



IOWA DIRECT CARE  
ADVISORY COUNCIL

**Direct Care Worker Contributions to  
Rebalancing Health, Support, and Long-term Care**

Submitted by the Iowa Direct Care Worker Advisory Council

September 2009





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September 30, 2009

Director Tom Newton:

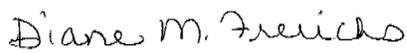
On behalf of the Direct Care Worker Advisory Council, we submit the following report regarding the contribution of direct care workers to rebalancing health, support, and long-term care. The Advisory Council is pleased to be one of nine Councils providing recommendations and expertise that will continue to improve access to and quality of health, support, and long-term care services in Iowa.

This report is provided at the request of the Iowa Department of Public Health as part of the Council's work during State FY2010. Specifically, the report identifies five primary contributions of direct care workers related to health, support, and long-term care reform based on state and national research. The contributions examine how direct care workers are currently utilized in these systems and what roles they are well suited for in the future.

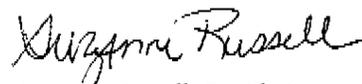
The Advisory Council has also been working concurrently on a report that will be provided to the Department in January 2010. This report will provide updated recommendations for a career pathway for direct care workers and will also highlight national research on the outcomes of similar efforts targeting the direct care workforce.

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

Sincerely,



Diane Frerichs, Co-Chair



Suzanne Russell, Co-Chair

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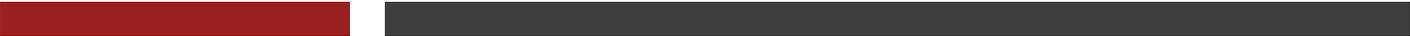
## Introduction

Iowa and national efforts toward health care reform and rebalancing health, support, and long-term care provide an opportunity to examine how direct care workers are currently utilized in these systems and what roles they are well suited for in the future. To better understand these issues, the Iowa Direct Care Worker Advisory Council, at the request of the Iowa Department of Public Health, has developed the following report that highlights the key contributions and future potential of the direct care workforce in reformed health and long-term care systems that rely more heavily on home and community services.

In researching the contributions of direct care workers as a component of broader health, support, and long-term care reform, the Advisory Council has identified the following key contributions:

- Direct care workers are a necessary component of a quality health, support, and long-term care workforce that ensures public health and safety.
- Direct care workers are an essential member of a diverse interdisciplinary team.
- Direct care workers will play a more important role as the health, support, and long-term care delivery systems shift service delivery from more restrictive settings to include more home and community-based services.
- Direct care workers provide preventive and wellness care in settings comfortable to individuals served. This care has a positive impact on the capacity of other health and long-term care professions.
- Direct care workers play a key role in providing quality supports and services to individuals with disabilities and health care needs that enhance their quality of life as they live, learn, work, and recreate in communities and environments of their choice.

This report compiles existing secondary research from various national and state sources to provide a profile of the direct care workforce in Iowa and to explain how this workforce contributes to larger initiatives to rebalance health, support, and long-term care. The Direct Care Worker Advisory Council uses the term “direct care worker” to represent a variety of workers providing services to diverse populations, including individuals with intellectual, developmental, and physical disabilities, mental illness and brain injury, and individuals living with chronic and acute health conditions of varying ages in a wide variety of settings, including long-term care and assisted living facilities, adult and child day programs, hospitals and clinics, and homes and other community-based settings. Existing research is limited to studying the workforce based on nationally-recognized job titles such as home health aide, certified nursing assistant (CNA), and direct support professional (DSP). Research citing these job titles is utilized in this report to provide a representative profile of the broader direct care workforce, much of which has not been studied due to a number of factors, including isolated and diverse settings, lack of resources to study the Iowa direct care workforce, and fragmented service provision to diverse populations.



The Iowa Direct Care Worker Advisory Council was established in House File 2539 passed during the 2008 legislative session. The Advisory Council is charged with advising the Iowa Department of Public Health (IDPH) regarding regulation and certification of direct care workers. The work of the Advisory Council builds on recommendations from the Iowa Direct Care Worker Task Force that provided a framework for statewide standards for training and education for the direct care workforce. Additional reports from the Advisory Council and Task Force can be found at [www.idph.state.ia.us/hcr\\_committees/direct\\_care\\_workers.asp](http://www.idph.state.ia.us/hcr_committees/direct_care_workers.asp).

