

**Meeting Summary**  
**Thursday, September 20 2012**  
**9:00 a.m. – 12:00 p.m.**



**Urbandale Public Library – Meeting Room A**  
**3520 86<sup>th</sup> Street**  
**Urbandale, Iowa**

**Council and Committee Members**

Ann Aulwes Allison  
Don Chensvold  
Matthew Clevenger  
Erin Drinnin  
Di Findley  
Vicky Garske  
Terry Hornbuckle  
Melanie Kempf  
Julie McMahon  
Kelly Meyers  
Ann Riley  
Lin Salasberry  
Anita Stineman  
Anthony Wells

**Guests**

Jamie Bargman, Easter Seals  
Kris Bell, Iowa Senate Democratic Caucus  
Jean Bohall, DCP  
Deanna Clingan-Fischer, State Long-Term Care  
Ombudsman  
Pam Conder, DCP  
Linda Dunshee, Link Associates  
Patty Funaro, Legislative Services Agency  
John Hale, Iowa CareGivers Association  
Carla Harris, DCP  
Jack Hatch, Iowa State Senate  
Elaine Holthaus, Northeast Iowa Community  
College  
Barb Huey, Iowa Department of Public Health  
Megan Kelley, DCP  
Julie Kennedy, DCP  
Geoffrey Lauer, Iowa Olmstead Consumer Task  
Force  
Dennis Lauterbach  
Christina Leach, DCP  
Mary McLaughlin, Iowa CareGivers Association  
Alyssa McMahon, Iowa Health Care Association  
Sara Nadermann, Candeo  
Emily Noel, American Institute of Caring

Kristie Oliver, Coalition for Family and Children's  
Services  
Julie Paulsen, DCP  
Cindy Ramer, DCP  
Jennifer Schumann, Iowa Health Care  
Association  
Kelly Schwatel, DCP  
Amy Stevens, Easter Seals  
Annie Strawn, Iowa Home Care  
Shannon Strickler, Iowa Hospital Association  
Deborah Thompson, Iowa Department of Public  
Health  
Nancy Tretina, Ask Parent Resource  
Aaron Todd, Legislative Services Agency  
Carol Warren, Progress Industries  
Jeff Weinstock, DCP  
Jamie Wheelock, Des Moines Area Community  
College

**SPPG Staff**

Indira Blazevic  
Erin Davison-Rippey  
Arlinda McKeen  
Michelle Rich

## **Welcome**

Arlinda McKeen, SPPG facilitator, welcomed the Advisory Council and guests to a special meeting. Introductions of all in attendance were made. Due to the large number of guests, McKeen also noted that the protocol for the meeting called for the Advisory Council to conduct its business, with guests having an opportunity to contribute to the discussion at the appropriate time and when recognized. Senator Jack Hatch introduced himself and briefly spoke about the importance of training and credentialing for direct care professionals.

## **General Updates**

McKeen introduced the updates on project activities to be provided by members of the Direct Care Workforce Initiative team.

## **Outreach**

Erin Davison-Rippey from SPPG provided a review of the outreach work of the Initiative. Four informational forums were held during June in Waterloo, Dubuque, Des Moines, and Mason City. Five forums are being conducted during September in Cedar Rapids, Sioux City, Sheldon, Council Bluffs, and Ottumwa. Initiative staff have also been involved in presentations at conferences and visiting one-on-one with interested parties to explain the Initiative and answer questions. Davison-Rippey encouraged individuals to let staff know about others with whom these conversations could be held.

## **Ambassadors**

Davison-Rippey also spoke about the role and activities of the Ambassadors who are DCPs, employers, educators, and people who are connected to the work of the initiative. Ambassadors make local connections, get the word out about the Initiative, and provide information about the training and credentialing recommendations. Ambassadors have played an important role in the informational forums around the state this summer and fall.

## **Curriculum Update**

Anita Stineman, curriculum director for the Initiative, updated the Council about the curriculum development efforts. Each of the completed curricula has been offered through the two PHCAST pilot regions at least once. Northeast Iowa Community College received a Department of Labor Grant to develop curriculum for the Health Monitoring and Maintenance module. That group will be meeting at end of the month to finish first drafts, then will be seeking participants for resource group to review it before it will go to the DCP Education Review Committee for review and comment.

