2006
3:00 - 5:00 p.m.
1 participant

Discussion Topic 1: Self Introductions and Warm Up

As we begin our discussion, I thought we could introduce ourselves. First names only, please. Also tell us about your role/relationship as/with a direct care worker(s) so we can better understand your perspective.

- **The term direct care worker is used broadly in the health care delivery system. When you hear the term direct care worker, what comes to mind?**
  - Helping people get to bed, because that's the thing they most ask. 'Help me get to bed,' 'I want to go lay down.
- **What services do you provide/receive?**
  - Range of motion, walking, anodyne treatment (heat therapy), OT/PT kinds of things. I kind of function like a physical therapy aid. I help with gate belts, pulleys, bike, lower range of motion, leg lifts.
- **What is your title or the title of the person providing those services?**
  - Restorative aid and CNA (on the weekends) at a care center (nursing home).
  - **Does the title tell you what they know, what services they are trained to provide, or what they are allowed to do?**
    - I usually say 'let's do your exercises.' I'm sure they don't know what my training has been. Once in awhile, they will ask. I'll tell them I went to school or the PT person will show me or tell me, and they see that connection that that's what I do.
  - **How do you know what kind of training a worker has had?**
    - We work hard at everyone doing whatever possible for the person. Just because I'm restorative doesn't mean I don't do nutrition or get maintenance to fix something. We all help each other. I needed the CNA for the job. Our facility requires so many hours of in-service per year.

Discussion Topic 2: Classifications of Direct Care Workers

In order for the Task Force to make recommendations regarding direct care workers, they were first charged with identifying the existing classifications of direct care workers. Given the size of this workforce and the wide range of services they provide, opinions can differ on the types of workers included in the population we are discussing.

The first inclination of the Task Force was to organize the existing classifications of direct care workers by job title. The group quickly discovered that job titles vary dramatically by agency and setting, and do not always reflect the functions those workers perform. The Task Force decided it may be more meaningful to identify existing direct care workers by the types of services they perform, regardless of setting or job title. This process resulted in the creation of six classifications.

- **What are your thoughts on the way direct care worker functions have been organized?**
  - You see all these initials of people and you don't understand what they mean. I put my initials of my training on the sign-in sheet and I don't know if you know what that means. (CRA, CMA, CNA)
  - Are you working on the registry, too, because right now it is only CNAs, right? And that's just stupid.
  - Shouldn't we all have the same training whether you work in a home or an agency?

- So you can be in several of these categories? Yes.
- Several of these are listed in all of them except for the environmental chore. So that just shows that it's necessary in everyone.
- It says here (personal care – support) there is no physical contact, but then it lists bathing, skin care, etc. It means providing direction, coaching in those areas.
- And each of these builds on to the other? Because with health monitoring, we also do a lot of the personal care.
- Don't you think it's necessary to be overtrained, not just limited to the things you think you might do. You should be training in a lot of things in case something comes up.
- If someone is only going to do ADLs, would you require them to do all of the clinical?
- Yes, in case there's something that comes up. Because you may try to help other staff and you need to be trained. If you're in long term care working, you're doing it to help people. And you're going to want to help people, not turn your back on them. You need to be trained to do it.
- So, based on function, do they kind of make sense to you?
- Yes.

- **Do you see any gaps or overlap among the functions listed for any classification?**
  - These are all just basic things, there's no quality of life issues, and that was left out on purpose? Like, putting together puzzles, trying to find things to occupy their time. Because if you're a home health care person, you'll want to find things to do. Because we're always thinking of ideas to occupy the person's time - different activities - and we are encouraged not to go to the activity department. If we can do it and it's beneficial to the client, we have the power to do it.
  - So, you're thinking the activities component is really integrated into the care?
  - Yes, everything's integrated.
  - Stimulate the mind so that they'll want to continue to be as active as they are; they'll want to dress, etc.
  - Well, you can't get anywhere if you don't first have a relationship with someone. I would say 50% of my job is skill based and 50% is human nature/relationship based.
  - Does communication/interpersonal skills cover that need for training?
  - The consumer-centered care, too, we do a lot.
  - With dementia, it takes special training to know what to say to them, whether you should feed into their perceptions. I think the dementia stuff should be on the other function areas, too (not just a specialty). It should either be put under overarching training and education, or listed on every single one. Yes, I think it is that important.
- **In your opinion, are the functions grouped appropriately under each category for the level of skill necessary for a direct care worker to perform or provide assistance to consumers?**
  - No responses given.
- **Are the functions grouped logically in relation to the type and level of training needed to perform the functions?**
  - Yeah, I guess.
  - It deals with the issue - if you're a home health aide, you may not need ostomy care training.
  - I don't see why not. If you're a home aid, I don't see why not.
  - But, typically the worker with the right training will be sent based on what they know about the client's issues?
  - But, another client may have it. So, they want to cater their training to each particular scenario or it should be a broad-based training so that if you do run into something, all you need is a little refresher on it.
  - Just like in high school, not everyone wants to take algebra, but everyone has to take algebra. Even if it's only three sentences in a paragraph, you'll know what an ostomy is - you never know what you're going to run into.

