

**Minutes**  
**Health and Long-term Care Access Advisory Council**  
 January 29, 2013  
 10:00 a.m. – 3:00 p.m.  
 Urbandale Public Library

**Members Present**

Libby Coyte  
 Brian Farrell  
 Ryan Hopkins  
 Susan Lutz  
 Catherine Simmons

**Members Absent**

Carol Alexander  
 Roy Bardole  
 Kyle Carlson  
 Shelly Chandler  
 Michele Devlin  
 Steve Johnson  
 Brian Kaskie  
 Laura Malone  
 Daniel Otto  
  
 Cindy Baddeloo  
 Wendy Gray  
 Leah J. McWilliams

**Others Present**

Michelle Holst, Iowa Department of Public Health  
 Kevin Wooddell, Iowa Department of Public Health  
 Laura Hudson, Iowa Board of Nursing  
 Anthony Pudlo, Iowa Pharmacy Association  
 Deng Wour, Iowa Pharmacy Association  
 Megan Ohrland, Iowa Pharmacy Association  
 Gloria Vermie, Iowa Department of Public Health  
 Melissa Havig, Magellan  
 Francisco Olalde, The University of Iowa (rep for Carol Alexander)  
 Sarah Dixon Gale, Iowa Primary Care Association  
 Sandy Nelson, Iowa Medical Society

\*Health and Long-Term Care Access Advisory Council Web site [http://www.idph.state.ia.us/hcr\\_committees/care\\_access.asp](http://www.idph.state.ia.us/hcr_committees/care_access.asp)

<b>Topic</b>	<b>Discussion</b>
Introductions and Welcome	The meeting started with a brief welcome and introductory comments from Michelle Holst followed by members and guests introducing themselves.
Direct Care Workforce Initiative  Erin Drinnin, Iowa Department of Public Health	Erin Drinnin, Iowa Department of Public Health presented on the Direct Care Workforce Initiative. Please see <a href="#">slides</a> for presentation content.  How does the Direct Care Workforce Advisory Council approach the issue of direct care being a stepping stone into nursing? <ul style="list-style-type: none"> <li>• Principle for the council – do no harm to the system now</li> <li>• Yes, a number of Direct Care Professionals (DCPs) are pursuing nursing as a career pathway</li> <li>• However, a huge number of DCPs do NOT have a career pathway</li> <li>• Design a way to grow within the career of direct care, other than becoming a supervisor or manager which does not fit what all individuals want to do and doesn't always make best use of their professional strengths.</li> </ul> Council Members asked how many hours of training are involved for the advanced pathways. The number of hours varies significantly depending on the module.  Where would the training happen? Currently most direct care professionals are trained on the job. The pilot project is working with community colleges and employers to develop and deliver training for direct care professionals. An online training module is also being developed but not currently being piloted. A goal is to develop and provide training in a way that it is accessible to anyone.  A lot of turnover happens in the first 30 days and there is a problem with a lack of respect. How will this program help that? Comment: It seems like an individual employer

management issue. Speaker: It is a combination of things. There seems to be a lot of excitement among direct care professionals about the credentialing and the recognition provided through having a credential. One of the things DCPs have said is they are “hungry” for training. Direct care professionals have indicated a desire for continual training, and there is a lot out there, but there is a lack of standardization. Direct care professionals end up going through the same training over and over again. Also, the employer seems to own the training. Whereas with this pilot, there seems to be appreciation on the part of the DCPs that they own their training. Also, mentoring is being piloted and they are seeing incredible results from the mentoring.

Where is the positive feedback happening? The pilot is within two regions of the state. The first region is the Des Moines area and 10 surrounding counties. The second region is the city of Ottumwa and surrounding counties. The pilots are partnering with the community colleges and local employers.

Do the pilots serve only the elderly or do they include persons with disabilities? It is a pretty good mix. There is approximately an even split between the pilots and many of the participants are working in home and community based services.