The Educational Review Committee has been working on grandfathering, including reviewing each curriculum and coming up with the behaviors that an individual can document that they have met. This will allow them to receive credit and be grandfathered in for that material. Three modules have been covered: Home and Community Living, Personal Support, and Instrumental Activities of Daily Living. There is a two-level set of criteria – critical and essential elements – for determining whether an individual receives credit for that particular module.

Work has been occurring on competencies for two specialty endorsements, Alzheimer's and Dementia, and Positive Behavior Supports (PBS). The Alzheimer's work group began with competencies developed several years ago under a separate initiative led by the Alzheimer's Association – Greater Iowa Chapter under contract with Iowa Department on Aging. Positive Behavior Supports competencies were developed by a group and started with model competencies developed by other initiatives. Two Council members who participated in the groups offered comments:

- Terry Hornbuckle commented that the Alzheimer's competencies were solid, and they just made a few tweaks to the work of the previous task force.

- Ann Riley commented about participants in the PBS group and the variety of entities that have been using PBS to assist individuals in different settings; the competencies are being built upon introductory topics.

Stineman continued, saying that once the specialty groups are finished with the process at the end of the month, they will be provided to the Advisory Council. She also reported on the development of an online version of the Core, which is in the initial stages, with the support of the Upper Midwest Public Health Training Center (UMPHTC).

### **Pilot Site Updates**

Erin Drinnin, Project Manager for the Direct Care Workforce Initiative and PHCAST grant, facilitated an update and discussion of the pilot activities. The two pilot regions are the central Iowa region and southeast region around Ottumwa. Des Moines Area Community College and Indian Hills Community College are key partners and have completed a lot of core training at these sites, as well as the employers who are partners.

Mentoring is an important part of the pilot projects. Some agencies already have a peer-to-peer mentor program in place. Thus far, 28 mentors have been trained. Iowa CareGivers Association is leading the mentoring training and has developed an Online Mentor Manager Toolkit, which is on the ICA website. This toolkit is available to all, regardless of whether an agency is part of the pilots.

### **IT System Development**

Drinnin reported that development continues on the IT system to support the training and credentialing system. Under contract with a developer, a website is being built that will help automate and streamline application and renewal of credentials. It is designed to be simple, user-friendly, and efficient. The website will include public access to certain information about DCPs. Significantly, this database that will be part of the IT system will provide the first tool to track the workforce and gather reliable data about the workforce, its size, and demographics.

IT system testing continues. Clearly, it is a complex system with several components. Current plans call for testing some of the online application processes and grandfathering processes with DCPs in late February.

### **Exam Development**

Drinnin also noted that the Initiative continues to work on developing credential exams. Plans are to conduct some test development in November. A solid bank of question is being developed, with a spring goal for making the tests available to pilots.

### **PHCAST Grant Evaluation**

Evaluation of the pilot project is also underway, led by The University of Iowa's Kellee McCrory. Early data is being collected on the numbers of DCPs trained in Core as well as the pre-assessment data. Each DCP participating in the pilot completes an extensive assessment prior to beginning training. These assessments will provide the baseline on which effectiveness of the training will be measured.

Pilot participants offered their thoughts on the training thus far. One individual noted that the Core training required anywhere from four to eight hours to complete, depending on how many people are in the group. Another participant noted that she thinks people who have been in the field for a long time should also take this training. One provider is doing multiple Core trainings per week. At DMAACC, Personal Activities of Daily Living (PADL) will be offered on campus in conjunction with their provider partners. Drinnin noted that Indian Hills Community College is seeking to expand their partnerships.

An important distinction is that the HRSA PHCAST grant has focused on developing and piloting training for home and community-based providers. The Department of Labor grant to NICC is focused on the Health Support Professional credential, which will provide the course content required for recognition as a CNA for work in a nursing home.