## Profile of the Direct Care Workforce

The significance of direct care workers as a component of broader health, support, and long-term care reform is evidenced in part by their sheer numbers in today's health and direct support workforce. The Bureau of Labor Statistics reports that personal and home care aides will be the second-fastest growing occupation between 2006 and 2016, and home health aides will be the third-fastest growing occupation during the same time period. In fact, by 2016 demand for these workers will grow by an additional 1 million new positions to a total of 4 million workers in the U.S. exceeding many other professions including teachers from kindergarten through high school (3.8 million), all law enforcement and public safety workers (3.6 million), fast food and counter workers (3.5 million), cashiers (3.4 million), registered nurses (3.1 million), and all child care workers and pre-school teachers (2.2 million). (PHI, April 2008).

Workforce projections in Iowa indicate the need for an additional 10,000 new direct care workers between 2006 and 2016, mostly in home and community based settings. Much like the national statistics, Iowa home health aides and personal and home care aides are projected to be in most demand (43 percent and 36 percent job growth, respectively). In Iowa, home health aides and personal and home care aides rank as the first and third fastest-growing occupations generating the most jobs between 2006 and 2016 (PHI, July 2009).

A direct care worker has been defined by the Iowa Direct Care Worker Advisory Council as an individual who provides supportive services and care to people experiencing illnesses or disabilities. Direct care workers are the front-line of Iowa's health, support, and long term care workforce, providing hands-on care and support to individuals of all ages and abilities in settings that range from acute care in hospitals to services in home and community-based settings. The Advisory Council has estimated that there are somewhere between 75,000 and 100,000 direct care workers in Iowa working under an estimated 40 unique job titles. According to national statistics, these workers are mostly middle-aged women with at least a high school diploma (PHI, January 2009).

Much of the demand for direct care workers is directly influenced by systemic changes to the health, support, and long-term care service delivery and financing systems. In 2008, the Iowa General Assembly passed House File 2539, also known as the health care reform bill, which created several working groups to develop strategies to meet the state's goals for reforming the health, support, and long-term care systems. Some of the working groups include the Medical Home System Advisory Council, Health and Long-Term Care Access Advisory Council, Health Care Quality and Quality and Cost Transparency Workgroup, and the Direct Care Worker Advisory Council. Iowa has also recently committed to several activities aimed at "rebalancing" the state's long-term care system by increasing the availability of home and community-based services and funding.

The evolution of these systems represents an effort to meet the changing needs of individuals. As such, a majority of direct care workers are currently employed in home and community-based services, with this number predicted to rise as demand increases over the next decade (PHI, January 2009). The Iowa Association of Community Providers (IACP), a statewide association of over 150 community-based organizations that provide services to children and adults with mental illness and mental health related issues, mental retardation, brain injury and other developmental disabilities, reports that community providers often depend primarily on part-time college students, retired workers who want to supplement their incomes, and family or friends of individuals who need supports and services to serve the role of direct care workers in their agencies. Today, direct care workers serving all populations represent 70 to 80 percent of the hands-on long-term care and personal assistance delivered to individuals with disabilities and chronic conditions, and the elderly in the U.S. (PHI, January 2009).

These figures are especially compelling for Iowa, given the state's significant population of aging individuals and individuals with disabilities, recent and predicted health and demographic shifts, and the rural landscape of the state. The last two decades have ushered in vast demographic changes throughout Iowa's communities. For example, Hispanic students in Iowa's public school system have increased 600 percent in the last twenty years, followed by increases in the percentage of American Indian students by 162 percent, African American students by 109 percent, and Asian populations by 80 percent (Iowa Department of Education, 2007). In addition, Iowa's aging population is growing—people age 65 and over accounted for almost 15 percent of the total population in 2008 and the percentage is expected to increase to 22 percent by 2030 (State Data Center of Iowa and the Iowa Department on Aging, 2009). Unfortunately, Iowa has also experienced trends in poor health outcomes due to national cultural and lifestyle changes. Almost 61 percent of Iowa adults are obese or overweight, which puts them at higher risk for hypertension, diabetes, and high cholesterol, among other chronic conditions (Iowa Department of Public Health, nd1).