Discussion Topic 3: Education and Training for Direct Care Workers

The primary charge of the Direct Care Worker Task Force is to determine the appropriate training and education requirements for each direct care worker classification. The Task Force has been asked to consider this issue from the perspectives of direct care workers, employers, and consumers/family members.

- **Tell us a little bit about the training and education you/workers in your agency have received.**
  - 180 hour nurse aid training. I tested out and I don't know if they can still do that. They do the training at NIACC or other nursing home and testing is done at NIACC. At my agency, everyone has to be a CNA within three months of their employment. So they (assisted living) aren't under a government mandate to have training?
- **What level of training would you expect if a direct care worker was providing care to a member of your family?**
  - **Minimum v. Maximum**
    - At a minimum, I would want them to be certified, like a CAN, and at a maximum level I would want a registered nurse.
- **Given the incredible responsibility and importance that the direct care workforce plays in the overall health care system, do you feel that the current, required training and education is adequate? (Remember we are talking about all types of direct care workers, not just CNAs)**
  - No.
  - **What additional skills do workers need to know?**
    - I think they should all be trained as CNAs so that if they want to move from one job to another, they can have the flexibility of moving from one situation to another and not worry about additional training. So you could pay the expense up-front.
  - **Flexibility to offer special training or training focused on specific populations (i.e. MR, Alzheimer's, cultural competencies)?**
    - You have to hunt for some of these courses; they're not given all the time. It should be offered and I know they have limits and I don't think you should wait for a class of 15; you can do it with seven or eight students. You could do more on-site training, more than just the typical in-service.
  - **Do you see any differences regarding the training and education of direct care workers that may be performing similar duties?**
    - I can't answer that because I haven't been exposed to anything else. My in-laws are in another nursing home but all of them are certified. And the home health aides I know were CNAs and then went to home health aide.
  - **How does this differ based on setting? (i.e. nursing homes v. assisted living v. home care)**
    - No responses given.
  - **Should direct care workers employed at private pay agencies also be required to have the same training and education? Why?**
    - I don't know.
- **The goal of the Task Force is to ensure that direct care workers receive the appropriate level of training and education to provide quality service to all Iowans, regardless of where those services are delivered. How can the Task Force structure training and education requirements to ensure flexibility and allow for consumer choice? (i.e. consumer choice options or self-direction)**

  - Can folks choose someone who is not qualified and trained according to what we're talking about? If you want to do the best job for your loved one, you'll want to go get training. So, should that caregiver be required to get the training? Not required. I think it should be offered; they should be made aware of it. The care receiver made the choice, but the caregiver should be given the opportunity to get training if they want it.
- **What do you see as major barriers to training direct care workers – both existing and future barriers? (i.e. cost, turnover, emerging models of care)**
  - Cost; wages are so low that they can't afford to pay for additional classes plus day care - because a lot of them have children. Nothing else that I can think of.

Discussion Topic 4: Direct Care Worker Registry (Formerly Nurse Aide Registry)

As you may know, the Iowa Department of Inspections and Appeals maintains a database of all certified nursing assistants (CNAs) eligible to work in long-term care facilities and other entities throughout the State of Iowa. The Registry is used in three ways:

1. By employers in determining eligibility of a worker for employment and to review/update the status of employed CNAs.
2. By CNAs to update personal information and access certification documents.
3. By consumers interested in reviewing the status and history of CNAs.

Currently, the Direct Care Worker Registry contains information pertaining only to CNAs. The Registry has the capacity to include information regarding additional health care occupations. The Task Force is also required to make recommendations regarding the potential expansion of the Registry.