### **HRSA Grantee States Meeting**

Drinnin provided an update on the meeting held in August in Washington, D.C. for the six states that were awarded a PHCAST grant through HRSA (Health Resources and Services Administration). This was the first time the six states met face-to-face to report to HRSA and to share information and progress. The six states discovered that though they all have slightly different models for their grants, there is a lot of similarity in some of the issues and premises. Nearly every state has identified the same elements for their Core training. HRSA is interested in next-step discussions and what policy issues at the federal level may need to be addressed.

Drinnin also reported that on Sept. 24 she will be testifying in Washington D.C. at the Senate Committee on Aging's Congressional Briefing in conjunction with PHI. Iowa, California, and North Carolina will be represented.

### **Policy Discussion with Elected Officials**

McKeen explained the purpose and format of the remaining portion of the meeting. Senator Jack Hatch asked to be invited to this meeting to hear directly from Advisory Council members their priorities and concerns regarding the legislation to establish the training and credentialing system for the direct care workforce. The discussion would primarily be among members of the Advisory Council, though guests would be recognized and included in the discussion as time permitted.

Senator Hatch offered initial comments. He indicated he wants to find a way to move legislation to the floor of the House and Senate to get a vote and passage. There is a need for this training and credentialing. Direct care is a growing profession, with the least amount of required, standardized training. He noted the legislation was almost passed last year, coming close to passage in the Health and Human Services (HHS) budget. He asked the Council to help him understand what compromises are needed. He emphasized that he was present to listen to the Advisory Council.

Representatives of the Iowa Health Care Association offered the first comments. One noted that nursing homes already have 75 hours of training but did not know that home health does not have educational requirements. He feels that the emphasis for training should be on the community and home health provider. They asked that nursing homes be left alone in this initiative.

Senator Hatch noted that one objective of the Board is for everyone to have a minimum standard for training. Nursing homes and assisted living agencies currently meet a standard for the type of services they do. Another objective is to reduce re-training of DCPs when the worker moves to another job. This initiative is not meant to jeopardize institutions' position, but to bring high standards to all DCPs.

McKeen distinguished this Direct Care Workforce Initiative that focuses on standardized training and credentialing, with career pathways, as a workforce discussion. It is about development of a stable workforce. This is in contrast to the federal requirements placed on nursing homes to hire CNAs to meet their facility requirements. This initiative does not place additional regulations on facilities. The work of the Advisory Council is intended to do no harm to the workforce, but to strengthen it.

An Advisory Council member noted that no industry controls a segment of the direct care workforce; all employers are competing for the same workforce. This initiative is to serve the workforce and ensure workers can transition among settings and persons served.

Drinnin explained that an expansion of the current CNA registry would not be adequate for this purpose. The registry addresses compliance with federal rules and regulations. The state interprets federal rules and the Department of Inspections and Appeals regulates that. The Advisory Council has tried to align with the registry. Some federal rules cannot be changed right now, which is an item of conversation across states. The Direct Care IT system will have interaction with the CNA registry to provide a one-stop source to identify level of experience and credential.

A guest commented that she is a CNA who has worked in home care for years, and she provides more services in home care than she did in facilities. She said some people come to work from McDonald's. This Core training is really important to those who do not want to go to school, and it is training people well.

An Iowa Health Care Association representative reiterated that all direct care workers should be brought to the standards of CNA. He believes that people with dramatically different training standards are being brought into a single system and that he feels this is a step backward for nursing homes. McKeen pointed out that half of the workforce does not work in the nursing home setting that requires CNA training, yet there are many common points across the workforce. This is why the curriculum development and career pathways reflect different functions of the workforce.

A DCP commented about the frustration of seeing people in the field with training but no heart. As a group, DCPs want to be recognized and agree that DCPs should be certified. Turnover in long-term care is high, and that reflects poorly on the entire field. Training will help people understand what the job is about and they will want to be there.

The Iowa Hospital Association representative in the audience indicated the IHA members are empathetic of additional oversight. IHA thinks that on cost efficiency and need basis there should be focus on the groups of DCPs without requirements. Further, IHA think expanding the CNA registry would address that gap.