Are the direct care professional participants selected at random? Are these the “engaged” individuals, those direct care professionals who exhibit more enthusiasm? The pilot sites were selected via a Request for Proposal. Therefore, the direct care professionals participating are employed by the recipients of the RFP. The system being piloted puts the responsibility on the individual, so hopefully this helps balance the personal initiative element. Also beginning a pilot in the Dubuque area which will focus on the CNA population.

Iowa was one of six states (California, Iowa, Maine, Massachusetts, Michigan, North Carolina) to receive the federal grant and all states are facing the same challenge with the need for DCPs. The federal grant is to address the need for and development of a national model. Retention and mentoring support was highly encouraged by the federal partners, so it is included in the project. The grant supports a lot of IT development. Includes how to apply, renew and access their credentials online and also a way for the public to look up a DCP’s credentials much like the public can currently look up other licensed professionals.

Would this help by making the record check evaluation process smoother? We are working with DHS and want to make sure there isn’t duplication of effort. This is still being worked on because the board would conduct background checks. Are there ways to avoid duplicating efforts?

Has the pilot been going long enough to determine success? Would say that they’ve spent most of the first 18 months developing curriculum. One thing they are doing is interviewing anyone who leaves employment via the evaluator that works with the grant. They are seeing high satisfaction with the core training, but we don’t know yet whether this translates into higher job satisfaction.

With grandfathering, would they be grandfathered just to the core or to modules or how would that work? This piece of the process has been discussed in depth. There would be an assessment to help determine an individual’s grandfathering based on their work experience. This assessment is in development.

What is the charge? The charge to the Direct Care Workforce Initiative Advisory Council is to continue implementing the recommendations. Direct Care Workforce Initiative Advisory Council members provide feedback and expertise to carry out the recommendations and to provide a lot of the outreach and education (feedback on how that’s done).

Will the council make recommendations to the legislature on policy-related issues? Part of the goal will be to include recruitment and retention, but wages is not part of the scope. The

	<p>council specifically did not provide recommendations regarding wages. As far as policy, the March 2012 report was technically their final report, and the main policy recommendation was establishing a Board.</p> <p>Who is going to address the resulting demand for higher wages? Employers in the pilot have talked about the general systems shuffling and the amount spent on turnover. Hope is that the funds currently being spent on turnover can instead be used on retention efforts.</p> <p>Hoping for an opportunity for a continuation grant. All of the current states in the federal grant agree that they need to look at policy change. A lot of the issue is with service dollars, including Medicaid dollars. A piece of the discussion is partnering with the Centers for Medicare and Medicaid Services (CMS) on the project moving forward to address this question.</p> <p>Implementation of the ACA could have a major impact. Iowa CareGivers Association is helping find workers who can provide input about this impact through the University of Iowa Public Policy Center.</p> <p>Suggestion was made to emulate the movement in the education system to raise pay for teachers.</p> <p>How many FTEs would the state need to implement the Board? After 2 years, the Board would have to be self-sustaining. General fund dollars for first two years. Believe it was about 13 FTEs.</p> <p>What about family members who are caregivers? How would this apply to them? Legislation to date has exempted family members, although council members would have recommended a basic, 6 hour training. Also have discussed Consumer Directed Attendant Care (CDAC). The council is working to balance and not damage the existing system while still protecting the public.</p> <p>How does Iowa Caregivers Association dovetail into this work? They are a subcontractor to provide supports to the DCPs and are developing the two-day mentoring training.</p>
Public Comment	<p>What was the reason for two-years grandfathering? This is a balance to address what is too short of a time period but at the same time realizing the field and issues change, so it can't be too long.</p>
<p>Workforce Discussion</p> <p>Incorporation of any follow-up to DCWI Presentation</p> <p>Determination of any next steps and planning</p>	<p>The council is doing a wonderful job of creating and implementing their work. The effort lends itself well to the issues within the workforce. It has to potential for increased competition for already-trained staff and the possibility of more stabilization and retention.</p> <p>Concerns about an increase in bureaucracy but at what value? Not sure if it is practical to have it self-/fee-funded. Not sure what reaction of the overall workforce will be.</p> <p>This is the beginning of a transformation of this component of the workforce and not sure that the HLTCA AC has the expertise to weigh in on that transformation. Too early to tell how it would all work out. Not sure the HLTCA AC will be the major driving force moving forward. This is part of the HLTCA AC work, but the profession itself is undergoing a transformation and not sure HLTCA AC would make decisions on policy recommendations.</p> <p>See the component of owning credentials may add some accountability. It may help weed out individuals who should not be involved in providing direct care services. Health system overall has been looking at career ladders. So few people took/take advantage. Our experience, great benefits and good pay, helped with retention but not necessarily</p>