Iowa faces an impending health workforce shortage of significant proportions if worker vacancies are not filled as the state's demographics continue to shift. Not only is Iowa's aging and minority population growing, the number of Iowans with disabilities is significant; according to the Rehabilitation Research and Training Center on Disability Demographics and Statistics Iowa, more than 387,000 Iowans ages five and older report one or more disabilities (Stats RRTC, 2006). Yet, despite calls to action and leadership on the part of IDPH and many other stakeholders, there is significant work to be done to develop state infrastructures to support solutions to meet the impending worker shortage. What's more, the direct care profession has historically been plagued by high turnover, low wages, and inadequate accessibility of benefits.

The nature of the direct care profession has made the workforce hard to quantify. Currently, the actual size of the direct care workforce in Iowa is unknown; multiple job classifications and titles have been identified, but no common tool exists to determine who direct care workers are, where they work, or what training they receive. High turnover in the profession today is the reality for most employers; jobs are often physically demanding, while benefits remain mostly inaccessible to the employee due to eligibility and affordability. According to federal statistics, the nursing home aide occupation ranks second behind truck driver on the federal government's list of dangerous professions (cited in Dawson, 2007), but these workers often lack health insurance coverage. Nationally, one in every four nursing home workers and nearly a third of Personal and Home Care aides lack health coverage. While two-thirds of Americans under age 65 receive health coverage through an employer, only about half of direct-care workers (53 percent) have employer-based coverage (PHI, January 2009).

## Assumptions

For purposes of this report, certain assumptions have been made about current and future trends in health, support, and long-term care that assist in predicting the need for and contributions of direct care workers.

- **The current health care system does not meet the needs of individuals and their families in an efficient and effective manner.**  
Rising costs, growing numbers of uninsured, lack of coordination, and health care disparities are frequently cited issues of the U.S. health care system. The system has not effectively implemented models that work, like interdisciplinary care, care coordination, and preventive and wellness care.
- **It can be predicted that health, support, and long-term care will increasingly be delivered in home and community settings.**  
Policy changes at the state and national levels have shifted the focus of service delivery and financing to increase the options available to persons served to receive services in the home and community. Not only does it cost less to provide services to people outside of facility-based settings, but public demand requires it.
- **Health care reform in Iowa and nationally will emphasize preventive and wellness care.**  
Although prevention and wellness have long been known to improve overall health, policymakers, providers, and the public are increasingly recognizing the necessity of incorporating these services into the health care system.
- **The public health system in Iowa will implement statewide standards to increase capacity in access and delivery of public health services.**  
New standards will enhance organizational capacity and assure a basic level of public health service delivery in each of Iowa's counties. Standards will be set for educational requirements for the public health workforce and outline expectations for continuing education.

## Key Contributions of Direct Care Workers to Rebalancing Health and Long-term Care

- **Direct care workers are a necessary component of a quality health, support, and long-term care workforce that ensures public health and safety.**

Iowa's public health system currently consists of services in each of the state's 99 counties, although services vary from county to county. The Iowa Public Health Modernization Act has been implemented to address issues of fragmentation and inconsistent service delivery, as well as inadequate training for the public health workforce (Iowa Department of Public Health, nd2). The public health workforce in Iowa is made up of various job titles, including Registered Nurse, Home Care Aide, Environmental Health Specialist, Health Educator, Disease Prevention Specialist, Nutritionist, Epidemiologist, and many others. According to a 2005 survey conducted by the Iowa Association of Local Public Health Agencies and The University of Iowa College of Public Health, Institute for Public Health Practice, Home Care Aides are the second-most utilized employees in local public health, second to Registered Nurses. An additional 113 Home Care Aide FTEs were reported to be used on a contract basis by local public health agencies across the state. This was the highest-reported contract services requested by local public health (Iowa Association of Local Public Health Agencies and The University of Iowa College of Public Health, 2005).