Drinnin clarified that the registry is intended to be used by employers. The distinction is that the board of direct care professionals would oversee the credentialing and the profession. The requirement in the legislation for the board is that the minimum standard is six hours of training. The rest of the pathway and advanced training is voluntary. There is a lot of training out there already. The Core standardizes training so individuals are not getting retrained and retrained. Employers may have requirements beyond the minimum. The goal of this effort is to establish a bare minimum and provide options for advanced training that is standardized across the workforce. The instructors in the pilot have been sharing a lot across the different settings. They have been doing a lot of storytelling. The stories are a lot alike. Stineman added that one pilot agency is seeking an additional level of services. The career pathways allow additional training to open workers up to providing additional services.

Senator Hatch said he is looking at this as a career ladder, a workforce issue, but not jeopardizing the quality and standards that the nursing home industry has of its own. He noted that this is an emerging industry and workforce that doesn't have the infrastructure to provide training needed for the career an individual chooses. Credentialing is part of moving the growing industry, with new people coming into it, so they can move from one job to another without being retrained. It provides a means, through the credentialing system, by which an employer knows what a potential employees knows.

McKeen revisited the discussions from previous years through which the Advisory Council reached these recommendations. In the early years, there was discussion of a “medical model” and realization that the workforce is heading more into home and community services. The Council realized it could not think only of health care services, but also about services for individuals with disabilities and who are aging. Some even began to realize that people are living longer so that older people develop disabilities and people with disabilities get older. The services and functions overlap more than the Council realized at first. As a result, the career pathways were developed, allowing an individual to have multiple credentials and work in multiple settings – giving DCPs an opportunity to take control of their own career, like other professions.

Drinnin commented that the discussion is focusing on CNA. Part of the reason that the Council talked about this continuum of services and the different training is because, although CNA is easiest to identify, there are lots of hours of training that people take in other fields because CNA training would not prepare them to do jobs in other settings. Even for home care and disability settings, CNA training would not prepare them. Essentially, what the Council has recommended is what some are saying: training that much more fits the path that they choose.

A guest noted that the emerging industry of home care that Senator Hatch is referring to is absolutely true and DCPs need to be better trained. He asked that it be kept in mind that there is also a “legacy industry” in Iowa that has been serving people with disabilities for decades and has a workforce in place. There are probable unintended consequences of the training and credentialing proposed, and that is the funds. The people providing disability services are often the least trained. For those individuals that are paid by Medicaid and state funding, there will be a cliff where people will leave the service areas where they are not being reimbursed. Historically, people with disabilities have been fighting for more consumer choice, so these are not all agency-based issues. As the training bar gets raised, consumers are concerned that there won't be a reasonable accommodation made for them to still have the same impact in choosing and hiring their own DCPs. Many of the people in the direct care workforce do not see this as a career. Even if they should have more training, if it creates a barrier to them being willing in work, then people with disabilities have less choice about who works with them. The medical industry typically has more funding. People in the disability community do not have access to that type of funding. He requested that the proposed system make the accommodations that are necessary for consumer choice, person-centered care, and the funding in that legacy industry, in order to not push people with disabilities off another cliff.

It was noted that two important premises have been in place since the beginning of this work: do no harm to the existing workforce and do no harm to the consumer. The system needs to change and it has to consider the people who receive services, no matter what types of services they are, and has to reflect the needs of a stable and well-trained workforce, trying to reduce some of those costs, turnover rates, and offer standardized training so that people can move to another job and not have to repeat training. That is why employers are being engaged in pilots. The proposed system is very flexible, both for employers and how training is delivered, to create opportunities.

An agency leader providing disability services pointed out the critical issue of not being allowed to bill for training of staff; it is included as part of the capped administrative item for reimbursement through Medicaid. This agency fundraises to pay for training of staff. This project is appealing if only to let them reinvest the money they are paying in unemployment and subsidized benefits into payroll for individuals who would consider this work a career.