	<p>recruitment. It will be interesting to see how DCWI translates into retention.</p> <p>Does HLTCA AC have a specific role? With access, we have some expertise and could pose questions for DCWI to look at. Will HLTCA AC be the standard bearer, the ones who would push policy for the direct care workforce? No.</p> <p>Would there be commonality between direct care workers, home care aides, and pharmacy technicians? Hate to see every group reinvent the wheel. Could there be similarities? They have looked at the subcategories that have been put in their purview. Wonder if there could be extensions of the core training. Not sure if there would be value there or not, but maybe in terms of efficiency. Some of the very basics of working with patients.</p> <p>A lot of people will start at direct care level and move into other professions, so it could be important to address this at some point.</p> <p>Potentials for HLTCA AC involvement or other involvement:</p> <ul style="list-style-type: none"> <li>• Perhaps, strategies for industry as a whole to reduce (64%) turnover</li> <li>• Some issues must and can only be addressed at the employer level (worker satisfaction); facility’s culture, geographic area</li> <li>• DCWI chose to focus on a specific area and other areas not currently addressed (wages, etc.)</li> <li>• Where do other issues related to DCWI fall? Probably a productive conversation to have not only about direct care workforce but also about other health professions.</li> <li>• Is it the job of HLTCA AC or workforce commission that we’re recommending? <ul style="list-style-type: none"> <li>○ If so, what will the cost be? Will the cost be addressed?</li> <li>○ Governor’s recommendation that HLTCA AC be eliminated.</li> <li>○ If so, where will these issues go? A commission? In the absence of a commission, what is “Plan B”?</li> <li>○ If not, where do the issues go?</li> </ul> </li> </ul> <p>HLTCA AC sees that direct care workforce issues are part of its charge but does not see that HLTCA AC will be a driver of change in policy for these issues at this time. HLTCA AC will address DCW issues as appropriate given timeliness of events and scope of the HLTCA AC’s work.</p> <p>Question: What does it mean if funding goes away for HLTCA AC? Uncertain whether it eliminates only the HLTCA AC or all Iowa Code language related to strategic plan.</p> <p>Commission idea – in addition to information in conference call notes:</p> <ul style="list-style-type: none"> <li>• We would not at this time recommend a solid set of subgroups but that the commission could do that</li> <li>• Therefore want to avoid the commission being divided by profession to avoid representing only the profession</li> <li>• Lots of different areas we probably didn’t think of</li> <li>• There are global organizations that do planning but are not profession-specific; don’t need to be on the commission but a part of the commission’s work</li> <li>• If HLTCA AC goes away, would still need to work on workforce. The commission may be an opportunity to narrow the focus and determine a more specific charge.</li> </ul>
<p>Infrastructure Fact Sheet and Planning</p>	<p>Infrastructure Fact Sheet</p> <p>Discussed including council’s definition of infrastructure in upper left corner (where key data is located on workforce fact sheet).</p> <p>Brainstormed potential content for sections of a fact sheet consistent with format of</p>

workforce fact sheet.