Direct care workers add significant capacity to cost-effective, community-based strategies for targeted health issues and conditions such as smoking, diet and nutrition, diabetes, and obesity. Direct care workers are key partners in implementing strategies used to assist these populations, including such strategies as outreach, coordination of services, early intervention strategies, and ongoing management. Community health workers are used in health care delivery throughout the country and provide services such as health education and information, assistance with daily needs, informal guidance and counseling, advocacy for individual and community health needs, and minimal direct health services such as first aid and blood pressure screenings (U.S. Department of Health and Human Services, 2007).

Community health workers usually share ethnicity, language, socioeconomic status, or life experiences with the people they serve. Direct care workers may be able to play an important role reaching underserved populations, as they themselves often represent minority groups; nationally, one-third of all direct care workers are African American, 14 percent are Latino, 21 percent are foreign-born, and the vast majority (88 percent) are women (PHI, January 2009). This is an important consideration for public health, health care, support, and long term care as the population continues to change and diversify. In 2007, while the total population in Iowa grew by less than 2 percent, the Latino population increased by 39 percent and the African American population by 18 percent (Radio Iowa News, 2007).

Particularly in Iowa, where individuals are dispersed widely in smaller communities, maintaining continuity of care and medical homes can be difficult. Research shows that many primary care practices in Iowa do not currently have the resources to implement aspects

of the medical home, such as information systems, personnel, and quality improvement initiatives (Abrams, Davis, and Haran, 2009). Direct care workers can play a role in providing continuity of care and helping ensure maintenance of health.

- **Direct care workers are an essential member of a diverse interdisciplinary team.**

The interdisciplinary team is being recognized in health, support, and long-term care as an effective and efficient way of meeting the needs of people, particularly those with multiple and complex health and social service needs. Interdisciplinary teams are often a core component of care coordination, also known as care management, in which an individual's care is coordinated among all providers working with the individual to meet stated goals (Leadership Council of Aging Organizations, 2009). Team members share resources and responsibilities and there is a "collective ownership of the care plan" (cited in Cooper and Fishman, 2003).

Research demonstrates that for individuals with chronic conditions, such as diabetes, congestive heart failure, and individuals with disabilities, an interdisciplinary team provides continuity, care coordination, and ongoing monitoring. Although there is limited aggregate data regarding the use of interdisciplinary teams, it appears that high quality, coordinated comprehensive care does lead to improved outcomes and earlier detection of issues as they arise (Cooper and Fishman, 2003). Direct care workers serve as the first line of detection because of their often close and consistent relationship with the individual they serve. Thus, the role of the direct care worker in these valuable interdisciplinary teams is vital to early detection of illness or infection, and also in the maintenance of chronic conditions of individuals of all ages.

Service options for individuals with disabilities have increased significantly during the last two decades, increasing the number of direct care professionals working with such individuals. Community supports for people with disabilities have changed dramatically since the 1970s and early 1980s when persons with developmental and other disabilities were provided basic care and protection in institutions throughout the United States, and when people who were aging only received long-term care services provided in nursing homes (Hewitt, February 2008). Philosophy of delivery and approach has changed over time, and recent shifts in service delivery have empowered individuals with disabilities to make decisions regarding how and where they receive services.

Additionally, funding has shifted to support the demand for greater access to services in home and community-based settings. The Home and Community Based Services (HCBS) waivers available through Medicaid require a person-centered approach to planning with an interdisciplinary team chosen by the individual. The Money Follows the Person grant, funded by the Centers for Medicare and Medicaid Services, assists individuals in transitioning away from more restrictive settings into less restrictive settings in communities of their choice. The grant requires that an interdisciplinary team help the individual identify the supports needed to assist each in achieving personal goals related to health, housing, work, social needs and community life. Direct care workers are essential members of these teams and provide the

bulk of hands-on support when the person moves to a community setting of his or her choice. Direct care workers are often an essential member of these teams and provide the majority of hands-on support to individuals with disabilities.