Also regarding funding for disability services, an Advisory Council member commented that those services have been underfunded for years and are very restricted in what they can and cannot use the funds for. The difficulty of not being able to build training into the reimbursement rate is even more critical when they are a waiver-funded option.

CNAs on the Advisory Council commented that they have worked for many years and consider this their career. One expressed concern about the variation in quality of services in a facility, such as assisted living, when they have both CNAs and untrained hires "off the street" working in the same jobs. There needs to be consistent training and options for portability for DCPs.

Drinnin explained that what is incorporated in the Core is an introduction to the profession. Turnover is often early in the job, within the first 30 to 90 days. Much of the purpose of Core is to provide this early introduction, including the code of ethics, and to allow people to consider the different paths and opportunities that they might want to choose to go into direct care. About portability, with the advancement opportunities that are all voluntary, it offers opportunity for people to advance and grow. There is a lot of training available to people, and this is a way of validating that and providing them recognition and credentials and titles for that. It offers both portability throughout the continuum, and advancement opportunities within the field of direct care.

A guest asked whether employees providing services for children would be covered. It was suggested that taking the Core would provide them the basic credential.

Stineman addressed the perception that the proposed training and credentialing is a "medical model" because the CNA is so prevalent. But competencies in other modules like personal support and home and community living are not medical models. The curriculum development groups listened to what the disability world had to say and used the appropriate terminology and strategies. Curriculum has been reviewed by resources group made up of individuals from agencies that work with people with disabilities, and they were pleased with the content. The degree of medical content depends on the module. McKeen observed that over the years Initiative partners have heard people say that even though they work in a disability setting, they would like Alzheimer's training. Likewise, people in a nursing home setting have said they are moving to a person-centered approach, and they want the positive behavior support specialty.

One individual is currently unemployed, looking for a new job, and wants to stay in health care. The credentialing and the portability are more important to her now than ever. She is concerned about losing her active CNA status because she left a long-term care facility. Right now there is no way to keep that credential.

A CNA related his experience of moving to Iowa from a state where he had multiple state-recognized certifications. He lost ownership of those certifications by lack of reciprocity. He likes the idea of the modules because he will regain some ownership. Several other individuals agreed.

A guest reported she has been a Nurse Aide Instructor for over 13 years. Now, she has to add more training because states that are next door, Illinois and Wisconsin, do not recognize Iowa's 75 hours because theirs is at about 120 hours. Drinnin noted that, in terms of reciprocity, this issue comes up a lot. The Council has made some recommendations about this, and it would align with the process of grandfathering. Iowa would provide an opportunity for people to reciprocitate. The goal of the federal grant is building a national model for standardized training and credentialing. Nationally, they are still at the data-gathering phase. Iowa will have a chance to be part of those discussions.

A guest asked how many hours of training are required for a DCP in the field of disability services. While there are no standard requirements, many providers say they provide up to about 40 hours of training for these employees in order to meet their Medicaid certification.

Ann Riley of the Center for Disabilities and Development noted that there has not been a lot of state legacy for disability. The disability industry has been seeking training and support from national groups because this was the direction of their funding sources.

Drinnin commented that the Initiative is also looking into how the background check can be aligned. A focus is creating standards for what is already in existence and being used.

It is intentional that development of the system is toward flexible and competency-based training and credentialing. Stineman explained that some of the modules are considered to be competency-based. If an agency or organization has a curriculum that meets those competencies, they can bring it to the Board for approval. If it matches up, then it is approved for use, which fits the agency's setting. The two curricula that are different are PADL (Personal Activities of Daily Living) and Health Monitoring and Maintenance (HMM). Those two are different because they have to comply with the federal Nurse Aide guidelines, and there are specific criteria that need to be included, so those two need to be taught from a standard curriculum.

It was also noted that specialties can be taken above and beyond the Core and endorsements sought for those. The system is designed to be so flexible that an individual will have opportunities in many directions of the profession. Continuing education is also linked to credentialing that will ensure ongoing competence in the credential.