[*For Employers and Direct Care Workers*]

- **As previously stated, the Registry currently includes only information pertaining to Certified Nurse Aides. If the Registry were expanded, what types of direct care workers should be included?**
  - It should be everybody; it should be the home health aide; hospice; anybody who has direct care with a person, you want someone who has the training and will not abuse the person financially or emotionally.
  - So any direct care worker listed in any of these classifications? Yes, anyone who has contact, even a maintenance man who goes in the rooms.
  - **With the understanding that many direct care workers are not licensed, registered, or certified with the state, how do employers, consumers, and the workers themselves currently track or access status and qualification information?**
    - I don't know. How would they? If you're not on the registry and you're employed – other than that employer has a record of training. By law, an employer can only say yes, she was employed with us. You can't tell how good of a worker they were or why they were dismissed.

Discussion Topic 5: Implementation and Systems Change

It was the intent of the Legislature and is the intent of the Task Force to streamline and improve the level of training and education available to direct care workers and continually improve the quality of services to all Iowans. You have already discussed numerous issues relating directly to training and education of Iowa's direct care workforce. These changes have implications for the broader direct care workforce system.

- **Recognizing that there are many direct care workers already in practice, the issue of grandfathering these workers into a new training and education system will be an**

important element of Task Force recommendations. What considerations relating to this issue would you like the Task Force to address?

- Do I want to grandfather everybody? Because you never know. Maybe grandfathered if they've worked in the system so long, but I still think you need to have a background check. If they've been working in the system three years. We have very long term people at my agency – at least four or five years. We have many people who have left and come back. You either like it or you don't. It's about relationships.

- **What is your opinion regarding agencies offering training and education in-house versus direct care workers accessing training and education from more traditional educational institutions (including continuing education)?**
  - And online? In-house is good because people don't have to go anywhere but I don't think it should be in-house personnel doing it. It should be other people coming in. Otherwise it's too easy to – 'this is the way we do it here' - but not the way it should be done. Sometimes a training may be a distance to drive. If you can eliminate that obstacle, people may be willing to do it. It should be a standard training; what I get now is a standard training, there's a text, everyone has to pass a test. A standardized curriculum is a good thing. Just like everyone had to learn English, algebra, science.
- **The Task Force continues to place importance on having a structure in place that will monitor and respond to system, workforce, and consumer needs. The idea of a governing body such as the Iowa Board of Nursing has been suggested as a mechanism to continually oversee and review training and education for all direct care workers. What considerations relating to this issue would you like the Task Force to address?**
  - Gosh, if Uncle Bill wanted Mary to do his care, she would have to report to the board? Well, there has to be somebody overseeing it, but it might be too much for the existing board to do it. If they already are doing so much unless this would eliminate part of their job, I don't want to increase their responsibilities because this is a huge thing. So I think it would have to be another board on equal footing, not beneath the nursing but as equal boards. It should be in public health or human services, not inspections and appeals.

Discussion Topic 6: Round Robin King/Queen of the World

For our final premise, we have what we refer to as the King or Queen of the world question. We asked you a lot of questions, some general and many specific. Regardless, we asked you about what WE wanted. However, you came here to tell us something. Is there something you want to make sure you tell us tonight?

Pretend you are king or queen of the world. Resources and money are not an issue. You can do anything. What would you like the Task Force to know as they prepare recommendations for the Legislature?

- There are a lot of people out there doing wonderful work. And don't try to limit their job by more foolish legislation. Remember to keep the client/resident in mind when you're making these decisions because it all focuses around them.
- CNAs don't have access to request their own certification – that's not fair. If you get another job, the employer has to access that for you. A problem especially when your hire is contingent upon whether you have the adequate training. We are supposed to keep our own certificate, but they don't go by that, they still have to get the phone call from the state.
- Even though I get additional CEUs, they don't count for additional training required for my job. They say I need to have their 12 hours. Workers may not want to access other training if it doesn't even count toward what the agency requires.

Mason City Focus Group – Consumers/Family Members
June 29, 2006
5:30 – 7:30 p.m.
1 participant (consumer)

Discussion Topic 1: Self Introductions and Warm Up

As we begin our discussion, I thought we could introduce ourselves. First names only, please. Also tell us about your role/relationship as/with a direct care worker(s) so we can better understand your perspective.