Service delivery has changed, as well, to meet the changing needs of the country's elderly; medical advances have allowed people to live longer lives, but increasingly with more complex chronic needs than in the past. The average Medicare beneficiary now has multiple chronic conditions, partly due to longer life spans. These conditions increase not only the need for non-medical services, but also increase the potential for inappropriate hospitalizations. The Program of All-Inclusive Care for the Elderly (PACE), a Medicare program benefit, is often cited as a model for managing complex health conditions in an effective and efficient way. A team of professionals, including direct care workers, conducts assessments, develops a plan of care, and coordinates delivery of services. Hospices are required to use an interdisciplinary team approach to receive reimbursement from Medicare, and the team often involves home health aides or other direct care workers involved with the consumer (Cooper and Fishman, 2003).

Direct care workers are now and will increasingly become members of the interdisciplinary teams in health, support, and long-term care settings. However, the health and long-term care systems do not currently utilize direct care workers to their full capacity and are ill-prepared to meet the future needs of the public. Three major obstacles exist: an impending shortage of workers; inadequate training of those workers; and a poorly supported and undervalued direct care profession. Direct care workers are in high demand, and the demand for them will only increase in the near future – a total of 4 million workers is estimated to be needed by 2016 (an additional 1 million new positions) (PHI, April 2008). Training for direct care workers is mostly un-standardized, subject to a combination of federal, state, and employer requirements. Research indicates a direct correlation between quality training, low turnover, and job satisfaction (Dawson, 2007). With a profession that is generally low-paying and physically demanding, more than just recruitment will be needed to meet the size and quality of workforce that is needed in the near future.

- **Direct care workers will play a more important role as the health, support, and long-term care delivery systems shift service delivery from more restrictive settings to include more home and community-based services.**

The last decade has ushered in dramatic changes in the way we not only think about delivering health, support, and long-term care services, but also in the way services are actually delivered and funded. The landmark United States Supreme Court case *L.C. and E.W. v. Olmstead* determined the right of individuals to access services in the most integrated setting possible. The U.S. Supreme Court ruled that states have a responsibility to make community services available to individuals if it is appropriate and what they desire.

Most importantly, consumer surveys and habits demonstrate a strong desire to receive services in the home as much as possible. In a 2009 survey of a sample of seniors in the U.S. and Canada, 86 percent of respondents said they want to continue living at home for as long as possible (Home Instead Senior Care, 2009). Iowa's Medicaid program currently manages seven Home and Community Based Services Waivers. The HCBS waivers allow individuals otherwise eligible for a facility level of care to access services in their homes and communities. The numbers of individuals interested in receiving services from the waivers increases monthly, and many waivers have waiting lists that exceed one year (Iowa Medicaid Enterprise, 2009).

As states began implementing changes due to the Olmstead Decision and Medicaid HCBS waivers became available nationally, individuals with intellectual and developmental disabilities receiving HCBS increased from 62,429 in 1992 to 402,438 in 2003 – an increase of more than 600 percent. Between 1967 and 2003, the U.S. population of individuals with intellectual and developmental disabilities in state institutions decreased by 78 percent (U.S. Department of Health and Human Services, 2006). Even with additional options becoming available to individuals accessing such services, family caregivers remain the main providers of long-term care services to individuals with disabilities (AARP Public Policy Institute, March 2009). More and more Iowans receiving services through HCBS waivers are now opting for the Consumer Choice Option (CCO) which allows them to direct funding to services and providers of their choosing, often utilizing family and friends as caregivers. As of June 30, 2009, 1,203 Iowans were using CCO for their HCBS services (Iowa Medicaid Enterprise, 2009). Therefore, support for family caregivers, including supplemental services provided by direct care workers, is essential for persons served and family members, and provides significant cost-savings to the economy. AARP estimates the national aggregate economic value of family care giving to be \$375 billion (March 2009).

Nationally, the majority of direct care workers work in home and community-based settings and not in facility-based settings. This trend will continue to increase; projections estimate 64 percent of all direct care workers in home and community-based settings by 2016 (PHI, April 2008). Home and community-based services include assistance with daily activities, such as bathing, dressing, eating, and help with medications, as well as skill-building activities such as socialization, personal and home management, and community living skills.