An Advisory Council member offered a summary comment: "To the disability providers, I joined this task force two years ago, and now work as an advocate for people in long-term facilities. I came into this thinking it was mainly a medical model, too, and was set straight. It opened my eyes. Although today's conversation has been very CNA-focused, that has not been a general consensus of what we do on a general basis."

Longtime Advisory Council member Ann Aulwes Allison noted that she is very into the medical model, coming from the Iowa Board of Nursing. She explained there are 20-some states in which the National Council of State's Board of Nursing oversees testing for CNAs. The Board of Nursing does have a responsibility for CNAs, and she has wondered why the CNA is not more aligned with nursing. She said she is trying to listen to groups of people from other areas and communicate with the Board of Nursing.

A guest commented about his interest in the Direct Care Workforce Initiative. He sees the value of being involved is that he can travel and listen to a lot of discussions. Yesterday at the forum in Cedar Rapids, Senator Bob Dvorsky told a story from an article in the Council Bluffs newspaper, quoting Senator Mike Gronstal's comment when speaking at the Council Bluffs forum earlier in the week. Stressing the point that his barber is required to have 2,100 hours of training, Gronstal said, "No one ever died from a bad haircut," but in this business (direct care), this is really serious stuff. If we don't train people well, we have some really serious problems on our hands.

McKeen provided some observations of the day's discussion, noting that, while there are some different understandings, everyone wants the same thing, which is that those people that we serve have the best services possible. Employers want to make sure they are in good standing with their agencies. The workforce wants to have an opportunity to advance in their learning and education and create a sense of professional pride, and employers would agree that is positive. What is being faced now is how to get

there from here, and what are the issues that really need to be worked out. Some may simply be informational issues. Initiative partners will need to sit with representatives of several associations to really understand what is behind the discussion.

Senator Hatch offered some final comments. He commented that this meeting was better than he expected. From his perspective, "We weren't looking for agreement; we were looking for a discussion." For any politician to sit for three hours and listen is a chore. It is important that all of the stakeholders are here; these are industries that are really important to elected officials. One of the things Senator Hatch said he learned today is that there are different objections. He thinks people felt legislators were all putting stakeholders all in the same category. What is needed in order to push this in the legislature is to have meetings with these different industries mentioned, and really find out what kind of objections you have. The other thing he will ask is how this can move forward. He thinks stakeholders are much closer in sharing common objectives. Achieving a path forward means a focus on the needs and what must be done for all to be satisfied that the other is not interfering with you. In the end, it's really the consumer that has to have more choice and more satisfaction.

Senator Hatch related a personal story. "I have a father who is 94 years old. For eight years my sister says he's got early stage dementia. Well, he's 94 and she finally stopped saying that last year. He's just old, but as a family member we wondered. When we put him into independent living, that gave us some comfort, that's different than a nursing home, to tell us, 'Yeah, Dad has that' or doesn't. We were stuck as consumers to find out what do we do, where we go."

Senator Hatch said it is clear that both sides of the aisle want to do something. It is just a different way that these different industries are looking at it, and that will be worked through. Hatch will also have meetings with interested groups, and mentioned that Senators Pam Jochum and Jeff Danielson have been involved in this legislation. The legislators will be coming to stakeholders and asking to find a solution. They will be seeking clarity and hope to arrive at something that is good for everybody. They will try to figure out what is their next best step. Senator Hatch said he has talked to Representative Dave Heaton, who knows what is going on, and they will continue to confer. Senator Hatch is very excited about moving something next year, but does not want to get stuck because stakeholders are fighting with each other. The Advisory Council has put in an enormous amount of time. Senator Hatch thanked those present for keeping him in touch with the work of the Initiative and providing information and educating him.

### **Public Comment Period**

The public comment period included two additional remarks.

- As we look forward, as a DCP, most of us love what we do, and our biggest concern is the consumer and we want what is best for them, and someday that might be me. The majority are looking out for the little guy a lot of times.
- Julie McMahan, IDPH, noted that it was a good discussion and it got to some of the issues as far as CNA, disability, and support. Whatever we come up with needs to address all of those.

No other public comments were made.

McKeen thanked all for their participation and closed the meeting.