- **The term direct care worker is used broadly in the health care delivery system. When you hear the term direct care worker, what comes to mind?**
  - Those are people who work with people like myself. I work with Jill, Mary, Pam, Michelle, Becky, and some others. Some are the supervisors.
- **What services do you provide/receive?**
  - One helps with appropriate budgeting. I'm going to practice being thoroughly prepared for the activities of the day. Get proper sleep, cleanliness, rest. Getting myself motivated to work is the biggest problem. I get myself up and get there, but I have some problems, and they remind me.
  - I discuss some of my medication with Shelby. She helps advise me on what she thinks would be a good thing for me to talk to the doctor about.
  - I clean, label boxes, shrink wrap boxes, pack boxes.
  - A few months ago we got together and decided I needed some help getting to work on time/ I was on my feet almost all the time I was there; I was on my feet cleaning. I changed to do some of my work sitting down now and that is better.
  - Wages aren't the most significant thing about being there. I'm working on getting to work – that's more important. Pam and Becky help with that.
- **What is your title or the title of the person providing those services?**
  - No responses given.
  - **Does the title tell you what they know, what services they are trained to provide, or what they are allowed to do?**
    - No responses given.
- **How do you know what kind of training a worker has had?**
  - One has a bachelor of arts, another has a bachelor of arts, and the other is the SCL director and has a master's degree. Connie is the executive director of the whole place.

Discussion Topic 2: Classifications of Direct Care Workers

In order for the Task Force to make recommendations regarding direct care workers, they were first charged with identifying the existing classifications of direct care workers. Given the size of this workforce and the wide range of services they provide, opinions can differ on the types of workers included in the population we are discussing.

The first inclination of the Task Force was to organize the existing classifications of direct care workers by job title. The group quickly discovered that job titles vary dramatically by agency and setting, and do not always reflect the functions those workers perform. The Task Force decided it may be more meaningful to identify existing direct care workers by the types of services they perform, regardless of setting or job title. This process resulted in the creation of six classifications.

- **What are your thoughts on the way direct care worker functions have been organized?**
  - No responses given.

- **Do you see any gaps or overlap among the functions listed for any classification?**
  - No responses given.
- **In your opinion, are the functions grouped appropriately under each category for the level of skill necessary for a direct care worker to perform or provide assistance to consumers?**
  - The personal care support part is what I get for help. I don't know if she has training in all of those things.
  - She goes over these things like emergency care and first aid with me. And I sign the paper that says I know these things because my memory doesn't change. She helps me with financial things and the budget.
  - Shelby is an RN and she knows about disease and infection. I see her when I need to. She helps me learn about my medications and advises me.
- **Are the functions grouped logically in relation to the type and level of training needed to perform the functions?**
  - No responses given.

Discussion Topic 3: Education and Training for Direct Care Workers

The primary charge of the Direct Care Worker Task Force is to determine the appropriate training and education requirements for each direct care worker classification. The Task Force has been asked to consider this issue from the perspectives of direct care workers, employers, and consumers/family members.

- **Tell us a little bit about the training and education you/workers in your agency have received.**
  - They get some training in the agency, but they also go to NIACC for classes.
  - Sometimes it is hard for them to go for training because it takes people away from working with consumers.
- **What level of training would you expect if a direct care worker was providing care to a member of your family?**
  - **Minimum v. Maximum**
    - No responses given.
- **Given the incredible responsibility and importance that the direct care workforce plays in the overall health care system, do you feel that the current, required training and education is adequate? (Remember we are talking about all types of direct care workers, not just CNAs)**
  - No responses given.
  - **What additional skills do workers need to know?**
    - No responses given.
  - **Flexibility to offer special training or training focused on specific populations (i.e. MR, Alzheimer's, cultural competencies)?**
    - No responses given.
- **Do you see any differences regarding the training and education of direct care workers that may be performing similar duties?**
  - No responses given.
  - **How does this differ based on setting? (i.e. nursing homes v. assisted living v. home care)**
    - No responses given.
  - **Should direct care workers employed at private pay agencies also be required to have the same training and education? Why?**
    - No responses given.

- **The goal of the Task Force is to ensure that direct care workers receive the appropriate level of training and education to provide quality service to all Iowans, regardless of where those services are delivered. How can the Task Force structure training and education requirements to ensure flexibility and allow for consumer choice? (i.e. consumer choice options or self-direction)**
  - No responses given.
  - **What do you see as major barriers to training direct care workers – both existing and future barriers? (i.e. cost, turnover, emerging models of care)**
    - No responses given.

Discussion Topic 4: Direct Care Worker Registry (Formerly Nurse Aide Registry)

As you may know, the Iowa Department of Inspections and Appeals maintains a database of all certified nursing assistants (CNAs) eligible to work in long-term care facilities and other entities throughout the State of Iowa. The Registry is used in three ways:

1. By employers in determining eligibility of a worker for employment and to review/update the status of employed CNAs.
2. By CNAs to update personal information and access certification documents.
3. By consumers interested in reviewing the status and history of CNAs.