The increasing reliance on home and community-based services will require direct care workers to provide more skilled and complex services to the public. This shift means greater autonomy and responsibility on behalf of persons served with greater intellectual, behavioral, health, and functional needs and the direct care workers that support them (U.S. Department of Health and Human Services, 2006). Given these predictable issues, it is imperative that worker training and professional development should reflect the increased responsibilities and job duties faced by the direct care workforce.

- **Direct care workers provide preventive and wellness care in settings comfortable to individuals served. This care has a positive impact on the capacity of other health care professions.**

People have known for centuries that preventive and wellness care are essential to long-term health. The current health care reform discussions at the federal and state levels have renewed the call for investments in preventive and wellness care. Policymakers and advocates promote a focus on healthy care, not “sick” care in which individuals typically receive short-term, acute care only after being diagnosed with a condition. Numerous studies have demonstrated that preventive and wellness care cost less and improve health outcomes for all persons served. Funders, service providers, and employers are paying more attention to the importance of early and ongoing care and monitoring of individuals’ health.

Two examples of model service delivery in the health, support, and long-term care systems echo the importance of preventive and wellness care, and demonstrate the significant role direct care workers play in this approach. “Systems of Care” is an approach to services for children and youth with mental health needs supported and funded by the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration (SAMSHA) (U.S. Department of Health and Human Services, 2008). According to SAMHSA, “a system of care aims to help children, youth, and families function better at home, in school, and in the community throughout life” (2008, p. 1). Services and supports are provided through a coordinated network of providers. Youth participating in systems of care show improved behavioral and emotional support, and improved school attendance and grades (U.S. Department of Health and Human Services, 2008).

The medical home model is a similarly comprehensive and coordinated approach to providing services for primary care. According to the Joint Principles of the Patient-Centered Medical Home developed by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association, a medical home for an individual should include a personal physician, physician-directed medical practice, whole-person orientation, coordinated care, quality and safety, enhanced access, and adequate payment (2007). Medical homes, when fully implemented, have demonstrated improved quality, lower costs, and fewer disparities in care (Abrams, Davis, and Haran, 2009).

Prevention and wellness are especially significant issues considering that 82 percent of older adults in the U.S. have at least one chronic disease that requires ongoing care and management (Institute of Medicine, 2008). Recent studies concerning the return on investment from community chronic disease prevention show an immediate return after the first year and 5-to-1 savings within five years (Prevention Institute, 2009). Even employers are recognizing the value of prevention and wellness. In 2008, more than half of larger employers offered a wellness program, and 94% of employers offering the programs reported that they have effectively reduced medical costs (MetLife, 2008).

Prevention and wellness are not only important for the aging population. These services are also vital to the quality of life for individuals with disabilities. Early intervention services allow individuals with disabilities to maximize their potential when they are born with developmental disabilities such as cerebral palsy or autism. These services also help prevent secondary conditions and assist individuals experiencing traumatic brain injury or mental illness to recover quicker and more resilient (Ramey, 1998). The direct care workforce can be a primary avenue for increasing the access to such services for Iowans with disabilities.

A recent report from the Institute of Medicine, *Retooling for an Aging America*, recommends preventive home visits, caregiver education and support, chronic disease self-management, and transitional care as key components of effective models of health care delivery. Many of these activities can or are already being done by direct care workers in partnership with persons served and families, and the University of Minnesota reports that the importance of adding health and wellness to direct care worker curriculum has emerged recently (LaLiberte and Hewitt, 2008). Although not recognized in research or even by the professionals themselves, much of the work of a direct care worker is prevention and chronic care management. Direct care workers typically have more interaction with persons served than other health care professionals and can therefore identify issues and changes in condition more immediately. Also of significance to wellness care is the relationship that direct care workers develop with the people they serve; the trust and bond often elicits more forthright information and the ability to motivate individuals to take proactive steps to improve their health.

- **Direct care workers play a key role in providing quality supports and services to individuals with disabilities and health care needs that enhance their quality of life as they live, learn, work, and recreate in communities and environments of their choice.**

As stated previously, direct care workers provide an essential link between individuals, their families, and the health care system. The direct care worker's role in communicating essential health information should not be understated. In Iowa, families participating in focus groups for Iowa CareGivers Association noted the importance of communication with the direct care worker because although family members are not always present when services are provided, they are often heavily involved in the consumer's care (Iowa Better Jobs Better Care, 2005). Nine in ten Iowa AARP members think that appropriate amounts of face-to-face or hands-on care (often provided by direct care workers) are important to the quality of care of services received in a nursing home or at home (AARP Iowa, 2006).