**Data elements** discussed included:

1. Transition from fee-for-service to quality focus (reduction of infection rates, etc.)
2. Number of patients in Iowa in long-term care; acute care; etc.
3. Add ACO – how many covered lives as of X date are in the ACO system
4. Define covered lives (Medicare or also private insurance)
5. How many patients are in Medicaid health homes
6. How many previously uninsured Iowa patients will now have insurance coverage?
7. Try to find statistics on the number of existing EHR systems in the state (does eHealth have this statistic) and their inability to communicate (not interoperable)
8. What types of providers have already been included in EHR and what types have not
9. Rural versus urban use/coverage of EHR
10. Each EHR is tweaked and becomes so customized it is not interoperable.
11. Number of people on various waiting lists for the state.
12. Data to articulate the anticipated ongoing need for the safety net. (Massachusetts examples.)
13. Multiple definitions of care coordination and multiple terms for care coordination function.

Iowa Health, Mercy, University of Iowa Hospitals and Clinics, Genesis – provide us with their covered lives data.

1. Other payment reforms – health homes
2. NCQA site – search certified health homes

Key for each data element will be to say “as of X date” because this the data will be changing continuously.

**Outcomes**

1. Reduction in re-hospitalization. (Iowa Healthcare Collaborative potential resource.)
2. Blue Zones – reduction in chronic disease.
3. Interoperability among EHRs or reduce number of EHRs that are not interoperable.
4. Increase the number of certified medical homes (through multiple certification entities.)
5. Reduction of numbers of patients on waiting lists.
6. Uncomplicated care coordination term and function that is easily understood by patients, family members and professionals.

Revisit further after gathering “key data”.

**Next Steps**

1. Develop a readily accessible knowledge base and/or information to be available for professionals, patients, and families to know the full range of their options for care. Assure services are seamless to the individual.
2. Development of the community utility idea in Iowa; especially helpful for rural areas.
3. Individual professional requirements to demonstrate impact on quality care (continuing medical education not solely adequate) by national certifying organizations.
4. Financial assistance to independent practitioners, public providers, and community based providers (those unable to take advantage of economies of scale or don't fit with well by nature with existing large-scale systems) for infrastructure development.
  - a. Training modules
  - b. Incentives to participate
  - c. Grants
  - d. Support organizations

	<p>e. Consultants</p> <p>5. Ensure that the safety net providers are included in infrastructure development at both local and statewide level. Adjust support to include new or different providers as the safety net evolves.</p> <p>Encourage input from other HLTCA AC members to add to this list.</p> <p>Revisit and revise Outcomes and Next Steps after gathering further information and key data elements.</p> <p>Issue – huge knowledge deficit about options available the variety of care options.</p> <p>Both fact sheets should include a link to the council’s webpage.</p>
Public Comment	<p>Is there a possibility that with this list, there is scope creep in the council’s work? Suggest a sheet with operational definitions of terms in the fact sheet. For example, would a general reader know what “community utility” is? Discussed linking the word “community utility” to an issue brief; however, the sheet will not always be used electronically, so this doesn’t address the issue when the sheet is used in hard copy. Also asked whether the word “funding” is the correct word, questioning whether the HLTCA AC has the ability to “fund” or if “support funding” is more appropriate.</p>
Next Steps & Closing	<p>Idea – Combine Next Steps from both, Workforce and Infrastructure Fact Sheets into one document.</p> <p>If we do this, should we establish stages or tiers for the next steps? Are some steps needed before other steps can happen?</p> <p>Should the HLTCA AC’s webpage be changed to include grant opportunities? How can visibility of the council be increased so work of the council is known? Could things like loan repayment possibilities be listed on the HLTCA AC’s webpage along with things like calling attention to the Governor’s state of the state address (coverage of workforce).</p> <p>How can the work of the HLTCA AC be linked with other entities, for example, work of the Board of Nursing to address workforce so that we aren’t reinventing the wheel?</p> <p>Some members have not been here in a while – issue was raised whether membership should be reexamined.</p>

Next Meeting: Wednesday, April 3, 2013; 10:00 a.m. – 3:00 p.m.; Urbandale Public Library, Meeting Room A