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[*For Consumers*]

- **How do you currently choose your direct care service provider/agency?**
  - No responses given.
- **Are you familiar with the Registry? Have you ever accessed the Registry for information about a CNA?**
  - No responses given.
- **If the Registry were to be expanded, what types of Direct Care Workers should be included?**
  - No responses given.
- **What information would you like to know when considering the qualifications of a direct care worker?**
  - It isn't necessary for me to look at this. I feel comfortable working with everyone except Jill. I wouldn't mind leaving it the way it is because it would be good to be able to, but I don't need to do that.
  - Some workers have their certificates or degree on the wall. The agency has a lot of them on the wall.
  - If I want to know something I ask them.

Discussion Topic 5: Implementation and Systems Change

It was the intent of the Legislature and is the intent of the Task Force to streamline and improve the level of training and education available to direct care workers and continually improve the quality of services to all Iowans. You have already discussed numerous issues relating directly to training and education of Iowa's direct care workforce. These changes have implications for the broader direct care workforce system.

- **Recognizing that there are many direct care workers already in practice, the issue of grandfathering these workers into a new training and education system will be an important element of Task Force recommendations. What considerations relating to this issue would you like the Task Force to address?**
  - No responses given.
- **What is your opinion regarding agencies offering training and education in-house versus direct care workers accessing training and education from more traditional educational institutions (including continuing education)?**
  - No responses given.
- **The Task Force continues to place importance on having a structure in place that will monitor and respond to system, workforce, and consumer needs. The idea of a governing body such as the Iowa Board of Nursing has been suggested as a mechanism to continually oversee and review training and education for all direct care workers. What considerations relating to this issue would you like the Task Force to address?**
  - I think it would be all right if there was a board or something to see if people follow through with their training. I think some people say they are going and then don't follow through.

Discussion Topic 6: Round Robin King/Queen of the World

For our final premise, we have what we refer to as the King or Queen of the world question. We asked you a lot of questions, some general and many specific. Regardless, we asked you about what WE wanted. However, you came here to tell us something. Is there something you want to make sure you tell us tonight?

Pretend you are king or queen of the world. Resources and money are not an issue. You can do anything. What would you like the Task Force to know as they prepare recommendations for the Legislature?

- I wonder if it would be possible for direct care workers to explain to people about how the funding works. For example, how transportation works. I get too tired walking and then working. I requested transportation assistance, but I was told we can't do that. Later I found out that it had something to do with the funding and they couldn't get paid for providing transportation.
- Some consumers are not educated enough about community resources; direct care workers need to provide that education.
- We need more doctors who will accept patients without insurance. Psychiatrists. And they need to listen better...everyone needs to do that.
- It wouldn't hurt for direct care workers to be educated or educate consumers on not interrupting or to say "excuse me."
- Nurse could educate consumers more on diet, exercise, and nutrition. Also about sleep patterns.
- Direct care workers could teach consumers how to not spend more money than you have. I was fortunate that there was no legal action. Workers could help other people from having more trouble with their budget.

About State Public Policy Group

State Public Policy Group, Inc. (SPPG) was retained by the Iowa Department of Public Health (IDPH) to facilitate the Iowa Direct Care Worker Task Force. In this role, SPPG was responsible for all aspects of staffing the work of the Task Force, and ensuring a final report including recommendations about education and training needs and requirements was submitted to the Governor and General Assembly by December 15, 2006.

State Public Policy Group is an independent organizational development, issue management, and policy development company. SPPG is a private, for-profit firm and is not part of any government entity. SPPG was founded in Des Moines in 1984, and has been involved in a broad array of interest areas and provides services at the local, state, national, and international levels.

SPPG has been or is involved with health issues related to the uninsured, children's health, children's health insurance, health issues of minority populations, mental health, mental retardation and developmental disability, patient safety and others. In the past, SPPG managed and provided services to a number of health-related associations, including the Iowa/Nebraska Primary Care Association, Iowa Physicians Assistant Society, Iowa Association of Rural Health Clinics, and the National Association of Rural Health Clinics. SPPG has also facilitated the Iowa Asthma Task Force, Valued Added Agriculture Task Force, Covering Kids and Families Now Task Force, Study of the Structure of Emergency Management, Childcare Quality Rating System, and the EOD and SWAT Task Forces.

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