Direct care workers serving individuals in home and community-based settings, sometimes referred to as direct support professionals, play an integral role in enhancing the quality of life of individuals served by providing assistance and plans to achieve goals, lead a self-directed

life, contribute to their community, and encourage attitudes and behaviors that enhance community inclusion.

Significant research exists demonstrating the direct influence that direct care workers have on quality of care and quality of life issues. According to the Institute of Medicine (2001), essential elements affecting quality of care to residents in nursing homes include:

Education and training of staff, supervision, environmental conditions, attitudes and values, job satisfaction and turnover of staff, salaries and benefits, leadership, management, and organizational capacity. This finding is confirmed by various studies showing greater satisfaction and improved quality of life among patients when the organizational culture emphasizes teamwork and participatory decision-making (in one instance, CNAs led care-resource teams) (Institute of Medicine, 2008).

Research has primarily been conducted in facility settings typically serving older individuals. Although there is little research available on quality of care and quality of life related to direct care workers in home and community-based settings, anecdotal evidence suggests satisfaction with the services, primarily through individual choice and family feedback directly to providers and direct care workers. In addition, quality of care interviews (through the Personal Experience Survey) are regularly conducted with individuals served through the Intellectual Disabilities, Elderly, and Physical Disabilities HCBS waivers. The survey includes questions such as “Do you help pick your support staff?” “Do the support staff who come to your home respect you?” “Do the support staff listen carefully to what you ask them to do?” and “Can you always get to the places you need to go, like work, shopping, the doctor’s office, a friend’s house?” Aggregate results indicate high overall satisfaction with services, particularly the ability to direct and manage one’s own services (Iowa Medicaid Enterprise, 2008).

## Conclusion and Implications for Planning

The areas of contribution by direct care workers outlined in this report, along with the challenges the profession currently faces, require necessary focus by the Advisory Council in planning. This

planning, along with other work of the Advisory Council, will ensure a direct care workforce ready to meet individual needs in a reformed health care, support, and a long-term care system. These necessary areas of planning are:

*Diversity of the Direct Care Workforce* – The direct care workforce must reflect the increasingly diverse population of the individuals they serve. Racial, ethnic, and gender diversity in the workforce will be a priority and a necessity for long-term planning to meet the projected demand for direct care workers.

*Focus on Recruitment* – Recruitment efforts to draw individuals into the direct care profession have been and will continue to be a critical element of planning by the Advisory Council. Current Council recommendations aim to enhance the value, opportunities, and quality of the workforce by establishing state standards for training and education that are part of a career pathway with continuing education and professional development opportunities. These efforts are designed to improve worker retention and create an attractive profession to enhance recruitment.

*Provision of Accessible, Comprehensive Training* – The Institute of Medicine’s recent publication, *Retooling for an Aging America*, cites lack of adequate training as a primary reason why the health care system is not fully prepared to meet the needs of future populations. Research indicates that professional development of direct care workers not only improves quality of care but reduces turnover rates and increases job satisfaction (Dawson, 2007). Direct care worker training has been the primary charge of the Advisory Council. Current work of the Advisory Council is focused on the identification of competencies for a comprehensive career pathway.

*Integration with Other Health Reform Initiatives* – Improvements in direct care worker training and education should be integrated with other health care reform initiatives for greatest impact. Direct care workers, as part of an interdisciplinary team, have the potential to play an important role in reform efforts noted in this report including prevention and wellness initiatives and chronic care and disease management. New training and education for direct care workers can align with other initiatives to achieve common goals.

*Development of Data Systems to Monitor the Workforce* – Gaps in information about the direct care workforce, including workforce size and composition, pose serious challenges for planning and implementing new initiatives targeted toward the direct care workforce. Nationally there are many initiatives under way that address recruitment, retention, and training, but evaluation remains a challenge without systems for collecting and monitoring data on the workforce.

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